Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue: Board Room, SGH

Date: 4 February 2016; 1330h – 1630h

Members attending:

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

In attendance:

Mrs C Rickards	(CR)	Trust Convenor
Ms R Wilkin	(RW)	Director of Communications
Mr A Kenny	(AK)	Director of Estates

Board Support

Mr D Whitehouse	(DW)	Head of Corporate Governance

Time	Item	Title	Reference Number	Lead
1330	1.	**Apologies**	Verbal	DW
	2.	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting.*	Verbal	Chair
1335h	3.	**Patient story**	Presentation	CO
1355h	4.	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 7 January 2016 as a true and accurate records of discussions*	SWBTB (01/16) 218	Chair
	5.	**Update on actions arising from previous meetings**	SWBTB (01/16) 219	DW
1405h	6.	**Questions from members of the public**	Verbal	Chair
1420h	7.	**Chair's opening comments**	Verbal	Chair
		UPDATES FROM THE BOARD COMMITTEES		
	8.	Update from the **Configuration Committee** held on the 22 January 2016	To follow	RSM/ TL
	9.	Update from the **Public Health, Community Development & Equality Committee** meeting held on the 28 January 2016	To follow	RSM/ TL

Time	Item	Title	Reference Number	Lead
	10.	Update from the **Audit and Risk Committee** meeting held on the 28 January 2016	To follow	**RR/ KD**
	11.	Update from the **Finance and Investment Committee** meeting held on 29 January 2016	To follow	**RSM/ TW**
	12.	Update from the **Quality & Safety Committee** meeting held on 29 January 2016	To follow	**OD/ CO**
	MATTERS FOR APPROVAL OR DISCUSSION			
1435h	**13.**	**Chief Executive's report**	SWBTB (02/16) 225	**TL**
1450h	**14.**	**Trust Risk Register**	SWBTB (01/16) 226 SWBTB (01/16) 226(a)	**KD**
1500h	**15.**	**Board Assurance Framework**	SWBTB (01/16) 227 SWBTB (01/16) 227(a)	**KD**
1510h	**16.**	**Draft 3 Year Clinical Effectiveness/ Quality Objectives**	SWBTB (01/16) 228 SWBTB (01/16) 228(a)	**RST**
1520h	**17.**	**3 Year Safety Plan: Draft Always Events**	SWBTB (01/16) 229 SWBTB (01/16) 229(a)	**CO**
1530h	**18.**	**R&D Plan update**	SWBTB (01/16) 230 SWBTB (01/16) 230(a)	**RST**
1540h	**19.**	**Financial Performance – P09 December 2015**	SWBTB (01/16) 231 SWBTB (01/16) 231(a)	**TW**
1550h	**20**	**Integrated Performance Report**	SWBTB (01/16) 232 SWBTB (01/16) 232(a)	**TW**
1600h	**21.**	**Safe Nurse Staffing**	SWBTB (01/16) 233 SWBTB (01/16) 233(a)	**CO**
1610h	**22.**	**Information Governance Toolkit**	SWBTB (01/16) 234 SWBTB (01/16) 234(a)	**KD**
	MATTERS FOR INFORMATION			
1620h	**23.**	**Q3 Complaints and PALs Report**	SWBTB (01/16) 235 SWBTB (01/16) 235(a)	**KD**
	24.	**Any other business**	Verbal	**All**
	25.	**Details of next meeting** The next public Trust Board will be held on 3 March 2016 at 1330h in the Anne Gibson Board Room, City Hospital.		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC

Venue Anne Gibson Board Room, City Hospital **Date** 7 January 2016 1.30pm – 5.10pm

Members Present

Mr Richard Samuda	Chair
Ms Olwen Dutton	Vice Chair
Dr Paramjit Gill	Non-Executive Director
Mr Mike Hoare	Non-Executive Director
Mr Robin Russell	Non-Executive Director
Cllr. Waseem Zaffar	Non-Executive Director
Mr Toby Lewis	Chief Executive
Ms Rachel Barlow	Chief Operating Officer
Miss Kam Dhami	Director of Governance
Mrs Raffaela Goodby	Director of Organisation Development
Mr Colin Ovington	Chief Nurse
Dr Roger Stedman	Medical Director
Mr Tony Waite	Director of Finance & Performance Management

Also in attendance:

Mrs Chris Rickards	Trust Convenor
Ms Ruth Wilkin	Director of Communications

Board Support:

Mr Duncan Whitehouse	Head of Corporate Governance

Minutes	**Paper Reference**
1. Apologies.	
Apologies were received from Mr Harjinder Kang.	
2. Declaration of interests	
There were no declarations of interest.	
3. Patient Story	
Due to technical issues with the IT equipment the patient story was not shown.	
4. Minutes of previous meeting – 3 December 2015	SWBTB (11/15) 204
Resolved: the minutes of the previous meeting were agreed as an accurate record with the addition of Mr Mike Hoare being in attendance and the changes as discussed. In regard to the Integrated Performance Report the dataset in terms of workforce vacancy figures were being analysed through the Group Review process over the coming weeks. This was part of the assurance process in terms of getting an accurate vacancy figure for the Trust. A line by line exercise was being undertaken to ensure a starting point for business planning for the coming year that was accurate. Mr Lewis suggest that he expect the 'true' vacancy figure would	

be closer to 400-500 rather than the current 780 once the data had been cleansed.	
5. Update on actions arising from previous meetings The action log was agreed.	
5.1. Patients on waiting list pre dating eDTA introduction Ms Barlow provided an update on patients on the waiting list pre dating eDTA introduction. There was one patient waiting in December who had now received treatment. This was important because our consent model relies on completion prior to wait listing. In response to a question from Mr Lewis Miss Dhami highlighted that monthly audits were being carried out and the upshot of those would return to the Board in May.	
6. Questions from members of the public	
There were no questions from the public on this occasion.	
7. Chair's opening comments	
Mr Samuda highlighted the event that would be taking place on the 22 January 2016 to mark 1,000 days until the opening of the Midland Metropolitan Hospital. He encouraged as many Board members to attend the event as possible. He highlighted the amount of work still left to do. He once again wanted to thank everybody involved in getting us to this point. He was also heartened by the number of partners that had agreed to attend the event.	
8. Minutes of the Quality and Safety Committee held on the 27 November 2015	SWBTB (12/15) 117
Ms Dutton introduced the minutes of the previous Quality and Safety Committee meeting highlighting the positive lessons that were being learnt from the SAU move in terms of bringing disciplines together and building a culture of effective working relationships. The Committee had also discussed performance in respect of readmissions and cancer care waiting times. Mr Samuda highlighted that the Safety and Quality Plans would be coming to the Board in February which provided an opportunity to reflect on the forward programme for the committee.	
9. Minutes of the Workforce and Organisational Development Committee meeting held on the 3 December 2015 and 7 December 2015.	
Mrs Goodby highlighted the detailed discussions that had taken place in regard to the workforce transformation proposals for 2016-18 and the focus on sickness absence and leadership development. Mr Lewis stated that work was taking place within the Executive to ensure recruitment aligned with the pace of priorities the Trust was committed to with the right skills in place to deliver against our ambitions. Mrs Goodby suggested that in March she would bring that work back to the Board. Ms Dutton challenged the communication messages needed in terms of recruiting nurses from overseas whilst making redundancies and the perception this create for some members of the public. Mrs Goodby highlighted there were specific areas where there were shortages in skilled staff and that there were targeted recruitment campaigns to address these shortages which	

included seeking skilled staff from overseas. It was important to recognise that some of these staff shortages were a national issue and not unique to Sandwell and West Birmingham Trust. Mr Lewis made clear that whilst there could be future redundancies, there was no foreseeable expectation that that would affect the areas being recruited abroad. In response to a query from Mr Zaffar it was confirmed that no staff were on zero hour contracts that were directly employed by the Trust, although bank contracts were inevitably zero hours.	
Action: workforce vacancies would form part of the discussion on the workforce transformation work that would be brought back to the Board at its March meeting. **Action: A convincing recruitment end to end process and 'pitch' would be brought to the Board.**	RG RG
10. Minutes of the Finance and Investment Committee held on the 27 November 2015	
Mr Samuda introduced the minutes highlighting the discussions that had taken place around the Capital Programme and the management of the Trust's financial outlook. In response to whether there was any further information from Lord Carter in terms of his national review Mr Waite stated that additional information had been supplied in terms of reference costs and benchmarking information but this needed to be set within the context of more granular local data that would enable informed decisions to be taken going forward. Headline details put the Trust in region of being 3% inefficient which equated to a potential saving in the region of £51m. Further detail was expected from Lord Carter but timescales were unclear.	
11. Minutes of the Charitable Funds Committee on the 3 December 2015	
Mr Zaffar outlined the work that was being undertaken to consolidate and rebrand the trust charity. The changes provided greater flexibility in the use of the funds and importantly would raise the internal and external profile of the charity. There would be further discussion on the Private Board agenda on the matter.	
12. Minutes of the Public Health, Community Development and Equality Committee held on the 26 November 2016	
Mr Samuda introduced the minutes highlighting the conversations that had taken place around protective characteristics. In terms of the Public Health Plan the main area of deviation related to objective 5: reducing alcohol related admissions which was now receiving detailed attention from Dr Stedman. In terms of objective 6: serving food that promotes healthy choices Mr Lewis stated that chip purchases on the Trust's site had reduced by over 50% with a shift to smaller portion sizes. From April new 24-7 hot food vending machines would be offering healthy options together.	
13. Chief Executive's Report	
Mr Lewis introduced the report highlighting in particular the actions taken in response to the failure of the CDA IT system in the run up to Christmas. This had resulted in the loss of data for the period July –December 2015. The majority of data had been recovered and work continued. Some of this data was available in hard copy where it would not be value for money to digitalise. At this point in time it was not possible to give a guaranteed assurance that such failures would not occur again. Dr Stedman stated that a root cause analysis meeting had been organised for the following week in respect of the system failure. He reiterated that the majority of data had been restored but that there were some known areas of complete data loss. Mr Lewis outlined the position whereby the Trust's register of backup systems appeared incomplete. This was being remedied and that he would receive assurances over this and the	

areas of greatest risk over the coming days. In terms of data guardianship the requirements were focussed on a loss of data in terms of confidentiality breaches rather than a complete loss of data. In regard to Oncology there was good progress in terms of recruitment. Discussions were ongoing with UHB and NHSE. Whilst there remained some outstanding issues the intention was to be able to brief patients and GPs during February 2016. Mr Lewis went on to highlight the ongoing work needed around cancer services. Services were safe but needed to be modernised with patient waits still being measured in weeks rather than days. The intention was to quickly move to the standard of service that is delivered elsewhere. There remained practices which if modernised would be more effective. The Board re-agreed to support Aston Medical School, subject to the caveats previously approved in 2014. It was agreed that capacity would be assessed within the Board's workforce committee, and the commercial terms would be considered in the finance and investment committee. Dr Gill sought assurances around the relationship with the University of Birmingham and whether this would impact upon capacity in terms of training places. Mr Lewis gave an assurance that that relationship would continue. He noted that the University of Birmingham was itself looking to alter placement numbers and perhaps focus more work on the Queen Elizabeth Hospital. Ms Dutton sought assurances on the progress against the top 10 annual plan commitments outlined in the Annex to the report. In particular she asked for clarity on actions in regard to commitments 3, 5 and 17. In regard to commitment 3 Mr Ovington stated that work was continuing since the last update to the Board in regard to Ten out of Ten. Implementation continued to be variable which was frustrating but actions were in place to deliver against the plan. Ms Barlow added that most admissions were through the Assessment Units where the holistic assessment of patients was still not consistent on every occasion. Some of these messages came through the recent mock CQC inspections. In terms of commitment 5 (tackling caseload management in community teams) Ms Barlow highlighted that a caseload measurement tool was in place and re-profiling of workloads was underway. Ms Barlow retained close oversight until she has assurances that the right progress was being made. Mr Lewis sated that it was important to define what success would look like. In terms of priority 17 (creating balanced financial plans) Mr Waite noted that most Groups continued to not live within their budget. The LTFM was based on starting the new financial year in a clear recurrent balance position. Levers in terms of CIP delivery and pay control were essential with managers having a clear focus on these.	
Action: The Board supported ongoing negotiations with Aston University and asked the Workforce Committee to review any capacity issues and the Finance and Investment Committee to review any financial implications over the coming 6 months whilst negotiations continued.	RSt
14 Trust Risk Register	SWBTB (01/16) 207 SWBTB (01/16) 207(a)
Miss Dhami introduced the Trust Risk Register drawing the Board's particular attention to the following: • Planned care activity had been below plan with a risk in terms of SLA income.	

• An ongoing reliance on premium rate temporary staff and the subsequent impact on pay costs. • The scale and pace of CIP development and delivery being behind plan. Mr Samuda challenged the extent to which the remedies that had been put in place were truly sticking. Ms Barlow responded by saying that in terms of planned care there was capacity if theatres operated differently to how they do now. She had met with Clinical Directors who understood the need to utilise full capacity of the theatre lists and that under utilisation could not continue to be tolerated. In terms of booking capacity on a six week cycle then there was not yet consistent oversight in terms of recycling appointments where patients had cancelled. There remained variance across specialities which needed to be there and demand/ capacity issues needed to be managed more effectively. Mr Lewis pointed out that improvements could no longer be made through the use of premium rate working. Capacity needed to be built without recourse to throwing money at the issue. He highlighted the income plans for the coming year and the plans around planned care and elective outpatient procedures and in terms of repatriating work. Ms Dutton challenged the extent to which middle managers were brought in to the journey that needed to be taken and their role in managing the financial pressures facing the organisation. Ms Barlow highlighted that that in terms of middle managers the Trust was on a journey. Buy in was strong in some areas and less so in others. Mr Lewis reiterated the need to book capacity against all three priorities in terms of case mix, weight and volume with volume being the key priority moving forwards. In terms of pay bill costs Mr Waite stated that pay remained flat. Significant action had been taken to address agency usage with agency requests now being signed off at Executive level by the Chief Nurse. There was a shift away from the use of premium rate agency staff. In terms of sickness absence November had seen an increase to 5.1%. Mr Lewis highlighted the expectation that there would be a spike in ill health dismissals as a firmer grip of long term sickness management came through the system. In terms of CIP delivery the major schemes had been identified. The need was to ensure effective and timely planning and execution of these. Mr Lewis highlighted the key issues around reaching end of year targets and the cash burn that had been occurring. He asked for the Board Assurance Framework to be brought to the February Board meeting to permit a wider discussion of the risks and control measures in place against our key priorities. Ms Dutton queried the RAG rating of some of the risks highlighted in the register. Taking risks 566 and 770 as examples it was unclear why the residual risk score remained red when there appeared to be adequate remedies in place. It was agreed that the residual risks scores would be reflected upon outside of the meeting.	
Action: that the Board Assurance Framework be added to the agenda for the February Board meeting.	**KD**
14.1 Line management of doctors	SWBTB (01/16) 191 SWBTB (01/16) 191(a)
Ms Barlow introduced the paper stating that the report had been produced to ensure clarity around the line management arrangements and how these would be standardised across the Trust in terms of consistency of responsibilities and accountabilities and in terms of ensuring staff	

welfare. Mr Samuda queried whether there had been any resistance to the changes proposed. Ms Barlow responded by saying that there was a risk around wanting to protect professional silos. A lot of progress had been made however and discussions had been positive such as in terms of how registrars were managed. Surgery B and Women and Children's stood out in terms of performance but there remained a few senior leaders who retained an old fashioned approach. Mr Lewis suggested that in his experience medical staff were not resistant to the proposals. The issue was with managers having the confidence and being comfortable managing a multi-disciplinary team including clinical staff. Dr Gill sought assurances that the welfare of doctors was effectively being picked up. Ms Barlow gave an assurance that they were. Clarity of the working relationships would be made explicit as part of induction of junior doctors.	
Action: Updates on this would be brought through to the Workforce and OD Committee as a standing item.	**RB**
15 Integrated Performance Report	SWBTB (01/16) 209 SWBTB (01/16) 209(a)
Mr Waite introduced the report highlighting that performance against the 4 hour wait standard had fallen in December and hence was unlikely to achieve the monthly or quarter 3 standard. Relative performance was however holding up well. The 62 day cancer wait target had been the subject of discussion at the last Board meeting and December targets were due to be met. Internal and national standards had also been met for Fractured Neck and Femur performance. Ms Barlow highlighted that in terms of Rapid Access Chest Pain standards these were likely to be delivered in January compared to a fall in performance in November. Issues were being addressed in terms of referral and tracking systems on a cross site basis. The expectation in terms of RTT was that incomplete RTT measure will be met over the coming 3 months. Miss Dhami highlighted the ongoing progress in terms of responding to complaints within agreed timescales. The change in data in April was a consequence of a miscalculation against the definition which had now been corrected. Overall 100% of complaints were being acknowledged within 3 working days of receipt.	
15.1 Learning Disabilities: Peoples Parliament	SWBTB (01/16) 210 SWBTB (01/16) 210(a)
Mr Ovington introduced the report highlighting that with the introduction of a Lead Nurse for Learning Disability at the City site there was now consistent coverage over the two sites. There was an action plan in the report that set out the compliance and next steps against local and national standards. There was a proposal to work with organisations such as Changing our Lives to undertake an audit of progress against the standards from April 2016. Mr Zaffar sought clarity over the extent to which staff were trained in regard to the Mental Capacity Act. Mr Ovington confirmed that training was delivered to all staff through induction with targeted awareness raising sessions across the organisation where appropriate. Dr Stedman highlighted that the Trust had commissioned work around mortality of those with a Learning Disability. Mr Lewis challenged the plan, and suggested that it should not be approved by the Board, because the forward actions did not reconcile to the five commitments. In that vein he sought	

further assurances around certain elements of the plan including effectively identifying and flagging patients with LD, patients' records developed in conjunction with service users and increasing the number of people with LD employed by the Trust. There was a lot of work being undertaken in these areas but further assurances were needed. Tangible deliverables and success criteria were also needed. Mr Lewis went on to highlight frustration in terms of GPs having an LD register that the Trust was unable to access. There may be potential to work with a small group of local GPs to develop options around how to more effectively share information going forward. This would be best achieved through informal channels, as for 18 months the approach being used locally had not delivered.	
Action: A revised more detailed action plan to be brought back to the Trust Board in Q1, together with an update on progress.	**CO**
16. Financial Performance Report	SWBTB (01/16) 211 SWBTB (01/16) 211(a)
Mr Waite introduced the report highlighting the focus on the delivery of an improved run rate position. Target delivery included significant use of contingencies. In November I&E saw a deficit of £821,000 which was £1,991, 000 adverse to plan. There was now no clear route through to achieving a £5m stretch surplus target. Mr Lewis informed the Board that there remained a number of disputes with local bodies in terms of payments that were being progressed through dialogue. He highlighted that the Audit Committee may want to reflect on the accounting of these as the outcomes of these negotiations became known. Mr Waite highlighted that the Trust had issued a draft SLA in respect of Maternity Services which was currently out for comment then agreement. There had been constructive feedback from the Women's Hospital who had been supportive in the drafting of the SLA. Dr Gill raised the issue of the cost of drugs and the opportunities to work with local GPs around prescribing discrepancies in terms of the cost of the drugs. Dr Stedman highlighted the role the Area Prescribing Committee had in terms of issues of this nature. Mr Lewis stressed the opportunity to start discussions around this with local GPs to work this idea up further. He suggested that work be undertaken outside of the meeting with a report brought back to the June Board.	
Action: discussions to take place around developing local protocols around prescribing drugs and the use of generic drugs where appropriate.	**RST**
17. CQC Improvement Plan	SWBTB (01/16) 212 SWBTB (01/16) 212(a)
Miss Dhami introduced the report stating that following on from previous discussions at the Board the report provided an update on the delivery of the CQC Improvement Plan and how the in house inspection process had been used to test progress against the plan. Headlines in terms of the feedback from the recent mock inspections was that action had been taken in some areas such as new lockable trolleys, the identification of patients with a DNACPR order and resuscitation trolley check. There were however also examples of actions that needed further attention such as person centred care documentation, the embedding of Ten out of Ten and reductions in sickness rates and consistent hand hygiene. There remained clear messages around staff being caring. The intention was to link clinical and internal audit activity to the improvement plan to retain a focus on improvement. Consideration would also be given to peer audits. Mr Samuda queried whether these mock inspections would continue now that we had feedback from the first round.	

Miss Dhami said that the mock inspections had gone well and had received very positive feedback from those that had taken part. We were currently taking stock and considering how these could be rolled forward in the future taking on the feedback provided.	
18 Wider Safe Staffing- taking a wider view	SWBTB (01/16) 213
Mrs Goodby introduced the report that provided a detailed update in regard to safe staffing beyond simply nursing staff. This work included a focus on ward clinical teams and clinical time spent directly caring for patients. The 7 day working pilot work was being fed into this process. Dr Stedman highlighted the number of out of hours contact with patients and the example of 4 junior doctors covering one ward during the day and the same number of junior doctors covering a number of wards at night. Ms Barlow expressed caution in terms of the data accuracy and the need for a more in depth table top review of rotas to more effectively identify and verify the time spent on wards and for verification through Group management structures. Mr Lewis stressed the need to be in a place where we could clearly articulate where people worked especially given the work being undertaken around workforce transformation.	
Action: The Chief Operating Officer, Chief Nurse, Medical Director and Director for Organisation Development to undertake further work with a report back to the Board in April 2016.	
18.1 Safe nurse staffing	SWBTB (01/16) 214 SWBTB (01/16) 214(a)
Mr Ovington introduced the report highlighting the ongoing manual collection of data which was being checked daily. This method was providing the most accurate picture of what was going on the ground. In terms of issues then in terms of Maternity and Women's and Children's the figures were not reflecting the feedback from the nurses in those areas. Mr Ovington reported that the bank nurse module had been introduced but was being subject to testing in terms of assurances on accuracy. A report was requested back to the March Board in terms of e-rostering. Mr Lewis highlighted the data in terms of the Children's Wards at Sandwell and if these were not correct the fact that this was yet to provide real assurance to the Board.	
Action: that the March safe staffing report include an update on e-rostering.	**CO**
19. Fully staffed-apprenticeship delivery at SWBH	SWBTB (01/16) 215 SWBTB (01/16) 215(a)
Mrs Goodby introduced the paper setting the context in terms of the announcement made to introduce an Apprenticeship Levy where all organisations with a pay bill in excess of £3m would be required to pay a levy equivalent to 3% of their wage bill and collected through PAYE. This levy would come into effect from April 2017. The Trust had a target of creating 100 apprenticeship roles annually. The new national targets would increase that to 200. The new announcements would mean they would now form part of the Trust's staffing establishment. The paper set out three options as to the actions the Trust could take with option two being the recommended option. These options were to: • Continue with the Trust's existing approach but double the number of apprenticeships.	

• Introduce apprenticeship first where an apprenticeship is the first choice for vacant band 1-3 positions • Introduce a combination of options one and two over a transition period Mr Samuda sought clarification on whether there would be any exceptions. Mrs Goodby highlighted that potential exceptions would include where there would be a large number of apprenticeships in one area unbalancing the skill and experience mix within a team, where there may be permanent staff at risk or where there was no training path or formal skill requirements. Mrs Rickards highlighted potential issues in apprenticeships being offered one years training and support whilst regular appointments to a role may expect to be trained after 2-3 weeks. This may lead to people being paid on an apprenticeship rate when actually fullfilling the full role after a short period of time. She also challenged why the focus on only bands 1-3 roles. There was a need to look at substantive posts and where there were appropriate career opportunities. She warned of the risk of timing in terms of implementation. A sudden increase in apprentices at a time when redundancies were being made risked people accusing the Trust of making cuts to permanent roles to replace them with cheaper apprenticeship roles. If the apprenticeship programme was to work then there needed to be the right mix of staff. Mr Lewis queried why we would exclude certain groups of staff in terms of the opportunities for apprenticeships. He reiterated that it was government policy to increase the number of apprentices across larger organisations. He rebutted any concerns anybody had in terms of cheaper workforce reiterating the Trust's commitment to the minimum wage. He also highlighted that the Trust already had higher banded apprenticeships that were working successfully. He said it would be important to monitor hire rates for apprenticeships to dispel the accusation that apprentices were being taken on but then not hired after 1 year resulting in a perpetual apprenticeship cycle in some roles. He highlighted that the Trust's commitment was already to ensure all jobs came with a training commitment which was a core value of the Trust. Mr Lewis made clear that the funding of the levy was a corporate risk.	
Resolved: that the Board endorse the option of an apprenticeship first approach from April 2016 in advance of the government requirement of April 2017, applying it to all bands 1-4 roles	**RG**
20. Annual Equality Report	SWBTB (01/16) 216 SWBTB (01/16) 216(a)
Mr Ovington introduced the report stating that the Trust is required to produce an annual diversity report which must be published by the 31 January 2016. An updated version would be shared at the end of the week and feedback from Board members was welcomed. Mr Lewis queried the references to volunteering within the draft document. It was agreed that Board Members provide feedback to Mr Ovington and that the final version be agreed and signed off by the Public Health, Community Development and Equalities Committee before the deadline for submission.	
Action: that the Board provide feedback to Mr Ovington on the Annual Equality Report and that it is delegated to the Public Health, Community Development and Equality Committee to sign off the final version of the report.	**RG**
21 Any Other Business	
No items were raised under any other business.	
22 Details of the next meeting : 4 February 2016	

The next meeting will be held in the Board Room, SGH, commencing at 1:30pm.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board Action Tracker

Last Updated: 29 January 2016

	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.488	CEO Report	SWBTB (8/15) 123	06-Aug-15	Mutual Tolerance Report at 6 months	TL	01/03/2016	Report scheduled for the March 2016 Board meeting.	Open
SWBTBACT.486	Consent on the day of surgery	SWBTB (7/15) 122	06-Aug-15	Provide update with analysis of how many people on our waiting list pre-date eDTAs introduction	RB	07/01/2016	Update was provided to the 7 January Board meetingstaing only 1 preson on waiting list in December who has now received treatment.	Closed
SWBTBACT.508	Chief Executive's Report	SWBTB (11/15)	11-Nov-15	Partnerships to be considered at next Board Development Session	RSM	19/02/2016	The matter was deferred from the December Development Session	Open
SWBTBACT.509	Kirkup Report	SWBTB (11/15) 180	05-Nov-15	Report back on duty to ensure inter personal and inter professional relationships within obstetrics and maternity	CO	07/01/2016	Report considered at the Private Board in January 2016. Learning from obstetrics and maternity to be used as a basis for developing early warning indicators through governance review process	Closed
SWBTCACT.510	Smoking Cessation	SBBTB (11/15) 181	05-Nov-15	Updates to be provided to the Board as the policy is progressed	TL		Update to be given at a future meeting	Open
SWBTBACT.511	Matter arising from 6 August	SWBTB (10/15) 172	06-Aug-15	R&D Plan to be considered by the Board	RG	04/02/2016	Report scheduled for the February 2016 meeting	Open
SWBTBACT.512	Integrated Performance Report	SWBTB (12/15) 192	03-Dec-15	Report back to the Board in Quarter 4 2015-16 regarding progress around cancer targets	RB	03/03/2016	New action	Open
SWBTBACT.513	Integrated Perfromance Report	SWBTB (12/15) 192	03-Dec-15	Report back on progress around the Trust's 5 Learning Disability commitments	CO	07/01/2016	Paper considered at the January 2016 Trust Board. See SWBTACT. 521 for subsequent actions.	Open
SWBTBACT.515	Integrated Performance Report	SWBTB (12/15) 192	03-Dec-15	Report setting out the management accountabilities for junior doctors	RB	07/01/2016	Report was considerd at the January 2016 Board meeting. Future updates to the Quality and Safety Committee.	Closed
SWBTBACT.517	100,000 Genome Project	SWBTB (12/15) 202	03-Dec-15	Board update on palliative care and patients ability to choose where they die	RSt	03/03/2016	New action	Open

SWBTBACT.518	The contribution of volunteers to SWBH	SWBTB (12/15) 199	03-Dec-15	Meeting to be organsied to cohere ambitions in terms of contribution of volunteers and for a report back to the Board	CO		Updated action	Open
SWBTACT.520	Mortality update	SWBTB (12/15) 193	03-Dec-15	Update on palliative care coding changes	RSt	04/02/2016	New action	Open
SWBTBACT.521	Learning Disabilities: People's Parliament	SWBTB (01/16) 210	07-Jan-16	1 page scorecard to be developed providing assurances around objectives and in particular objectives 1, 4 and 5	CO		New action	Open
SWBTACT.522	Chief Executive's Report	SWBTB (01/16) 206	07-Jan-16	Briefing note to be issued to the Board on mitigation actions around IT systems and register of backup systems.	TL		New action	Open
SWBTACT.523	Financial performance	SWBTB (01/16) 211	07-Jan-16	Report to June meeting on list of generic drugs agreed between Trust and GPs	RSt	02/06/2016	New action	Open
SWBTACT.524	Wider safe staffing	SWBTB (01/16) 213	07-Jan-16	Report back on table top review of ward rotas determining accurate ratios of wider staff time on wards.	RG	03/03/2016	New action	Open
SWBACT.525	Safe nurse staffing	SWBTB (01/16) 214	07-Jan-16	Safe staffing update to include update on implementation of e-rostering system	CO	03/03/2016	New action	Open
SWBACT.525	Minutes of Workforce Committee	SWBTB (12/15) 117	07-Jan-16	A convincing recruitment end to end process and 'pitch' would be brought to the Board.	RG	03/03/2016	New action	Open
SWBACT.526	Minutes of Workforce Committee	SWBTB (12/15) 117	07-Jan-16	Workforce vacancies would form part of the discussion on the workforce transformation work that would be brought back to the Board at its March meeting	RG	03/03/2016	New action	Open
SWBACT.527	Learning Disabilities: Peoples Parliament	SWBTB (01/16) 210	07-Jan-16	A revised more detailed LD action plan to be brought back to the Trust Board in Q1, together with an update on progress.	CO		New action	Open
SWBACT.528	Wider Safe Staffing- taking a wider view	SWBTB (01/16) 213	07-Jan-16	The Chief Operating Officer, Chief Nurse, Medical Director and Director for Organisation Development to undertake further work with a report back to the Board in April 2016.	CO, RB, RST, RG	07/04/2016	New action	Open

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE TRUST BOARD HELD IN PUBLIC

Chief Executive's Report – February 2016

The period being reported at today's Board has been one of considerable contrast. As last month I am reporting significant pressures and business continuity issues. And again at the same time, the tremendous community and partnership celebration behind our 1000 day countdown clock launch has energised many for what is ahead of us. Darren Cooper, John Clancy, Nick Harding, and MPs John Spellar and James Morris supported the celebration ourselves and Carillion undertook on January 22nd - as we look forward to October 2018. The multi-faith blessing for the ground to be developed and the labour ahead talked of a beacon of hope at Grove Lane, both for the NHS and local communities.

Addressing our medium term IT needs through the business case that we will consider in early April (choosing between two suppliers) has to be managed alongside the immediate resilience issues we have seen with CDA and the continued issues with PACs. These slowed care for a week in our Trust. A key theme of our 2015 improvement plan was to make it easier to work in our organisation, thereby tackling retention and morale. The organisation has pulled together to address these issues, but it is wearying for individuals and teams. Modernisation cannot come soon enough.

1. **Our patients:**

In mid-January, our nursing leaders travelled to Manchester to report on the work we have done on focused care. This is typically the enhanced care offered to those with additional needs especially dementia. The four pilot wards at the Trust presented significant improvements in quality of care and experience, and looked ahead to work to be done during 2016. This includes the implementation of John's Campaign in our organisation, designed to welcome and support carers who stay with and help inpatient loves ones. This national initiative sits well with our 2020 vision, and follows on from the open visiting project we applied Trust-wide during 2015. Like Ten Out Of Ten, and the issues implied by today's reports on our three year safety ambitions, the challenge is to take the great practice in some areas and make it Trust-wide. There remains real focus on compassion at the bedside in our Trust, and in the midst of winter pressures it is encouraging to see in the IPR that overnight patient bed moves have again been cut.

As we meet we have a ward at Sandwell closed to flu. This is in spite of the Trust again being in the top 10 nationally for vaccination work. It only serves to underscore the dangers and risks. Good infection practice is being applied, although bed pressures have meant that a clinical risk based judgement led us to have to re-open the ward earlier than we would have wished. Since Christmas we have consistently had 50+ beds open at Sandwell above our winter plans. These rely on temporary doctors and nurses, and inevitably stretch substantive staff further too. In addition to the immediate risks, we risk normalising a completely unacceptable position. It is encouraging that the IPR shows our work to cut unplanned readmissions is beginning to succeed. But for next winter, this summer, and 2018, we need to find the route to cutting average length of stay by half a day.

Meanwhile, we continue to press for a root and branch re-look at how better care funds monies are being committed, given the comprehensive failure of both local programmes to cap or cut admission rates.

Unavoidable elective cancellations have fallen to their lowest level for some time. On the other hand elective volumes are below our plans, with consequent effect on our finances. Our wait list numbers have continued to fall sharply and we remain a low wait organisation compared to local peers. We again met cancer and diagnostic waiting times. Whilst these are national minimum standards, we are sustaining good care. Our commitment to cut first outpatient waits to six weeks or below remains, and we would expect to enter March achieving that in 70% of cases. Cutting DNA rates is part of our plan to balance demand and supply, and it is too early to say with certainty whether our partial booking work is succeeding in that regard. In looking again at elective work for 2016-17 we will need to examine apparently large rises in referrals from areas such as Worcestershire, and whether we truly have capacity to address routine care needs from further afield here.

During 2015-16 we have completed two major service reconfigurations: The move of interventional cardiology to City and the transfer of acute surgery to Sandwell. Data on our key metrics continues to suggest that these have both succeeded in improving quality of care. There is work to do in spring to drive down emergency surgery waiting times further in line with our ambitions. But concerns that the extra travel time involved would create safety or workforce pressures have not been borne out by events, because of the actions taken by our teams. In January's staff feedback seminars (hot topics) we asked for commentary on how patient feedback drove our work. Lots of good ideas were shared. But what is also striking is how we do not always explain that it is patient feedback that underpins many of our changes – these two included. We will make sure we focus survey work in these areas as the changes bed down to make sure that we can match qualitative improvement with the quantitative gains we have reported.

I advised the last Board meeting about our significant progress around food, and the wider public health agenda. Most saliently, chip consumption has halved over the last year. In April new menus kick in which aim to ensure that all 'green' food is the dominant offer at each sitting. Our food summit produced other firm outcomes for coming weeks and months: The installation of 24/7 health hot food dispensers took place this week; efforts to localise supply intensify and we are exploring the right food waste recycling model. Our porcelain plate pilot has not met our wishes and we are now reverting to melanin. In line with the Board's wishes all servings now monitor 'last dish' temperature, as well as first dish.

2. Our workforce

The Trust has exceptional feedback on the training experience of junior doctors in our organisation. As we prepare for the upcoming combined foundation/undergraduate inspection it is clear that we deliver exceptional education and a supportive environment. Since last autumn executive directors have attended every monthly junior doctors' forum to try and improve further communication and learning between the organisation and trainees who routinely bring insight into care at the frontline. During April we will restructure how medical education is organised within the Trust to ensure a single multi-site approach, but also to give even more time to supporting methods like simulation.

We continue that work of engagement and education, but now do so against the disappointing background of the January 12th strike. It is important to reiterate that at City we were able to maintain safety and to observe the action. However, at Sandwell bed flow pressures led to the Local Negotiating Committee (LNC) and Trust leaders agreeing a recall from action. That did not go according to the pre-agreed plans. Attached to this report is a lessons learned review from that failure, reflecting the ideas and views of those involved, and influenced too by feedback from trainees. In summary our plan did not meet a probably foreseeable set of circumstances. It was insufficiently scenario based. At the same time agreed arrangements about how to respond were overruled from London. Our strike planning for February 10th has sought to learn lessons from these experiences, and in particular to operate a command structure from 24 hours prior to the strike that makes major decisions rapidly. Named consultant staff will be in place on each ward and in A&E where typically over 70% of our medical workforce is drawn from trainee ranks. How we cope will reflect in large part the day and night before the strike itself. We will publish on that day documents agreed with the regional BMA about our strike response plans. On February 10th, as on January 12th, our overwhelming priority will be patient and staff safety.

Autumn months had begun to see improvement in our sickness rates. Data for December is less encouraging, with a rise in short term ill health. Seven of eight groups have seen long term sickness fall. This must be the basis with which to enter 2016-17 determined to continue the emphasis on support to staff but also on timely intervention. Dismissal rates are rising as we aim to ensure that by 28 days into someone's absence there is a clear, credible, firm plan understood at Group or Executive level.

We published on time our annual Equality Duty declaration. This month we deploy the tolerance guidance that we debated and agreed in August 2015 at the Board. This is an important change, both for staff, and for patients. It makes unambiguous what we will accept and what we will not. It is clear that for planned care we will exclude patients who abuse our staff, including abusing their race, faith, gender or orientation. Similarly with employees it is clear that the organisation is not neutral in how we view 'banter' or comments, including those on social media. There are no excuses at all for islamophobia or bigotry about disability in our organisation. In the last six months we have taken firm steps to improve safety and security at work in the face of violence. This new guidance takes the same firm stance on psychological attacks.

3. **Our partners**

The Black Country Alliance that we launched in summer 2015 is beginning to see some progress made. After Easter we expect to share interventional radiology cover across a number of local sites at weekends which will make us safer. And we are developing a shared rheumatology service in support of patients in Walsall. This change is part of the wider programme SWBH has to change the shape of medical specialties, getting the balance right between primary care, outpatient medicine and time for specialist and inpatient work. Clearly given research excellence in rheumatology, the larger scale of the BCA is an important step.

The CQC have chosen to place Walsall Healthcare into their special measures regime. It is too early to assess the impact of this on local services in our area. However, investment in physical facilities at Manor may help to slow the flow of ambulance born patients into Sandwell, which has grown

sharply since changes in Stafford. We are exploring any issues arising from the CQC report where we might be able to provide support to our neighbours and partners.

Close collaboration partnerships are being developed with a number of local GP groupings. Two are now at the stage of developing memorandums of understanding as a precursor to longer term contracts. It remains to be seen how this works with CCG-led commissioning. Ideally, we are together able to develop longer term service agreements more consistent with changing and reforming services, which can take longer than the standard twelve month model.

National planning guidance requires provider Trusts to contribute to documents to plan the sustainability and transformation of systems at scale. We understand that we are obliged to join the same system as our CCG decides is relevant, and latest discussions are moving away from the Right Care, Right Here footprint and towards a broader Black Country one, allied to West Birmingham. It is unclear what the Sustainability and Transformation Plans are intended to achieve but we will seek to contribute actively to them as we move towards June. These plans are different to the renewed Better Care Fund work, being undertaken locally, which is no longer focused on preventing admissions (an objective in which it failed in 2015-16) but on reducing other forms of delay including delayed transfers of care. Given the continuing challenges we are faced with from these issues, especially in Birmingham, this could be an important piece of work in the coming months.

4. Our regulators

Other than the issuing of planning guidance, there has been limited interaction with regulators in the last month. Our own in-house inspection process continues and the Board has seen plans for that to be deployed in 2016. We have agreed with the NHS Retirement Fellowship that they will provide some ex-NHS employees, drawn locally and regionally, to contribute a perspective to our inspection squads.

Toby Lewis, Chief Executive

29 January 2016

Annex A – Lessons Learned submission arising from Junior Doctor's strike January 12th 2016

Tuesday 12-01 saw a 24 hour trainee doctor strike which locally was well observed. The Trust built a plan to maintain services where possible, cancelling planned care where necessary. Nationally the BMA expectation was of Christmas Day cover. This was problematic because inpatient acuity and emergency department demand were not remotely akin to Christmas Day, nor were our discharge expectations.

On 11-01, as on 04-01 and for one day in December, Sandwell was considered to be at a level 4 state of escalation. This reflected in particular 50+ beds open beyond our routine bed base and a surge in demand in early afternoon on Monday 11th. This meant stretched cover, but also that there was physically no remaining space for surge capacity on the site.

NHS England guidance issued on 08-01 indicated clearly that sustained pressure should be considered a basis to alter local strike arrangements. This position was not agreed with the BMA.

Services at Sandwell were safe. At City we succeeded in maintaining services and facilitating action. It is very disappointing to everyone that we were not able to do the same at Sandwell. In practice a handful of trainees returned to help, and enormous effort for consultant and nurse practitioner staff saw discharge volumes achieved sufficient to enter the evening of 12-01 in a stable position.

In addition to discussions with the LNC subsequently, a one-off meeting with trainees hosted by the Chief Executive, we completed a post-event review with those involved. This gives rise to some lessons learned relevant to future strike and incident planning. They are listed below.

Issue arising / lesson learned	Suggested future remedy
Plan: The plan agreed with the LNC was not scenario based but static. The EMS escalation agreed with the LNC was belated (16.00 on Monday 11.01)	A clear mathematical model for what will be done in each step of increased pressure is needed. This should be done further in advance than in this case.
Plan: The plan was, at every stage, agreed with relevant local trade union representatives. They were over-ruled from London on January 12th. This raises both practical and perhaps ethical questions.	A written delegation agreement is needed in working with the BMA. This can then be used to tackle untruths with staff and the media and to reinforce trust.
Plan: Standard control group arrangements were not deployed the day before the strike. This allowed confusion to develop about decision making. Decisions were slower and not wholly consistent from 2pm-10pm.	A written normative restatement of how we operate major projects will be shared, together with written instruction to executive directors about decision hierarchy. No external inputs or guidance will vary or confuse this local accountability model.
Plan: For major disruption, we would expect a decision countdown to be in place, together with a clear separation of silver and gold structures. This was fuzzy.	A day-plan will be in place with decision points, permitting senior staff to overview the position. All serious incidents will have a gold and silver command in place, as was true from Tuesday 12th am.
Decision making: It cannot be definitively established that the *only* way to speedily discharge 40+ patients was to recall some FY1/2s. Clinic doctors could have been redeployed the day before. By the time of decision, this was not feasible.	Every ward must have sufficient on the ground manpower to both make decisions and execute them. Visibility of these named individuals should be in place in the control room.
Guidance: No single repository of external guidance and advice was maintained, leading to slower decision making. National guidance was unclear what was agreed with the dispute parties and what was not.	All single signatory documents will be treated as un-agreed in future (e.g. Keogh letter 08-01). Shared drive arrangements will span departments allowing control room access to guidance to allow judgements where that guidance is inconsistent.

Guidance: Internal communications with staff show confusion, or potential confusion, between major and serious incidents. The term major incident was used in the media extensively, where the position was a serious incident with the potential to deteriorate further.	All staff communications for employees in strike situations will be cleared through the communications function.
Communication: There is only 1 area where the Trust did not do what we said we would in the plan. We told staff we would telephone them, but instead wrote to them, once at 4.30 pm on 11-01 and once at 8am on 12-01..	If we do not do not what we say we would, we should be explicit about the change and articulate why it has happened. The letters did not explain why a phone call was not made, albeit phone calls took place between 08.00-10.00 am on 12-01.
Communication: To succeed in deploying c.10 employees we contacted over 200 employees explaining who we needed. There must have been a smarter way to do this.	Our communication model with doctors in training will no longer rely on consultants or medical personnel at FY2 and above level. Local managers will know how to do this, and a central dataset will exist in plans such as a strike.
Communication: No briefing of partners or other organisations occurred before 10am. This was regrettable and may have inhibited public statements of support when the BMA appeared to rescind their prior agreement.	This reflects the failure to create early enough a gold/silver structure, where gold would take responsibility for external liaison. On January 12th good communication was maintained with relevant national bodies to brief them on the issues faced in the Trust.

Discussions with junior doctors illustrate the frustration they feel at the way in which the issues were handled. BMA junior doctors' reps were heavily involved in planning January 12th and will be even more involved for February 10th. Understandably events bring other issues to the fore, including the pressure faced by trainees in winter months. Extensive hours monitoring took place during 2015, but further hours monitoring commenced on February 1st. In addition, we have sought to reinforce the many and various ways in which trainee doctors can raise concerns or issues as they arise, preventing any sense of accumulated grievance.

Annex A – top 10 annual plan commitments : January Monitoring Report

Ref	2015/16 Priority	Exec Lead	Ops Lead	Current status	RAG	Actions in Q4
Safe, High Quality Care						
1	Reducing admissions by 2%*	RB	NR	There is an improving rate in readmissions for December with readmissions (in-hospital) reported at 7.3% for December in-month [8.3% rolling 12 months].This is reflective of recent improvements across the trust but remains a key area of focus.		A continued focus on specialty wards and AMU opportunities and build on hot clinic model now running in surgery.
3	Achieving the gains promised within our 10/10 programme*	CO	DT	There is a concerted focus on consistent implementation of 10/10. This effort is however yet to be translated in consistent application across the Trust. There will be a clear focus on the programme over the coming weeks particularly across ward clinical teams. The CQC mock inspections further highlighted inconsistent application of the standards.		The Board has reaffirmed the importance of consistent application of the 10/10 programme and will continue to seek clear assurances that the plans in place to address inconsistent application are having impact.
5	Tackling caseload management in community teams*	RB	FS	As per prior Board papers work is ongoing, but a single plan of action is not yet visible.		There remains, with focus, a chance to make this a green item, but a change of pace is now needed.

Ref	2015/16 Priority	Exec Lead	Ops Lead	Current status	RAG	Actions in Q4
Accessible & Responsive						
9	Deliver our plans for significant improvements in our Health Visiting provision so children 0-5 years and their families receive high standards of professional support at home	RB	EN	Performance continues to improve but further work still needed to meet KPI thresholds.		Continued improvement is needed to achieve the metrics specified later in Q4.
10	Work within our agreed capacity plan for the year ahead	RB	AM	The Trust is within our capacity plan but is not delivering sufficient volume of care. Reform to remove premium rate working is strong in Surgery A and WCH, less so in medicine, imaging and especially Surgery B.		There is some evidence of change in bookings, but it is not yet translating into productivity indices improvement nor higher overall volumes of work done. The 8-6-4-2 model is proven to be effective but needs to be applied consistently.
Care Closer to Home						
12	Implement our Rowley Regis expansion plans, so that by March 2016 we have in place our Right Care Right Here model on the site*	RB/AK		Plan supported by the Board after extensive patient and staff consultation. Due to finish in next 2 months.		Ensure that the changes in care models in OPD are implemented, not merely a change in physical layout. Finalise the pharmacy option.
Good Use of Resources						
17	Create balanced financial plans for all directorates, and deliver Group level	TW	PS	Ongoing conversations taking place at Trust Board, national bodies and		Continued focus on our 3 areas of emphasis: CIP delivery, agency

Ref	2015/16 Priority	Exec Lead	Ops Lead	Current status	RAG	Actions in Q4
	income & expenditure on a fully year basis*			external auditors. The timing of CIP delivery, agency control and activity booking remains the key issue.		control, and activity booking.
21st Century Infrastructure						
21	Agree Electronic Patient Record Outline Business Case, and initiate the procurement process, whilst completing infrastructure investment programme*	AD	ME	Infrastructure project contracts let and on site. EPR running to timetable with hosting options to be agreed by the Board in February.		Meet the timescales previously agreed and see improvement from infrastructure investment in network resilience.
22	Reach financial close on the Midland Met Hospital*	AK	DL	Financial close took place in December to plan with final decisions signed off by the Chairman, Chief Executive and Director of Finance and Performance Management.		The next phase of work is now well underway and the MPA Committee has been established to oversee progress against all major projects.
An Engaged & Effective Organisation						
26	Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness*	RG	LB	Whilst progress is being made in terms of long terms absence with the expectation of a spike in ill health dismissals coming through the system over coming months short term absence has begun to creep upwards again in December.		There needs to be a strong focus on effective management intervention and support consistently applied across the Trust with a marked improvement in return to work interview rates and recording on the EPR

Ref	2015/16 Priority	Exec Lead	Ops Lead	Current status	RAG	Actions in Q4
						system.

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

Key deliverable	Commitment at July 15 board	Current state – Jan 16
The CLE education committee is overseeing analysis of training requests and training funds vs ESR protected characteristics data.	Work is ongoing with the overseeing of the analysis of training requests and training funds. A comparative exercise will be undertaken in regard to overall band staff profile. A draft will be completed in time for the annual declaration.	On track
The CLE equality committee and whole Board have received initial training in the duties of the Act and in the precepts of the EDS system.	A session is being planned for the February Board Development session.	This will happen during February.
We would undertake an EDS2 self-assessment for any single directorate in the Trust. Almost all directorates have submitted to post a draft for review.	It is to be reviewed in full and final form at the next meeting of the Board's PHCD&E committee.	On track.
Collect, collate and examine protected characteristics data on our workforce and, largely, on our staff: We will undertake a one off ESR data validation.	The use of outpatient kiosks (from Q3) will be our vehicle to improving patient data. Both will be compared through our Board committee against the demographic for SWB as per the ONS.	The start of this was planned for Dec 15 and has been delayed.
Undertaking monthly characteristics of emphasis in which we host events that raise awareness of protected characteristics (PC)		There is a clear schedule for the year ahead in place.
Add into our portfolio of leadership development activities a series of structured programmes for people with PC	Raffaela Goodby will determine how we move ahead by October 2015 with an unambiguous programme which will certainly include a specific BME leadership offer.	Plan developed, staffside consulted - implementation date to commence Q4.
We proposed and agreed with staff-side that Harjinder Kang, as	This work has commenced. Critically we are looking to determine not simply whether our	Method agreed,

Key deliverable	Commitment at July 15 board	Current state – Jan 16
JCNC independent chair, would review whether our workforce policies and procedures match (if implemented) our ambitions and commitments. This was due to occur in Q2 but will now occur in Q3.	policies avoid overt discrimination, but whether they actively take steps to promote diversity.	timetabling to be shared for completion by end of February 16
With partners to ensure a peer group in each protecting characteristic is active [we have BMSOG and there is an emerging LGBT group]	The next CLE committee will review the progress made with Raffaela Goodby in an effort to set a clear timetable for progress,	Consulted with staffside colleagues & programme confirmed at PHCD&E committee (Nov).
Work with senior leaders with protected characteristics for them to provide visible support within the organisation to others	We will start by producing a pictoral representation, and data graph, of who our leaders are. We will also use the next stage of the leadership development programme to explore how issues of diversity can become a more explicit part of our leadership programmes.	Plan developed, implementation date to commence Q4.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Risk Register
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Mariola Smallman, Head of Risk Management
DATE OF MEETING:	4 February 2016

EXECUTIVE SUMMARY:

The Trust Risk Register compromises high (red) risks that have been through the validation processes at directorate / group and Executive Committee levels.

The Trust Risk Register was last reported to the Board at its January meeting and Executive Director updates are highlighted where these were provided for the meeting. There is one additional risk submitted for the Board to review and decide whether to include on the Trust Risk Register. There is one risk that has been fully mitigated and it is therefore proposed that it is removed from the Trust Risk Register.

REPORT RECOMMENDATION:

- **RECEIVE** monthly updates on progress with treatment plans from risk owners for risks on the Trust Risk Register
- **REVIEW and DECIDE** whether to include the additional risk on the Trust Risk Register and to remove the mitigated risk.

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

Accept	Approve the recommendation	Discuss
	✓	✓

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

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

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

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

PREVIOUS CONSIDERATION:

Clinical Leadership Executive, January 2016

FOR DECISION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Risk Register

Report to the Trust Board on 4 February 2016

1. EXECUTIVE SUMMARY

1.1 This report includes the Trust Risk Register and an update on the implementation of the electronic risk system.

2. TRUST RISK REGISTER (TRR)

2.1 Clinical Group and Corporate Directorate risks were reviewed at Risk Management Committee and Clinical Leadership Executive in January.

2.2 There is one additional risk highlighted for escalation to the Board:

- As a result of significant reliance on non-recurrent measures and balance sheet flexibility to support the Trust's financial performance cash balances have been eroded and there is a risk that this may compromise future investment plans. **(**risk reference: **1603)**

2.3 The risk related to no longer being able to offer Rfa or USGF has been updated as the actions have been completed (two replacement Sonosite machines have been delivered). As this is no longer a high risk for Surgery A it has been downgraded by the Group and its removal from the Trust Risk Register is therefore requested. (risk reference: **775**)

2.4 Following discussions at various Executive committees all current (residual) risk scores have been reviewed and updated to reflect where mitigation measures are having a positive effect and/or the frequency of a risk is considered less than originally scored (based on reported incidents, complaints, litigation, etc.). Likelihood scores have therefore been amended for risks **119** (2nd on-call theatre team); **172** (TDA annual plan sign-off); **221** (EPR); **228** (IT stabilisation); **330** (Gynae. US); **410** (SGH Eye OPD); **534** (Oncology standards); **538** (Chemotherapy wait times); and **771** (risk of cancellation).

2.5 The risk related to lack of assurance of standard process and data quality approach to 18 weeks has been updated based on the findings of a review of the breaches. (**214**)

2.6 Actions to recall approximately 1400 babies affected by the national BCG shortage are progressing; as at mid-January babies that are under 3 months old have been vaccinated and those that are over 3 months old will be vaccinated by the end of March. (**332**)

2.7 The oncology risk related to differential and extended chemotherapy wait times between sites has been updated following successful recruitment and audit findings which provide assurances

that wait times have significantly improved; 9 days on each site. Monthly monitoring of performance will continue to check that staff recruitment maintains sustainable change. (**Risk 538**)

2.8 The trauma risk is anticipated to be mitigated January / February as a new trauma operating table is on order. Surgery A informed RMC that the residual (current) risk score was downgraded to a likelihood of 3 (previously 4) based on local mitigation measures. (**Risk number 770**)

2.9 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.

3. ELECTRONIC RISK SYSTEM

3.1 Implementation of the electronic risk system is ongoing. All risk registers provided by clinical groups and corporate directorates have been imported onto the system and implementation is well underway. It is anticipated that all directorates will fully transfer management of their risk registers onto the electronic system during quarter 4 so that the electronic system is in use Trust wide by quarter 1, 2016-17. As at writing all Group / Directorate risks have been imported onto the system and demonstration / Q&A sessions have been held with risk leads from the following areas:

- Community and Therapies
- Imaging
- Pathology
- Facilities
- Women's and Child Health
- MDO: R&D and Informatics
- MMH
- Finance
- Strategy and Governance
- Surgery B

3.2 Electronic risk system demonstration / Q&A sessions are being scheduled with all remaining Groups / Directorates. A "How to…guide" and FAQ is available on the Safeguard landing page and the Risk team continues to provide support and advice.

3.3 Risk register reports at various levels, including the Trust Risk Register, are available for all staff to access on the Connect Intranet System.

4. RECOMMENDATION(S)

4.1 The Board is recommended to:

- **RECEIVE** monthly updates from Executive Directors for high (red) risks on the Trust Risk Register.
- **REVIEW and DECIDE** whether to include the additional Finance risk **(1603)** on the Trust Risk Register and to remove the mitigated Surgery A risk **(775).**

Kam Dhami, Director of Governance
4 February 2015

Appendix: Trust Risk Register

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
114	Live (With Actions)	Human Resources	Human Resources	Cost Improvement Not Met	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment establishment reduction of 1400 WTEs, leading to excess pay costs (1414MARWK03)	4x5=20	The Executive led delivery plan is progressing the reduction of WTEs alongside a change management programme. Learning from previous phases, changes in legislation and broad stakeholder engagement are factored into the delivery plan.	Safe & Sound 2 year programme of workforce change 2014/2016 delivered 407 WTE reduction. Early planning & engagement on 2016/2018 workforce change TDA Deep Dive (30 Sep) completed re. change delivery, learning and plans for 2016/2018. Workshops, consultation and engagement	Raffaela Goodby	31/03/2016	03/11/2015	Quarterly	3x4=12	Treat
119	Live (With Actions)	Maternity And	Maternity 1	Incident	There is not a 2nd on call theatre team for an obstetric emergency between 1pm and 8am. In the event that a 2nd woman requires an emergency c/s when the 1st team are engaged, there is a risk of delay which may result in harm or death to mother and/or child.	2x5=10	Monitoring of frequency of near misses On call theatre team available but not dedicated to maternity (but where possible maternity is prioritised)	Reviewed by TB who advised the risk will continue to be monitored / tolerated.	Rachel Barlow	31/03/2016	22/01/2016	Monthly	1x5=5	Tolerate

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
							Good labour ward management practices and good communication between teams.							
121	Live (With Actions)	Maternity And	Maternity 1	Costs Not Planned	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.	**4x4=16**	Maximisation of tariff income through robust electronic data capture. Robust validation of cross charges from secondary providers.	Options for management of maternity pathways payment between primary and secondary provider for AN/PN care in progress by the Finance Director - with cross provider SLA planned to be in place by end Jan 2016.	Rachel Barlow	31/01/2016	15/12/2015	Monthly	**3x4=12**	**Treat**

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
172	Live (With Actions)	Strategy	Strategy	Loss Of Income	Risk of failure to achieve TDA sign off for annual plan return and failure to develop an integrated TDA annual plan submission compliant with TDA guidance requirements which triangulates the Trust's long term finance, activity and workforce projections, which also align to the Trust's long-term integrated business plan and LTFM.	4x4=16	Existing staff supporting work programme.	Recruit into two vacant posts	Toby Lewis	31/03/2016	22/01/2016	Quarterly	2x4=8	Treat
173	Live (With Actions)	Admitted Care	Priory 4	Service Level Agreement - Operational	Potential loss of the Hyper Acute Stroke Unit due to an external commissioner led review.	4x4=16	Standard operating procedure agreed and in place for data collection and validation. Outcomes rated well nationally. KPI monitoring in place. Review panel feedback being considered as part of strengthening position as preferred provider.	Continued monitoring through SSNAP Meeting held with Black Country Alliance stakeholders to discuss collaboration of Stroke services	Rachel Barlow	01/04/2016	29/12/2015	Monthly	2x4=8	Tolerate

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
								Any individual breach of agreed standards is monitored and pathway amendments made where identified.						
214	Live (With Actions)	Waiting List	Waiting List Management	Performance	Lack of assurance of standard process and data quality approach to 18 weeks.	**4x3=12**	SOP in place Deputy COO for Planned Care appointed Improvement plan in place for elective access All 52w breaches in last 18 months to have a RCA with detailed read across exercise on all opthalmology and orthopeadic breaches. Of RCA's currently undertaken, no evidence of harm caused due to delay. Training of admin staff commenced in November 15. TDA are providing support to the project. e outcome fully implemented.	TDA expert sought to assist in 52 week breach analysis and mitigation programme	Rachel Barlow	31/03/2016	29/12/2015	Monthly	**3x3=9**	**Treat**

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215	Live (With Actions)	Waiting List	Waiting List Management	Performance	Sustained high Delayed Transfers of Care (DTOC) patients remaining in acute bed capacity	4x4=16	ADAPT joint health and social care team in place. Progress made on new pathway. Joint health and social care ward established in October at Rowley.	ADAPT workshop with partners in Q3 to review progress and final implementation plan actions Confirm plans for a joint health and social care ward to be established and funded on the City site in 2016 Providers to social services to work 7 days with improved turnaround and access standards - being addressed through CCG led forum Workshop hosted by Trust in December agreed forward programme of focussed themes to be delivered in Q4. All have KPIs to measure delivery / impact. PMO to be set up and fortnightly meetings in place with partners. EAB and nursing home capacity remain unmitigated risks .	Rachel Barlow	31/03/2016	29/12/2015	Bi-Monthly	3x4=12	Treat

Trust Risk Register

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221	Live (With Actions)	Informatics	Informatics Systems (S)	IT Software - Clinical System Failure / Issue	There is a risk of failure of a trust wide implementation of a new EPR due to insufficient skilled resources in informatics, significant time constraints (programme should have started earlier) and budgetary constraints (high risk that in adding the full costs of an EPR into the LTFM that there is insufficient capital for related and pre-requisite schemes- e.g. Infrastructure Remediation / MMH Infrastructure preparation / Business Plan schemes)	4x4=16	Recruitment of suitably skilled specialist resources for EPR Programme and Infrastructure Stabilisation Informatics LTFM has been reviewed and prioritised with CEO and Finance engagement, to ensure appropriate funding is allocated and protected from additional Trust-wide delivery demands on Informatics Completion of the formal procurement process (SOC, OBC, and OBS) have been completed at speed to claw back time to enable appropriate implementation Board and managerial support for programme ensuring investment in infrastructure dependencies and required resource is prioritised appropriately	Establish formal Programme Board with appropriate governance including approved ToR Development of contingency plans in relation to clinical IT systems will be established, to ensure that if there is any slippage (for example, a TDA query / Legal challenge), there is an alternative and fully considered option. Management time will be given for programme elements such as detailed planning, change management, and benefits realisation	Alison Dailly	01/06/2016	22/01/2016	Monthly	3x4=12	Treat

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

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228	Live (With Actions)	Informatics	Informatics Systems (S)	IT Hardware - Clinical System Failure / Issue	There is a risk that a not fit for purpose IT infrastructure will result in a failure to achieve strategic objectives and significantly diminishes the ability to realise benefits from related capital investments. e.g. successful move to paperlite MMH, successful implementation of Trust Wide EPR.	**5x4=20**	Approved Business Case in place for Infrastructure Stabilisation programme (approved by Trust Board June 2015) Specialist technical resources engaged (both direct and via supplier model) to deliver key activities Informatics has undergone organisational review and restructure to support delivery of key transformational activities Informatics governance structures and delivery mechanisms have been initiated to support of transformational activities Phase 1 Deep Dive completed to identify detailed IT infrastructure issues - network element completed end May 2015	Review of resourcing requirements undertaken and appointment of additional specialist resources	Alison Dailly	01/04/2016	22/01/2016	Monthly	**4x4=16**	**Treat**

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
325	Live (With Actions)	Informatics	Medical Director's Office	Unauthorised Disclosure Of Info	There is a risk of a breach of patient or staff confidentiality due to inadequate information security systems and processes which could result in regulatory and statutory non-compliance.	**4x4=16**	Prioritised and protected investment for security infrastructure via Infrastructure Stabilisation approved Business Case Specialist Security Manager recruited on interim basis, to provide immediate focus to upgrades, improvements, and IGTK and best practice activities and standards, for onward knowledge transfer and documentation of approved process	Review all NHS Mandates for Informatics and Clinical Systems and ensure compliance to these Deep discovery activities undertaken to flush out 'under the cover issues' End of XP and Win 2003 support to be given higher priority to ensure this issue is mitigated (WIN 7 migration), This may involve the use of external consultancies to speed up process.	Alison Dailly	31/03/2016	06/01/2016	Monthly	**2x4=8**	**Treat**
326	Live (With Actions)	Emergency And Accident & Emergency (C)		Staffing	Not all shifts have an appropriately trained trauma nurse on duty due to a lack of nurses trained in ATNC or equivalent which could compromise the quality of care.	**5x3=15**	All shift coordinators have ATLS qualifications. The peer review team advised that these staff should have the Advanced Trauma Nurse Course (ATNC) or equivalent. Local trauma teaching in place.	All staff within ED are being trained through a rotation course to achieve ATNC.	Rachel Barlow	31/12/2015	29/12/2015	Bi-Monthly	**4x2=8**	**Treat**

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
327	Live (With Actions)	Interventional	Imaging Management (C)	Recruitment	Reduced ability to provide an Interventional Radiology service as a result of difficulties in recruiting Interventional Radiology consultants, results in delays for patients and loss of business.	4x3=12	Interventional radiology service is available Mon - Fri 9-5pm across both sites. The QE provides an out of hours service for urgent requests. IR specialist recruited to support and locum arrangements in place to cover IR Consultant leave.	Discussions have taken place with BCA partners to look at options for providing a weekend service. Discussions have taken place with BCA partners to look at joint provider options. Substantive Consultant post being discussed with potential candidate.	Rachel Barlow	31/03/2016	15/12/2015	Bi-Monthly	2x3=6	Treat
328	Live (With Actions)	Operations	Operations Management	Staffing	Clinical Groups are unable to transact basic business processes because of key person gaps resulting in performance delays and failures.	4x4=16	Investment in high quality agency staff and internal cover of the senior team	Recruitment making positive progress with a number of key appointments over Q2 Key vacancies covered with high quality interims	Rachel Barlow	31/12/2015	29/12/2015	Quarterly	3x3=9	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
								Recruitment to Medicine Director Operations in train. Interviews scheduled early February. Deputy COO planned care recruitment to start in January. Deputy COO for Urgent Care vacant and uncovered in Q4.						
329	Live (With Actions)	Maternity And	Maternity 1	Service Level Agreement - Operational	Current sonography capacity is restricted resulting in a number of women having dating USS performed > 12/40 and some being outwith the screening window and therefore not receiving screening as per National NSC guidelines which results in the potential for an inequitable service for those women choosing to book at SWBH.	**3x5=15**	Implemented alternative ways of providing services to minimise impact. Additional clinics as required Use of agency staff by Imaging to cover gaps in the current service. Ongoing review of referrals to ensure inappropriate scans are not being undertaken and requests are in line with best practice guidance.	Recruitment and retention strategy ongoing Training being scoped to support the development of Sonographers and other disciplines in house. Programme to start Q4 2015-16	Rachel Barlow	31/03/2016	15/12/2015	Monthly	**5x2=10**	

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330	Live (With Actions)	Gynaecology_Gyna	Gynaecology (C)	Recruitment	Provision of ultra sound support for Gynaecology services is at risk due to difficulties in recruitment and retention of ultra-sonographers which results in the potential for delayed diagnoses, failure to achieve 31 day cancer investigation targets plus impacts on the one-stop community service contract. Group lack confidence that the team will be able to maintain 100% attendance in the CGS resulting in the contract being at risk.	3x4=12	Use of agency staff by Imaging to cover gaps in the current service Robust communication with Imaging for timely alerts when sonography not required in clinics to ensure efficient use of sonography time.	Recruitment and retention strategy ongoing Training being scoped to support the development of sonographers and other disciplines in-house.	Rachel Barlow	31/03/2016	15/12/2015	Monthly	2x4=8	Treat
331	Live (With Actions)	Maternity And	Community - Midwifery (C)	IT Software - Clinical System Failure / Issue	BadgerNet connectivity problems associated with the use of I Pads is affecting Community Midwives' (CMW) ability to access/ update patient live records.	4x4=16	A proforma has been developed to enable CMWs to send critical information to the IT service desk. CMW have the ability to download patient caseloads whilst online so can access offline via their IPads.	IT Service Desk liaising with maternity and CSUs to install BN client onto GPs PCs.	Rachel Barlow	01/06/2015	29/12/2015	Monthly	3x4=12	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
							Utilisation of local super users and dedicated midwife for day- to- day support. CMW reverts to peer notes for retrospective data entry if unable to input data in real time							
332	Live (With Actions)	Maternity And	Maternity 1	Vaccination	National shortage of intradermal BCG vaccination leading to a potential increase in babies affected with TB.	**5x4=20**	Pooling all available vaccines from other areas in the Trust Getting the maximum number of doses out of each vial when opened to prevent unnecessary wastage. Recording of all infants who are discharged who qualify but don't receive the vaccine. All the community midwives informed that infants will be discharged without being vaccinated.	Clinics commenced Oct 2015 - 1400 babies to be recalled. As at mid-January babies that are under 3 months old have been vaccinated and those that are over 3 months old will be vaccinated by the end of March.	Rachel Barlow	31/03/2016	12/01/2016	Monthly	**4x4=16**	**Treat**

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
							Inform parents of eligible infants of the shortage and how to raise any concerns with relevant agencies. Extra vigilance by CMW in observing and referring infants where necessary.							
410	Live (With Actions)	Ophthalmology	Outpatients - EYE	Clinical Environment IC Related	Risk of Breach of Privacy and Dignity Standard, Information Governance Risk and Infection Control Risk at Sandwell 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. Risk that either a patient's health, or privacy/dignity will be compromised as a consequence of poor building design. Clean / dirty utility failings cannot be addressed without re-development of the area.	**5x4=20**	Reviewing plans in line with STC retained estate Staff trained in IG and mindful of conversations being overheard by nearby patients / staff / visitors	To rectify IC / IG issues or re-locate to another suitable workspace	Rachel Barlow	01/04/2017	26/01/2016	Quarterly	**4x4=16**	**Treat**

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Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
533	Live (With Actions)	Scheduled	Oncology Medical	Service Level Agreement - Operational	The Trust has excess waits for oncology clinics because of non-replacement of roles by UHB and pharmacy gaps.	3x5=15	Being tackled through use of locums and waiting times monitored through cancer wait team.	100% funding increase proposed by Trust. Strategic partnership working with New Cross and Coventry and Warwick. Actively recruiting two Medical Oncologist for SWBH. Regional networking through the Cancer Network	Rachel Barlow	/ /	29/12/2015	Monthly	3x3=9	Treat
534	Live (With Actions)	Scheduled	Oncology Medical	Performance	Trust non-compliance with some peer review standards due to a variety of factors, including lack of oncologist attendance at MDTs, which gives rise to serious concern levels.	3x4=12	Oncology recruitment ongoing and longer term resolution is planned as part of the Cancer Services project.	Meet standards	Roger Stedman	/ /	29/12/2015	Monthly	2x4=8	Treat

Trust Risk Register

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538	Live (With Actions)	Scheduled	Oncology Medical	Performance	Differential and extended chemotherapy wait times between sites due to staff vacancies results in inequality of service for patients.	2x4=8	Review / amend pathway Staff vacancies recruited to. Latest audit (Nov 15) provides assurance that wait times have significantly improved; 9 days on each site.	Monthly monitoring of performance carried out to check that staff recruitment maintains sustainable change.	Roger Stedman	/ /	27/01/2016	Monthly	1x4=4	Treat
566	Live (With Actions)	Emergency And Accident & Emergency (S)		Staffing	There is a risk that further reduction or failure to recruit senior medical staff in ED leads to an inability to provide a viable rota at consultant level which may impact on delays in assessment, treatment and patient safety.	4x5=20	Recruitment campaign through local networks, national adverts, head-hunters and international recruitment expertise. Agree a recruitment and retention premium. Marketing of new hospital plans pending approval of full business case. Leadership development and mentorship. Programme to support staff development. Continued	Recruitment ongoing	Rachel Barlow	31/12/2015	29/12/2015	Monthly	3x5=15	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
							communication and engagement of the Urgent Care Strategy.							
666	Live (With Actions)	Paediatrics	Paediatrics	Incident	Lack of Tier 4 bed facilities for Children-Young people with mental health conditions means that they are admitted to the paediatric ward. There is no specialist medical or nursing MH team to care for their needs with limited access to in/OOH CAMHS support. Whilst safety for the children can be maintained, therapeutic care is compromised and there can be an impact on other children and parents.	**4x4=16**	Mental health agency nursing staff utilised to provide care 1:1 All admissions monitored for internal and external monitoring purposes. Awareness training for Trust staff to support management of patients is in place Children are managed in appropriate risk free environments	The LA and CCG are looking to develop a Tier 3+ service whilst Tier 4 beds are reviewed nationally	Rachel Barlow	01/04/2016	15/12/2015	Monthly	**4x4=16**	**Tolerate**

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755	Live (With Actions)	Informatics	Informatics Systems (S)	IT Hardware - Clinical System Failure / Issue	There is a risk that the Trust's integration engine fails, as 50% of the disks have already failed and are not repairable and the current version is unsupported by the supplier. Resulting in inability to transfer key clinical information between key clinical systems, making these systems unuseable (e.g. CDA, eMBS etc).	4x5=20	Business continuity and communications plans in the event of hardware failure have been put in place. Rhapsody V2 has been successfully transferred off the original failed server onto a virtual server. The transition of Rhapsody 2 to Rhaphsody 5 is in progress.	Put in place business continuity and communications plan for the event of hardware failure. Activities underway to identify how to effectively and safely transition Rhapsody V2 off this server onto a virtual server. Treatment plan is to migrate of Rhapsody V2 to current V5 software. This will require downtime and implementation of business continuity over the migration period. Treatment plan is to migrate of Rhapsody V2 to current V5 software. This is in progress and will require downtime and implementation of business continuity over the migration period.	Alison Dailly	31/03/2016	23/12/2015	Monthly	2x5=10	Treat
768	Live (With Actions)	Elective Access	Elective Access Inpatient	Performance	There is a risk that within a large group of open referrals that there are potentially patients whose clinical or administrative pathway is not fully completed as a result of historical and inadequate referral management which may lead to delayed treatment.	5x3=15	Referral due to be closed on or before 31.10.15 New Deputy COO hired to oversee reform of planned care including referral management	The legacy open referral project was completed in November 2015, which identified that total numbers of open referrals is increasing which indicates inconsistencies in referral processes. Further analysis to identify which cohorts can be electronically closed, after being risk assessed, is taking place.Data quality group to be formed in	Rachel Barlow	01/04/2016	29/12/2015	Monthly	3x3=9	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
							Training for all medical secretaries and elective access team in Oct / Nov.	November to focus on and oversee referral management of data quality Internal audit review to be commissioned in 2016 Closure of c60k open referrals May 15-Dec 15 will commence in January 16. . Automated weekly closure of agreed cohorts from Jan 16. Training plan in development for admin staff with supporting SOPs will commence in Jan 16.						
770	Live (With Actions)	Theatres_Vascular	Theatres - Orthopaedic	Quality Of Care	Risk of Trauma patients requiring traction during surgery being delayed with associated morbidities due to both trauma operating tables being over 15 years old.	**4x4=16**	Increase training for medical and theatre staff to prevent any accidental damage to the table.	Replacement of Trauma Table. Table ordered with expected delivery Jan / Feb (3 mth lead time for this item). As at mid-January the residual (current) risk score was downgraded to a likelihood of 3 (previously 4) based on local mitigation measures.	Rachel Barlow	28/02/2016	12/01/2016	Quarterly	**3x4=12**	**Treat**

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771	Live (With Actions)	Theatres_Vascular	Theatres - 1st	Incident	Risk of cancellation on the day due to the unavailability of instrumentation as a result of off-site sterilisation issues due to the 24 hour turnaround process; migration of equipment; lost damaged instruments; lack of traceability.	4x4=16	Audit by Pan Birmingham team of turnaround times. Non conformance discussed daily and investigated. Monthly Theatre users group meeting with Trust and BBraun. Non conformance presented at TUG monthly. TSSU and Theatre practitioner to follow process at BBraun and spot check theatre compliance. Risk of cancellation on the day due to the unavailability of instrumentation as a result of off-site sterilisation issues due to the 24 hour turnaround process; migration of equipment; lost damaged instruments; lack of traceability. In addition this is compounded by ongoing industrial action 2 strikes have occurred and 2 more planned		Rachel Barlow	/ /	22/01/2016	Quarterly	3x4=12	Treat

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775	Live (With Actions)	Theatres_Vascular	Vascular Services	Medical Equipment	*** PROPOSED REMOVAL OF RISK FROM TRR AS NOW MITIGATED *** Risk of no longer being able to offer Rfa or USGF due to the poor quality and increasing loss of imaging on the screens during surgical procedures due to the age of the two sonosite machines.	1x3=3	Two Sonosite machines delivered.	Two Sonosite machines delivered	Rachel Barlow	31/01/2016	12/01/2016	Quarterly	1x3=3	Treat
1603	Live (With Actions)	Finance		Costs Not Planned	*** PROPOSED NEW RISK FOR TRR *** As a result of significant reliance on non-recurrent measures and balance sheet flexibility to support the Trust's financial performance cash balances have been eroded and there is a risk that this may compromise future investment	4x5=20	Routine medium term term financial plan update Routine cash flow forecasting Routine monitoring of supplier status avoiding any 'on stop' issues.	Establish and deliver operational plan consistent with living within means to mitigate further cash erosion Establish & progress cash generation programme Determine and progress accelerated programme of surplus asset realisation.	Antony Waite	31/03/2018	22/01/2016	Quarterly	3x5=15	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Owner	Expected completion	Latest review	Review	Residual risk score (LxS)	Control potential
					plans.									

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Board Assurance Framework 2015/16 – Quarter 3 update
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Duncan Whitehouse, Head of Corporate Governance
DATE OF MEETING:	4th February 2016

EXECUTIVE SUMMARY:

An updated version of the Board Assurance Framework is attached covering quarters 3 of 2015-16. Of the 32 risks listed in the BAF:

- 26 have a reduced controlled residual risk score following risk controls and treatment and relevant assurances.
- 6 controlled residual scores remain the same following risk control and treatment plans.
- 5 remain red in terms of residual controlled risks scores (006-national waiting time standards; 007-doubling the number of safe discharges; 017-creating financial balanced plans, 018-developing our capital plans and 020-reform of how corporate services operate).
- The priority in terms of reaching financial close on the Midland Met Hospital has been completed.

The 5 red risks have been subject to scrutiny by the Board or relevant Board Committee over recent months.

REPORT RECOMMENDATION:

The Committee is asked to receive and accept the updated Board Assurance Framework and discuss the assurances given 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		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	X
Clinical	X	Equality and Diversity		Workforce	

Comments:

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

Annual plan - Safe high quality care objectives

PREVIOUS CONSIDERATION:

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	001 -SHQC	Reducing readmissions **MF**	There is a risk that re-admission rates for the Trust remain significantly in excess of national norms, particularly at Sandwell Hospital, as result of poor coding or failure to deliver pathway changes accessing urgent acute or community assessment and ambulatory care. This not only represents poor care for patients but also carries a significant financial risk where tariff rules are strictly applied.	Q&SC	5	3	15	A refreshed approach to the treatment plan took place in December integrating readmissions into the Urgent Care Delivery Programme. 2 challenge weeks have brought focus to key elements of improvement : • Data quality improvements – planned readmissions for urgent care initiated pathways • Risk stratification and triage to follow up in community after discharge from AMU at city piloted from December 2015; this creates a virtual ward. The impact of the pilot is to be considered in February • LACE score and discharge pathways from wards	Internal: Overall trust readmission rates are reported in the IPR as well as by Clinical Group. The urgent care delivery group t a s k force meets fortnightly. Quarterly report to Quality & Safety Committee. Trust Board paper in Q4.	3	3	9		• Assess the impact of the virtual ward and community follow up pilot in February. • Confirm future operating model and resource. • Review robustness of specialty level MDT for high frequency attenders / readmissions	Q4 15/16	2	3	6
COO	002-SHQC	Improving outpatients by implementing phase 2 of our Year of Outpatients programme	There is a risk that the intended benefits of the projects in Year of Out Patients (YOOP) do not realise their full benefits due to failure to deliver technical infrastructure or change the workforce and organisational delivery model which may lead to long waits, poor patient experience and wasted capacity	Q&SC	3	4	12	YOOP delivery programme in place. Self-Check In Kiosks completed; the call systems are for completion in Q4. Partial Booking p h a s e 1 c o m p l e t e d . U n d e r e v a l u a t i o n , w i t h p l a n f o r f u l l r o l l o u t i n Q 4 . and other developments in line with YOOP programme. KPI measures include 6 week waits, DNA rate, patient satisfaction	Internal: IPR, programme exception report and minutes and action trackers from CLE, Q & SC and Trust Board. Patient satisfaction results. DNA rates. Communications on intended changes and benefits.	3	4	12		Work c o n t i n u e s to strengthen staff and user engagement	Sep-15 March -16	2	4	8
CN	003 -SHQC	Achieving the gains promised within our 10/10 programme **MF**	There is a risk that patient safety could be compromised as a result of not delivering fundamental checks and baseline assessments within the first 24 hours after admission to hospital which could lead to poor planning.	Q&SC	3	3	9	An ongoing training programme h a s been implemented and a monthly KPI dashboard has been introduced to report compliance. Individual patient checklists and audit tools were launched in December with care plans available via Connect. A set of smarter KPIs to be introduced from which assurance can be drawn up. Focused reintroduction of the tool into the assessment units to garner dedicated staff attention for the implementation at the point patients are brought into the hospital	Internal and peer: Audit of compliance with 10/10	1	3	3		Introduction of a review of KPIs at Clinical Group review meetings	Sep-15	1	3	3

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DG	004-SHQC	Meeting the improvement requirements agreed with the Care Quality Commission	There is a risk that the scale of the task leads to inconsistent implementation of the required standards and practices across the organisation leading to a statutory breach of the fundamental standards of care,	Q&SC	3	4	12	Clearly defined outcomes set for each action. Planned and spot audits and unannounced visits to validate compliance. Evidence vault. Protected time for discussions at a local level at QIHDs. Monitoring and oversight of delivery by the CLE, QSC and Trust Board.	Internal: Observed practice during walkabouts and First Friday. Audit findings and action plans. Staff and patient feedback e.g. Your Voice, FFT, complaints. Incident data.	2	4	8		Improvement Plan evidence vault to be created and launched March 2016. A further round of in-house inspections is planned for April – May 2016, building on the experience from the pilot inspections carried out in November 2015. The existing team of 50+ staff inspectors is to be strengthened with the introduction of 20-25 people from the NHS Retirement Fellowship, which will give us more bandwidth of experienced NHS staff.	March 2016	1	4	4
COO	005 -SHQC	Tackling caseload management in community teams **MF**	There is a risk that a caseload of community nursing teams remains too high and above benchmark as a result of poor management systems, too many patients being admitted to the case load, poor discharge patterns or the absence of team members leading to short appointments or too few appointments to be effective	Q&SC	4	3	12	Workload dependency tool (GEL) has been introduced for monitoring the position. Implementation of FASTA in community pediatrics. Improvement plan agreed with key milestones. New Director of Nursing for Adult Community has started in November. Complete the implementation of GEL and staff training across all teams. • Redesign work adult community services in Q3 – 4 has commenced: • Cohorting non-essential home visits to clinics near home, decreasing travel time • Improved scheduling • Improved use of PCAT	Internal and peer: Results of audit of caseload management and data monitoring from GEL. Group reviews.	2	3	6		The IT platform review for community needs completion and possible capital investment- to be reported back in February. Evaluation of adult community service redesign progress due end January	March -16	2	3	6
COO	006-AR	Meet national waiting time standards and deliver from October a guaranteed maximum six week outpatient wait	There is a risk that specialty compliance of the standards are not met due to failure to implement demand and capacity plans and associated workforce plans which may lead to un-forecast underperformance, poor patient experience and financial penalties.	Q&SC	4	4	16	Intensive work and focus remains in this area of planned care; incremental improvements at Trust level can be seen in the minimum 6 week wait. Specialties have delivery plans to deliver by March. 2 high risk areas are T&O and Dermatology who are under executive review. RTT delivered for incompletes which is the current focus nationally. Specialty level compliance planned for Q4; Daily PMO in place looking at forward bookings and theatre board monthly.	Internal: IPR scorecard monitoring discussions. The minutes of Group reviews, OMC, Q&S, and Trust Board. Balanced scorecard. Peer: CCG contract review meeting and TDA performance review	4	4	16		Electronic referral management in Q4 is planned for implementation. Contract under deliver affecting pace of specialty reduction of > 18 week RTT ; 8642 theatre scheduling process to be fully implemented to gain expected impact and benefits. Review of demand and capacity to be completed in Q4. Delivery chain for OP to be clarified. New substantive head of elective access to start in February.	March -16	2	4	8

COO	007-AR	Double the number of safe discharges each morning and reduce by at least a half the number of delayed transfers of care in Trust beds	There is a significant risk that the volume of patient discharges from hospital beds each morning is insufficient as a result of poor understanding of expected date of discharge, poor discharge planning or the coordination of activities to effect a safe discharge leading to not enough beds available to admit patients with an emergency or urgent requirement for hospital care and financial penalties	Q&SC	4	4	16	1. An Urgent Care Board has been established and standard operating procedures for 7 day safe discharge across all Clinical Groups have been developed 2. Full realisation of benefits of ADAPT pathway. 3. Arrangements for delivery and monitoring of associated KPI daily / weekly are in place 4. Monitoring through Capacity meeting. 2. ADAPT workshop successfully defined work programme for Q4 with measurable KPIs. 3. Additional community capacity (McCarthy Ward opened in December)	Internal: CLE discussions, Q&S reports up to Trust Board Peer: CCG contract review meeting, System Resilience Group and TDA performance review	4	4	16		1. ADAPT – programme delivery 2. Review with AMU triumvirate on holistic assessment on admission related to ADPAT and EDD ambitions. Focused support to deliver may be required. 3. Development of ward clinical teams including embedding the role of a supervisory ward manager has commenced through UC challenge week 3; however there needs to be further work to embed a new performance and development framework in Q4. Unmet demand for residential and nursing homes in SMBC and EAB beds in BCC area remains an unmitigated risk to DTOC.	March- 16	2	4	8

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MD	008-AR	Implement advice and guidance support for GPs in all specialities and expand the use of video technology to consult with patients	There is a risk that we fail to meet contractual requirements to implement A&G and lose engagement and reputation with our primary care partners. There are financial penalties in the contract if we fail to implement A&G	Q&SC	3	3	9	Implementation of advice and guidance is a key objective of the Year of Outpatients change program. At a national level the new electronic referral management system will be implemented on 15th June 2015. Uptake of A&G to improve steadily as primary care increase uptake of eRMS (choose and book 2)	Each Clinical group has reported back to YOOP services that have made available A&G through current systems that are commensurate with requirements	2	3	6		New National ERMS (choose and book 2) to become available June 2015	Q3 15/16	1	3	3
CN	009-AR	Deliver our plans for significant improvements in our universal Health Visiting offer **MF**	There is a significant risk that children and families may not have adequate access to a comprehensive range of NHS, Local Authority and voluntary services as a result of lack of knowledge or poor co-ordination by health visitors which could lead to physical, mental or social developmental delay, or poor use of safeguarding facilities	Q&SC	3	4	12	1. A recruitment programme into health visitor vacancies is in place. 2. Leadership development programme 3.regular performance reports are demonstrating continued improvement in universal screening	Internal and peer: 1. Report describing improvements in Universal Health Visiting 2. Annual report of performance	2	4	8		Portfolio of services to be developed. An integrated model of midwifery and health visiting has been proposed and work is ongoing with the commissioners and GP's on the detail	Jul-15	2	4	8
COO	010-AR	Work within our agreed capacity plan for the year ahead, thereby cutting Do Not Attend rates, cancelled clinic and operation numbers, largely eliminate use of premium rate expenditure and accommodating patients declined NHS care elsewhere **MF**	There is a risk that sustainable demand and capacity plans are not delivered as a result of failure to resolve capacity gaps and / or optimise resources both workforce and service assets e.g.; theatres or out patients. This may leads to unplanned costs and activity.	FIC	4	4	16	1. Demand and capacity plans agreed at start of year. 2. Underperformance of contract year to date 3. 8642 scheduling process implemented; current intensive support to realise full benefits with expectation to improve delivery and meet contract 4. Partial booking roll out in train and due for completion in Q4.	Internal: Project group review and via IPR and direct update reports via Group reviews, OMC, FIC to Trust Board.	3	4	12		Review of OP capacity in train Jan/Feb and implementation of' 642' booking and scheduling Demand and capacity planning for 16-17 in train Q4.	March -16	2	4	8
COO	011-CCH	Expand iCares and heart failure services to provide improved provision in West Birmingham, by agreement with local practices	There is a risk that expansion of services fails lack of commissioning and a shortfall in workforce and marketing of new services which may lead to SWBH patients receiving varying levels of access to community services resulting in longer length of stay, readmission and differing satisfaction levels	Q&SC	4	4	16	Services established	Internal: CLE scorecards and minutes , Group review External; CCG contract meeting	3	4	12		Evaluation of new services end Q4/Q1	Dec-15	2	4	8

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COO	012-CCH	Implement our Rowley Regis expansion plans (Rowley Max) so that by March 2016 we have in place our RCRH model on the site MF	There is a risk that the infrastructure required to deliver the plan is not in place as a result the delivery of the RCRH model for the Rowley site is delayed resulting in loss of market share and demand and the inability to redesign clinical service provision on the residual acute sites	CC	3	4	12	In year reconfiguration of specialty clinics to Rowley and active promotion and marketing of site.	Internal: Board Committee minutes	3	4	12		Market share analysis and train and post code analysis of current Trust patients to inform further profile of services at Rowley Regis.	Apr-16	2	4	6
CN	013-CCH	Ensure that we improve the ability of patients to die in a location of their choosing, including their own home	There is a risk that patients are not given a choice about the place they would prefer to die as a result of the Trust's inability to co-ordinate services in a timely manner which could lead to patients dying in one of our hospitals leading to high levels of dissatisfaction or complaints	Q&S	3	3	9	1. An End of life strategy is in place 2. An End of Life group has been established, leading implementation of new pathway 3. A set of KPIs to monitor the position have been developed, with arrangements in place to monitor these on a monthly basis	Internal and peer: An audit of preferred place of death	2	3	6		Evaluation of development in year to be assessed in February	Aug-15	2	3	6
CEO	014-CCH	Support agreed GP partners through the CCG's 'push sites' initiative, designed to fit care models to local population	Diverse projects, structures and relationships militate against sufficient successful delivery in 11 months that 16-17 decisions can be made by Trust and commissioners	TB	4	2	8	Primary care liaison team to track projects, in liaison with CCG, reporting monthly to the Chief Executive, and through him to EG and CLE. Increasing attempts to link this work into RCRH.	Assurance via senior involvement, escalated to formal review with CCG at mid-year if off track.	3	2	6		Project plans as necessary for key workstreams	Oct-16	2	2	4
COO	015-CCH	Respiratory medicine service sees material transfer into community setting, in support of GPs	There is a risk that the clinical service model remains with too much Direct Clinical Care time committed to routine clinic work in the acute hospital which will potentially result in late intervention on community patient pathways, which may result in a continued rate of readmissions	Q&SC	4	4	16	1. Community respiratory service in place across Sandwell (now part of iCares) 2. Respiratory COPD discharge bundle launched in December.	Internal: Readmissions reports to Clinical Effectiveness Committee, Demand and Capacity reports to FIC, New clinical model through Group review is reported to CLE.	3	4	12		7 day services are not provided in Birmingham yet. Early review of impact of discharge bundle required in Q4	March 16	2	4	8
CEO	016-GUR	Implement successfully and safely the new tariff regime (ETO) as the Trust moves to a PBR system with all commissioners by 2017	Marginal rate for specialist services in ETO necessitates active rationing of care and care modalities. Risk that this creates inequity, and reduces quality of care offered (as distinct from safety).	QSC	3	4	12	Explicit approach with Board oversight, supported by written policy taken through CLE. Escalation to CCG CQMS meeting if Q3/4 as active rationing needed.	Patient level tracking of any delayed care decisions	3	4	12		Highly likely ETO marginal rate will be abolished for 16-17 contract. No further controls required.		3	2	6

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	R&D Plan update
SPONSOR (EXECUTIVE DIRECTOR):	Dr Roger Stedman, Medical Director
AUTHOR:	Prof Karim Raza (R&D Director) & Dr Jocelyn Bell (Head of R&D)
DATE OF MEETING:	4th February 2016

EXECUTIVE SUMMARY:

The Trust Board has requested an R&D update following the R&D report submitted to the October 2015 Board meeting. That report is included as Appendix 1 (page 7 onwards). The current document provides **an update** in relation to the Objectives in the Trust's R&D plan. I have, in general, avoided repeating achievements described in the previous report.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

PREVIOUS CONSIDERATION:

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DOF	017a-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis **MF**	There is a risk that the identified opportunity for financial improvement is insufficient to deliver balanced financial plans across each and all directorates. There is a risk that the scale & pace of financial improvement delivered is insufficient. This is caused by a lack of necessary capacity and capability and risk of compromise to the safety and quality of services provided. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	4	5	20	Effective use of comparative information including peer benchmarking, best practice review and expert scrutiny. Focussed executive support to directorates to develop plans. Expedited recruitment to fit for purpose senior management structures and follow through on senior leadership development programme. Utilisation of expert support as necessary and appropriate. Effective QIA / EIA process. Transparent & explicit process for plan signs off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level. Business planning process designed to address 2016-18 cost efficiency improvement need. Includes scaled and specific workforce change.	Management assurance. Routine reporting of historic and prospective financial performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	3	5	15		Completion of necessary recruitment and leadership development programme. Confirm and establish fir for purpose change and improvement capability function. Effective use of Lord Carter review outputs to provide meaningful business intelligence to underpin real improvement opportunity and delivery. Confirm scale of challenge and route to remedy underlying run rate shortfall carried over from 2015-16 financial year. Confirm and progress plan to restore cash balances consistent with those necessary to meet forward investment plans	06/16 04/16 04/16 04/16 03/17	3	5	15
DOF	018-GUR	Develop our capital plan and execute in line with that plan on a quarter by quarter basis	There is a risk that the capital plan is constrained by the requirement to secure key financial metrics and which compromises the timely progression of key estate development and necessary equipment replacement without compromise to key statutory standards. There is a risk that the scale and pace of capital programme delivery is delayed as a result of lack of necessary capacity and capability and which compromises the timely progression of key estate development and necessary equipment replacement.	FIC	4	5	20	Detailed review of absolute and sequenced capital requirements in particular for imaging, medical equipment replacement and retained estate development. IM&T programme confirmed. Routine consideration of full range of financing options to optimise flexibility within financial plan. Appropriate focus and development of senior leadership. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective capital plan performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning & budgetary control. External audit review of arrangements for securing VFM. Regulator scrutiny of arrangements for compliance with statutory standards. The 2016-21 Capital Plan was approved by the Trust Board in December 2015	3	5	15		Conclusion of MES contract during 2015.16 for delivery of key fixed equipment from 2016.17. On track for contract closure 1 April 2016 Development of confirmation of granular Capital Development Control Plan. Establishment of Major Projects Authority as committee of the Trust Board Develop and confirm balanced financial plans as per 017a above	04/16 04/16 03/16	3	5	15

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COO	019-GUR	Reform how corporate services support frontline care, ensuring information is readily available to teams from ward to Board	The risk is that we do not achieve a performance cycle that drives changes required to delivery the annual and long term plan supported by an intelligent suite of business information. The impact is that may result in failure or delay to fully deliver efficiency, effectiveness in clinical services, with sound governance and assurance from board to ward	TB	4	4	16	• IPR initial version produced for day 5 of the month • Q4 resets performance cycle at Directorate and Group level • Kite mark assessment completed for all elements of the IPR	Internal: Trust Board, CLE, Group review reports. A reporting tool is in place at frontline service level and standard reports are visible monthly to support performance improvement cycle	3	4	12		Specify and procure dashboard information system Data quality group to be established	Oct-15	2	4	8
DOF	020-GUR	Reform how corporate services operate to create efficient transactional services by April 2016 that benchmark well against peers within the Black Country Alliance	There is a risk that corporate functions provide an inadequate level of support to front line teams as a result of an extended period of significant change and which may lead to a delay in service and financial improvement and failure to secure middle & back office efficiency at necessary scale.	TB	3	4	12	Follow through of revised arrangements for information production and effective performance management across finance & information functions. Development of IPR and related dashboards on basis aligned to and providing consistent information through the organisation structure. Routine reporting & coherent performance management arrangements. Middle & back office transformation effected through robust programme management arrangements and with expert support as necessary and appropriate. Limited progress during 2015-16 financial year.	Management assurance. Routine reporting of IPR & related dashboards at all relevant meetings. Independent assurance. Internal audit review of core systems and processes including performance management and data quality assurance programme. Regulator scrutiny of 'well led' assessment.	2	4	8		Establishment & implementation of effective middle & back office transformation programme. To include programme of work with BCA partners. Business planning process 2016-18 specifically includes plans for corporate functions workforce change and which requires ways of working to be improved.	03/17 04/16	2	4	8
MD	021a-21CF	Agree EPR outline business case and initiate procurement process, whilst completing infrastructure investment programme MF	There is a risk that due to inadequate IT infrastructure and lack of management capacity and capability within the IT team that we fail to achieve or fully realise the benefits of the procurement and implementation of the EPR prior to the move to midland Met	FIC	5	4	20	External contractors have been brought in to conduct a deep dive review of IT infrastructure across the entire estate. A remedial investment and action plan will result from the deep dive which will be actioned in advance of the implementation phase of the EPR project. A departmental workforce review will take place during 15/16 in order to ensure a team structure fit for purpose. Deep dive concluded with implementation programme in place. Upgrade to be completed by June 2016 and investment in team follows supplier selection in April.	Internal: Progress on these will be reported regularly through IT committee and thence to CLE. Direct reporting to FIC on progress of the EPR procurement and to MPA Committee on infrastructure and EPR implementation. Matter is subject to consideration by the Trust Board.	3	4	12		Until deep dive infrastructure review complete and work force review complete the risk remains	Q2 15/16	2	4	8

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DOF	022a-21CF	Reach financial close on the Midland Met Hospital **MF**	There is a risk that approving bodies [TDA, DH, HMT] delay or fail to approve the business case. This may be as a result of lack of confidence in the business case or trust ability to deliver, political or policy change, absence of a compliant bid, withdrawal of commissioner support or other significant reason. This would give rise to delay or absence of financial close and with potential requirement for expedient service change to secure safe, effective & financially viable services. There is a risk that the senior debt funding competition fails to secure sufficient funds as a result of lack of market appetite and which may cause the case to fail. Financial close occurred in December 2015 with the Trust Board delegating authority to the Chief Executive in consultation with the Chairman to agree the terms of the financial close. This priority is now closed but with a risk register being developed for the next phases of the programme.	CC	4	5	20	Delivery of coherent appointment business case consistent with OBC evidenced with sufficient cost improvement and workforce plans. Ongoing delivery against approval conditions. Confirmation of compliant bid through conclusion of evaluation process. Effective engagement with EIB to secure their commitment to [part-] funding of the development. Routine oversight and management through Stakeholder Board and Trust Configuration Committee.	Management Assurance. Routine oversight and assurance through trust Configuration Committee. Independent assurance. Due diligence using external advisors of bid and key elements of business case.					Further development of cost reduction and workforce plans and commissioner confirmation of downside plans. Contract closed. No residual risk to this objective.				
COO	023a-21CF	Complete consultation on, implement and evaluate the reconfiguration of interventional cardiology and acute surgery between our acute sites	The risk is that the patient pathways and intended benefits of reconfiguration are delayed through late delivery of estates infrastructure or not realised due to pathway or clinical service model implementation resulting in unintended outcomes such as increased LOS and negative impact on patient / staff experience	CC	3	4	12	Both configurations completed	Internal: Estates plans, pathway and clinical infrastructure via Group Review, project group and configuration committee reports.	2	4	8		Evaluate impact in Q4	Aug-15	2	4	8
COO	023b-21CF	**Cardiology**	The risk is that the patient pathways and intended benefits of reconfiguration are delayed through late delivery of estates infrastructure or delays in procurement resulting in continue risk and down time from aging equipment and the challenge of dual site rotas	CC	3	4	12	Configuration completed in Q3	Internal: Estates plans, pathway and clinical infrastructure via Group Review, project group and Configuration Committee reports.	2	4	8		Evaluate impact in Q4	Aug-15	2	4	8

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COO	023c-21CF	**Acute surgery**	The risk is that the patient pathways and intended benefits of reconfiguration are delayed because of a lack of complete multiprofessional engagement and ownership to deliver a standardised workforce a n d clinical model. This may result in delay in implementation resulting in unintended outcomes such as increased LOS and negative impact on patient / staff experience	CC	4	4	16	Configuration completed in Q2	Internal: Estates plans, pathway and clinical infrastructure via Group Review, project group and configuration committee reports.	3	4	12		Evaluate impact in Q4	Aug-15	2	4	8
DENHP	024-21CF	Develop, agree and publicise our final location plans for services in the Sandwell Treatment Centre	There will remain a risk that the final location plans may need to change in response to service need, business plans funding constraints.	CC	3	4	12	Monitoring arrangements are in place through the board and subcommittee structures, reports and risk registers. These arrangements will remain in place for the 2016 – 19 period whilst the STC programme is developed and implemented. The STC programme will report to the Major Projects Authority Committee which will be established from March 2016.	The December 2015 Trust Board received a specific STC paper as part of its assurance review of the MMH development and prior to signing contacts and Financial close. The Trusts January 2016 Heartbeat paper will be used to publicise location plans for those clinical and non-clinical services which will be provided from the Sandwell STC.	3	4	12		Detailed work to confirm delivery of the programme is ongoing and will be completed by March 2106. The programme has 3 phases over the 2016-19 periods. Discussions with individual services to confirm the scope/brief of works to be undertaken will identify any new or additional risks not previously identified and actions to be taken to mitigate and manage those risks.	Jun-15	3	3	9
COO	025-21CF	Finalise and begin to implement our RCRH plan for the current Sheldon Block as an intermediate care and rehabilitation centre for Ladywood and Perry Barr	The risk is that the commissioning of intermediate care is neither timely nor adequate for the demand and implementation. This may result in delay of gap in this level of care which may lead to increased delayed discharges and negatively impact on patient experience and outcomes	CC	3	4	12	1. Secure contract for activity. 2. With Estates working to identify estates plans and capital investment in agreed timeframe. This will include decant programme from Sheldon block for other services that are not located there in the RCRH model. 3. Community workforce strategy includes workforce model for Sheldon services with supporting recruitment plan.	Internal: Confirmed estates plans. Workforce scorecard discussed at Clinical Group Review. Signed contract to provide service discussed at Clinical Group Review External; Contract meetings	3	3	9		Delivery of successful recruitment campaign (Community Clinical Group working jointly with Medicine on recruitment plan) supported by corporate recruitment and communications expertise. Assess any further implementation requirements based on contract.	Mar-16	2	2	4

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOD	026-EEO	Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness MF		W&ODC	5	3	15	Full complement of escalated measures agreed at October. CLE. Increased confirm and challenge with group leads including a case by case focus on long term sickness and a focus on consistent application of disciplinary process.	Internal: Assessed through sickness absence data, Your Voice and national staff survey results	4	3	12		Development if a cohesive plan, embracing effective leadership, group ownership, Health and wellbeing use of business intelligence, coupled with consistent application of sickness absence management process		3	3	9
DOD	027-EEO	Finalise our long terms workforce plan, explaining how we will safely remove the paybill equivalent of 1000 posts between 2016 and 2019	There is a risk that future staffing models will not be well enough defined to enable the identification of sufficient posts to be removed leading to an inability to formulate a robust workforce plan which may lead to the non-delivery of the required workforce and pay cost savings between 2016 to 2019	W&ODC	4	4	16	Bottom up workshops held Sep-Dec 2015 Close alignment to business planning process planning for 16/18 Close scrutiny of board and WODC December 15	Workforce change schemes tracked through TPRS. Exec led PMO. TDA workforce returns	3	4	12		downside scenarios explored and planned - April 2016 Cross dependencies and alignment with training / development needs April 16		2	4	8
DOC	028-EEO	Create time to talk within our Trust so that engagement is improved. This will include implementing Quality Improvement half days, revamping Your Voice, Connect and Hot topics and committing more energy to First Fridays	Poor staff engagement levels that could be contributed to by ineffective internal communications systems and visibility, leading to lack of understanding of the Trust's vision and objectives, lack of ability to share good practice and improve services, low staff morale and high turnover.	W&ODC	4	3	12	Internal communications strategy in place and approved by June 2015. Quality Improvement Half Days implemented from April 2015. Improved engagement with Your Voice including how teams change and improve as a result of staff feedback. Increased attendance and team feedback at Hot Topics monthly briefings with implementation of hot topics improvement plan. Increased visibility of senior leaders with new multi-media films.	Internal: Engagement scores on Your Voice and improved feedback rates on internal communications systems Independent: National staff survey results	2	3	6		Publish internal communications strategy - June 2015; Implement Quality Improvement Half Days - April 2015, Relaunch Connect intranet site; December 2015,	Jun-15	2	3	6
DOD	029-EEO	Agree and begin to implement our three year Education Plan	The loss of highly skilled staff is a problem. The inability to recruit highly qualified staff is also a problem. The perception of staff is that there is no money to support training. The lack of visibility around who accesses the funding and the lack of clarity about Education Training and Development does affect staff morale and retention.	W&ODC	3	3	9	A draft strategy has been developed for agreement by the E, L&D Committee (April 15). Trust training plan has been collated and developed to show all Trust staff accessing development support and funding. Revision of the study leave policy is being progressed to address the issue of staff leaving upon completion of higher level education and training programmes. Plan agreed at August 2015 board and published	Internal: Minutes from the E, L & D Committee	1	3	3		Publish the strategy in June 15. Publish Trust Training plan in May 15. Monitor via E, L&D committee. Operational engagement and communications plan needed to be re-launched March 2016	Jul-15	1	3	3

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOD	030-EEO	Complete the second year of our leadership development programme, providing clinical leaders with the skills and expertise to lead the organisation forward	There is a risk of lack of engagement from staff due to delays in communicating the list of participants. Lack of engagement from the provider and willingness to continue with the programme delivery.	W&ODC	4	3	12	The list of participants is to be agreed and distributed. Promotional materials to be produced based on the success of the first year's programme. Increased involvement with the provider and assurances agreed.		1	3	3			Jun-15	1	3	3

KEY

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Draft 3 Year Clinical Effectiveness/ Quality Objectives
SPONSOR (EXECUTIVE DIRECTOR):	Dr Roger Stedman, Medical Director
AUTHOR:	Dr Roger Stedman, Medical Director
DATE OF MEETING:	26 January 2016

EXECUTIVE SUMMARY:

The enclosed quality objectives set out our ambitions as a Trust to equal or exceed the best quality standards in the NHS, across all the services we provide. These objectives have been developed through consultation with senior colleagues including the Clinical Leadership Executive.

In considering these objectives the Board are particularly asked to give feedback in terms of:

1. Are the outcomes meaningful from a patient's perspective? If they are not then which aspects of the objectives need to be reframed?
2. Are the targets, where these have been set, ambitious enough?
3. Does the Board think these objectives cover the breadth of activities we undertake as a Trust, if not what is missing?

REPORT RECOMMENDATION:

That the Board provide feedback on the quality objectives as currently drafted.

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	X	Patient Experience	X
Clinical	X	Equality and Diversity		Workforce	

Comments:

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

Annual plan - Safe high quality care objectives

PREVIOUS CONSIDERATION:

Quality Plan
Objectives 2016 – 2019

The Vision

- Our Vision for 2019 is to provide the outcomes that are equal or exceed the best in the NHS, across all the services we provide. We will do this by doing the right things in the right way, innovating and ensuring our teams base their practice on the best available evidence.
- Clinical effectiveness is about developing and delivering high quality care based on best available research evidence, together with clinical expertise and patient involvement.
- The Trust's vision of delivering safe high quality care for all clinical services requires a determined focus on the effectiveness of the care we provide for patients and the outcomes our services achieve. The Clinical Effectiveness plan sets out the Trust's commitment to deliver on these aims.

Below are a draft set of quality objectives and proposed measures which will drive our collective improvement trajectory in terms of clinical effectiveness and quality across the Trust.

	Objective	Proposed Measures	Current Performance	2019 Target
1	**By 2019 the Trust will be ranked in the top quartile of relevant peers for the reduction of Avoidable Hospital Mortality**	Avoidable Hospital Deaths as a % of total deaths in hospital Number of deaths reviewed within 42 days	3% 90%	<2% 100%
1a	**To ensure there is early recognition and treatment of sepsis leading to a reduction in avoidable deaths attributable to sepsis**	Reduction in hospital deaths for which sepsis was a contributory factor Percentage of patients screening positive for severe sepsis receiving sepsis 6 bundle within 1 hour	50% 50%	[40%] 100%
1b	**To achieve a year on year reduction in hospital associated venous thromboembolisms (pulmonary emboli [PEs] and deep vein thromboses [DVTs])**	Year on Year reduction in number Hospital Acquired thrombosis per 1000 bed days Year on year reduction in number of deaths in hospital with thrombosis as a primary or	2015 Data: Total episodes of care with VTE diagnosis: 165 Total number of Hospital Acquired Thrombosis: 44 Total number of HATs for which	

	Objective	Proposed Measures	Current Performance	2019 Target
		secondary diagnosis	RCA conducted: 43 Total number of deaths with VTE as 1° or 2° : 37 [Per 1000 bed days data not yet available]	
1c	**For the Trust to be amongst the best performers for implementing care processes for patient admitted with an acute stroke and for the rate of deaths in hospital within 30 days of admission**	SSNAP Audit performance 30 day mortality: Crude Risk adjusted ratio	1Q SSNAP level B 12.1% 86	4Qs SSNAP level A [8%] [<80]
1d	**The Trust will demonstrate the most effective management of patients admitted with a heart attack (Acute myocardial Infarction) by ensuring that they have prompt access to treatment in order to achieve the best possible outcomes**	MINAP Audit performance – Top Quartile door to balloon times <90 minutes. 30 day mortality: Crude Risk adjusted ratio	England Average – 92% City Hospital – 79% Sandwell Hospital – 92% 7.5% 92.8	England top Quartile – Trust – 100% [5%] [<80]
1e	**Patients presenting to the Trust as an emergency with a fractured neck of femur are routinely operated on within 24 hours and achieve outcomes that are better than selected peers**	NHFD Audit – Operations within 36hrs Return to own home Best Practice Tariff 30 day mortality: Crude Risk adjusted ratio	Trust (National) 69.8% (72.9%) 96% (59.9%) 67.7% (63.3%) 7.7% 102.7	 [>80%] [98%] [>80%] [5%] [<80]
1f	**For all high risk surgical patients an assessment of mortality risk will be made explicit to the patient and recorded clearly on the consent form and in the medical record so that the most appropriate level of care is provided in order to achieve the best possible outcomes**	Patients with Acute abdomen receiving PPOSSUM Score before surgery Percentage of patients with a mortality risk from PPOSSUM of >10% receiving critical care 30 day mortality from high risk surgery	Unknown Unknown [8.5%]	100% 100% [5%]
2	**Outcomes for the treatment of all common cancers will be amongst**	1 year and 5 year survival for:		

	Objective	Proposed Measures	Current Performance	2019 Target
	the best in the UK	Breast Colorectal Ovarian / Endometrial / Cervical Prostate / Bladder / Renal Skin Haematological Head and Neck Lung Upper GI		
3	**By 2019 avoidable readmissions are reduced to a minimum as a result of enhanced care coordination across interfaces between care settings and patient education and support for self-management.**	Emergency 30 day readmission rate	8.6% (6%)	<5%
4	**By 2018, our Trust will be amongst the best performers in avoiding preventable sight loss**	Posterior capsule rupture in cataract surgery Retinal detachment VR surgery AMD / Glaucoma national audit performance	2.3% (1.7%) Data not available Data not available	<1.5%
5	**To ensure that Trust operated screening services exceed national norms for uptake by local populations.**	Breast Screening service Bowel Screening	53.6% Unknown	>70%
6	**To reduce avoidable causes of peri-natal mortality**	Number of still births with CESDI level 3 Number of still births with IUGR as a feature	Data not available Data not available	[100% reduction] [50% reduction]
7	**The majority of our patients for whom death is expected and not avoidable will do so in the place of their choosing – receiving excellent end of life care**	Percentage of appropriate patients for whom the SPICT tool is applied and an advanced care plan made Number of admissions to hospital in the last year of life	Data not yet available >3	[50%] <2
8	**Paediatrics and**	Paediatric Acute Hospital	No data yet	No data yet

	Objective	Proposed Measures	Current Performance	2019 Target
	Community Child Health Services – Days of School Lost	length of stay Paediatric day procedures staying overnight		
9	**By 2019 the overall average adjusted health gain in the general health status reported for the Trust for patients undergoing all 4 index PROMS procedure, is higher than the national average**	Average adjusted health gain for all procedures measured to be above average for UK	Currently Hernia is a lower limit statistical outlier. All other procedures are within statistical limits. None are above average.	[All above England average]

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	3 Year Safety Plan: Draft Always Events
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington, Chief nurse
AUTHOR:	Debbie Talbot - Deputy Chief Nurse Alison Binns – Deputy Director of Governance Kam Dhami – Director of Governance
DATE OF MEETING:	4th February 2016

EXECUTIVE SUMMARY:

Trust Board have discussed the proposed safety plan on a number of occasions. This is the penultimate draft of objectives for consideration and sign off.

The clinical leadership executive have been consulted on a number of occasions about the plan and asked to consider whether the plan is sufficiently ambitious but workable and has the right ingredients to ensure that safety has been considered for every patient that needs to use the services of the Trust.

This is the high level plan behind which there needs to be detailed implementation plans with a focus on delivery and measurement.

The Board are asked to consider how we might consider the plan in the context of the diversity of the populations we serve. The plan does not currently detail any objectives that deal with equipment, the environment or safe staffing.

REPORT RECOMMENDATION:

Trust Board are requested to discuss and agree the objectives and support the development of an implementation programme

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

Accept	Approve the recommendation	Discuss
	X	

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

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

Comments:

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

Annual plan - Safe high quality care objectives

PREVIOUS CONSIDERATION:

Quality and Safety Committee
Clinical Leadership Executive

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SWBTB (01/16) 229(a)

3 Year Safety Plan

The Vision

SWBH will have the safest community and hospital services in the country

The Aim

To reduce patient harms in SWBH by 75% over the next 3 years

January 2016

Where EVERYONE Matters

Always Event 1A

M / SA / SB / WCH / CT

We will always ensure that no adult patient has avoidable harm from a pressure ulcer, fall or catheter related urinary tract infection

Why is this a priority? (rationale)

Prevalence data on pressure ulcers, falls, catheter related UTIs through use of the Safety Thermometer provides the Trust with an opportunity to review all harms at local level, determine if patients suffer more than one harm and identify potential clinical areas for further education, equipment, support and monitoring. (some level of national benchmarking can be utilised although designed as an improvement tool).

Current SWBH position

The Trust reports at least one harm on an average of 5% of patients reviewed monthly in all adult inpatient areas. Multiple harms on individual patients is rare.

Prompts for discussion

- Key is the frequency of assessment and measurement.
    - Currently measurement captured from safeguard with an aim to capture from EBMS
- Aim for 100 % avoidable harm free
- Important that the measure reflects community settings.

Always Event 1B

M / SA / SB / WCH / CT

We will always ensure that no child or young person has avoidable harm because of deterioration, an intravenous infusion into the tissues, pain or damage to skin integrity

Why is this a priority? (rationale)

Prevalence data on pressure ulcers, falls, catheter related UTIs through use of the Safety Thermometer provides the Trust with an opportunity to review all harms at local level, determine if patients suffer more than one harm and identify potential clinical areas for further education, equipment, support and monitoring. (some level of national benchmarking can be utilised although designed as an improvement tool).

Current SWBH position

The Trust reports at least one harm on an average of 5% of patients reviewed monthly in all adult inpatient areas. Multiple harms on individual patients is rare.

Prompts for discussion

- Key is the frequency of assessment and measurement.
- How are these counted and recorded
- Important that the measure reflects community settings.

Always Event 2

M / SA / SB / WCH / CT

We will always ensure that no patient's clinical condition deteriorates as a result of a lack of timely monitoring of vital signs and escalation

Why is this a priority? (rationale)

Review of cardiac arrests and EMRT illustrate a need to improve patient treatment plans, monitoring and recording ceilings of treatment. Multiple alerts for the same patient indicate missed opportunities to review the patient pathway and expectations of outcomes.

Current SWBH position

Current Vitalpac performance highlights delays in recording observations of our most ill patients.

Prompts for discussion

- Need to reflect community settings.
- Should always be reflective of
- NEWS – new early warning score,
  PEWS – paediatric early warning score
  MEWS – maternity early warning score
- Not all areas have vital pac and continue to collect observations on paper charts where necessary.

Always Event 3

M / SA / SB / WCH/C&YP / CT

We will always ensure that no patient has an avoidable use of antibiotics

Why is this a priority? (rationale)

The potent effect of antibiotics can alter the normal gut flora and make patients very susceptible to contracting serious infections such as *Clostridium difficile*. The second effect is that over use of antibiotics over time reduces their therapeutic effect

Current SWBH position

Antibiotic stewardship is led by a microbiologist and a dedicated pharmacist. There is a recognised list of antibiotics recommended for use across the trust which also includes duration of prescription in an attempt to control use.

Prompts for discussion

- Antibiotic usage to be discussed every 24 hours for any patient with a prescription

Always Event 4

M / SA / SB / WCH / CT

We will always ensure that no patient has an unplanned medication omission

Why is this a priority? (rationale)

Omission of medication is a medication error particularly relevant for high risk drugs (as defined within the medication Safety Thermometer document) and for management of long term conditions. Medicines reconciliation and provision is an essential part of a patient's care.

Current SWBH position

Medication omission charts are completed and audited by pharmacy with general improvements required in most areas regarding omission.

Prompt for discussion

- Focussed on ensuring we always administer prescribed medication on time. Any deviations recorded and reviewed.
- Medicines effectively reconciled.
- Effective coding.

Always Event 5

M / SA / SB / WCH / CT

We will always ensure a *Ten out of Ten* safety checklist is fully completed for every patient within 24 hours of admission

Why is this a priority? (rationale)

Ten out of Ten was developed to encourage real time patient centred assessment and treatment planning. Acting as an aide memoire to the multi-disciplinary team the aim is to assess all patients for key safety risks identified for that patient group. Discussion and challenge from patients/carers promotes partnership in health care.

Current SWBH position

The *Ten out of Ten* checklist has been introduced into adult in- patient wards with ad hoc integration. Individual patient checklists have been introduced in Surgery for a while and have now been disseminated to all wards. Audits are undertaken one day a month highlighting difficulties with health education.

Prompts for discussion

- Work underway to trial an approach which will work in community settings.
- Focused approach to re-implementation – starting with assessment units

Always Event 6A

M / SA / SB / WCH / CT / I / P

We will always ensure that no patient will suffer harm from avoidable delay in diagnosis

Why is this a priority? (rationale)

Mortality reviews, serious incident investigations and complaints identify that some patients have suffered through delays or failures in making a correct diagnosis along the pathways.

Current SWBH position

Mortality reviews reveal preventable death and promote learning individually and corporately. This is a retrospective response.

Prompts for discussion

- Need to reflect the level of ambition regarding this objective.
- This an always event around effective diagnosis.
- Is it a matter of 'preventable' harm?
- Pathway measures.

Always Event 6B

M / SA / SB / WCH / CT / I / P

We will always ensure that no patient will suffer harm due to an avoidable delay in requesting diagnostic tests or a failure to review the results

Why is this a priority? (rationale)

Mortality reviews, serious incident investigations and complaints identify that some patients have suffered through delays or failures in making a correct diagnosis along the pathways.

Current SWBH position

Mortality reviews reveal preventable death and promote learning individually and corporately. This is a retrospective response.

Prompts for discussion

- Need to set expectations in regard to the performance standards. Patients definition of a delay may differ to ours.
- This links closely to the work around 7 day working.

Always Event 7

M / SA / SB / WCH / CT / I

We will always ensure that all patients undergoing invasive procedures will have received timely and adequate information to make an informed decision with consent evidenced

Why is this a priority? (rationale)

Monthly audit data shows that documented evidence of information provision to patients is not robust and consistent.

Current SWBH position

Audit of consent forms reveals XX. Consent must be taken by a practitioner able to undertake the procedure or by a trained delegate

Prompts for discussion

- POSSUM score
- Evidence of consent key.

Always Event 8

M / SA / SB / WCH / CT / I

We will always ensure that no patient has an invasive procedure without having a safety checklist undertaken prior to commencement

Why is this a priority? (rationale)

The Trust has a history of Never Events, largely in surgical procedures. The recent introduction of National Safety Standards for Invasive Procedures (NatSSIPs) further emphasises the need for improving use of checklists. Localisation of these (LocSSIPs) will promote the use of checklists more widely.

Current SWBH position

The WHO checklist has been implemented for all invasive procedures and compliance is audited. Modified checklists have also been introduced and audited in some units (e.g. CCS)

Prompts for discussion

- WHO checklist.
- Other bespoke checklists e.g. imaging

Always Event 9

M / SA / SB / WCH / CT

We will always ensure that fully completed assessments must be undertaken and an informed plan of care documented with every patient

Why is this a priority? (rationale)

Electronic and paper based health care records are a communication and audit tool . 'If it wasn't written it did not happen' reviewing of complaints and incidents illustrates elements of poor record keeping . Professionals are contravening their codes of practice if they fail to maintain appropriate records. The CQC also identified non-completion of forms as an issue.

Current SWBH position

Health Care Records Audits and Case Reviews illustrate gaps for including evidence of patient 'sign up' to care plans.

Prompts for discussion

- Important that completed assessments and plans of care are undertaken with the involvement of every patient. All clinical professionals need to consider how this will be evidenced.

Always Event 10

All groups

We will always learn for the excellent care given and from those times when care is a concern for patients or falls short of acceptable standards

Why is this a priority? (rationale)

Continuous learning is everyone's business and is central to not repeating mistakes. Learning is our focus the prevention of harm and for the improvement of services and experience for patients. A culture of learning encourages openness when things go wrong, will help improve organisational reputation, it will also help us to target use of resources at key improvements.

Current SWBH position

Specific learning has been arranged when never events have taken place and shared across the trust, however it would be difficult to evidence other learning in a systematic way. Quality Improvement Half days is protected learning time when learning can be spread across the trust consistently

Prompts for discussion

- Learning is about driving positive behaviours.
- Need to draw links with the Trust's promises.
- Need to reflect the learning as an organisation but also that these are always events applied consistently with each and every patient.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	R&D update report
SPONSOR (EXECUTIVE DIRECTOR):	Dr Roger Stedman, Medical Director
AUTHOR:	Prof Karim Raza (R&D Director) & Dr Jocelyn Bell (Head of R&D)
DATE OF MEETING:	4th February 2016

EXECUTIVE SUMMARY:

The Trust Board has requested an R&D update following the R&D report submitted to the October 2015 Board meeting. That report is included as Appendix 1 (page 7 onwards). The current document provides **an update** in relation to the Objectives in the Trust's R&D plan. I have, in general, avoided repeating achievements described in the previous report.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

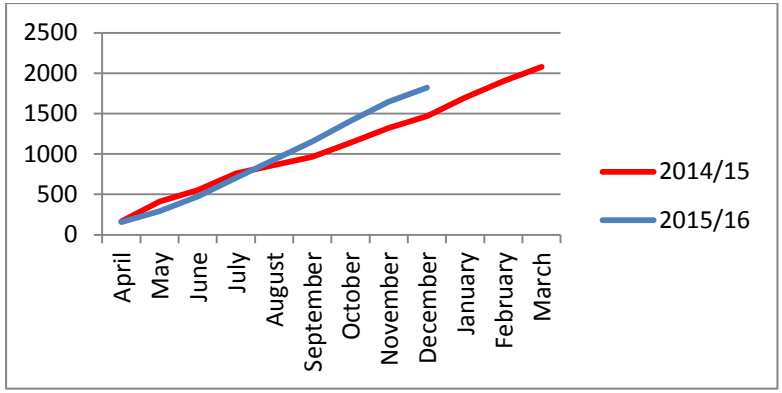
PREVIOUS CONSIDERATION:

R&D Update for the Sandwell and West Birmingham Hospitals NHS Trust Board meeting: February 2016

The Trust Board has requested an R&D update following the R&D report submitted to the October 2015 Board meeting. That report is included as Appendix 1 (page 7 onwards). The current document provides **an update** in relation to the Objectives in the Trust's R&D plan. I have, in general, avoided repeating achievements described in the previous report.

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

2014-15 saw us recruit our largest ever number of patients to NIHR portfolio adopted studies (2,085 patients). Current recruitment (as of December 2015) is 1822 patients (data will be up to 12 weeks behind real time due to delays in national uploading of recruitment information) i.e. **we are now exceeding our 2014-15 recruitment** and are on track to reach 2500 patients (the number predicted in the previous report to the Trust Board) by end March 2016.



A number of new and important trials are in the SWBH pipeline, for example:

- The NOAH trial (Principal Investigator **Prof Paulus Kirchhof**), a trial of anticoagulation in pacemaker patients, will start enrolment in the 2nd quarter of 2016. https://clinicaltrials.gov/ct2/show/NCT02618577

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

Over the last three months, investigators at the Trust have secured a number of **new major research awards** for example:

- **Prof Karim Raza** (Rheumatology) is a co-investigator on the Arthritis Research UK Strategic Programme Award 'The microbiome as a therapeutic target in inflammatory arthritis': £2 million.
- **Miss Si Rauz** (Ophthalmology) is a co-investigator on a Direct Pathway Finding Scheme MRC Major Award to develop a sight-saving synthetic, optically-transparent, patient-delivered, biologically-smart dressing for the prevention of corneal scarring during acute microbial keratitis. This is one of the largest grants awarded to Ophthalmology-based research in the UK: £2.36 million.

SWBH based researchers have been appointed to **prestigious national roles**. An example from the last few months includes:

- **Prof Sean Kehoe** (Gynae-Oncology) has been appointed as Gynaecological Cancer Chair for the National Cancer Intelligence Network PHE; this role will involve developing epidemiological publications on gynaecological cancers.

SWBH based researchers continue to publish important research findings in **journals of the highest international calibre** to benefit patient outcomes. Examples from the last few months include:

- **Clarke CE** et al. Physiotherapy and occupational therapy vs no therapy in mild to moderate Parkinson disease: a randomized clinical trial. J*AMA Neurol*. Jan 2016
- McInnes IB, **Buckley CD**, Isaacs JD Cytokines in rheumatoid arthritis - shaping the immunological landscape. *Nature Reviews Rheumatololgy*. Jan 2016

We are seeing our **upcoming research areas** continue to develop. An example from the last few months includes:

- **Dr Sissi Isopglou** has commenced recruitment to the HIPPS trial assessing the of the hippocampus role in post stroke dementia and delirium.

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

We continue to raise the profile of research amongst Trust staff using a number of strategies including:

- Promotion of R&D activity in Trust publications including Heartbeat and Innovation and via social media including Twitter.
- The institution of a regular forum for current and potential Investigators to meet and discuss best practice and the potential for collaborative opportunities.

We have worked with clinical groups to develop research in areas of historically limited activity. For example, we have developed new research portfolios in the following specialities with specific examples of recently approved studies as follows:

- **Renal medicine**: Principal investigator, Prof Paul Cockwell. SPIRO-CKD study. Approved 24/09/2015
- **Clinical Immunology**: Principal investigator, Dr Sadia Noorani. NIHR Bioresource Rare Diseases, the BRIDGE Study. Approved 22/10/2015
- **Dermatology**: Principal investigator Dr Amirtha Rajasekaran. Home Intervention and Light Therapy for the treatment of Vitiligo, the HI-light Vitiligo Trial. Approved 07/01/2016

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

We continue to support AHPs undertaking clinical research. For example, and as described in the previous report, a physiotherapist, **Roanna Burgess**, is currently studying towards a PhD. Another physiotherapist, **Neil Smith**, has commenced his NIHR funded MRes and as part of this: [1] Will be studying 'The role of suprascapular nerve block in the conservative management of shoulder pain' [2] Has stared research taster session at SWBH.

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

SWBH based researchers continue to publish important research findings in journals of the highest international calibre **to benefit patient outcomes**. Examples from the last few months include:

- **Fabritz L**, …. **Kirchhof P**. Expert consensus document: Defining the major health modifiers causing atrial fibrillation: a roadmap to underpin personalized prevention and treatment. Nature Reviews Cardiology. December 2015
- Flint J, …, **Gordon C**, Giles I.BSR and BHPR guideline on prescribing drugs in pregnancy and breastfeeding-Part I: standard and biologic disease modifying anti-rheumatic drugs and corticosteroids. Rheumatology (Oxford). January 2016

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

No new developments in this area since last report.

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

The R&D Directors of SWBH, Dudley Group NHS Foundation Trust and Walsall Healthcare NHS Trust have held a series of meetings to discuss research opportunities within the Black Country Alliance (BCA). At the request of the BCA board, a SWOT analysis is currently being developed but specific activities where progress is being made across the BCA include:

- Access to statistical support for SWBH based researchers via the BCA, with the SWBH based statistician having retired in 2015.
- The Lead for Stoke Research at SWBH and Deputy Lead for Stroke Research in the West Midland Clinical Research network (Dr Sissi Ispoglou) has met with clinical teams at Walsall and will meet with the clinical team in Dudley on 9th February to plan Stroke research developments across the BCA.
- Discussions have begun with Professor Greg Lip and Professor Paulus Kirchhof regarding potential cardiovascular research studies that could extend across the BCA.
- Professor Karim Raza has suggested Rheumatology studies that are active at SWBH and that could be rolled out to other BAC partners and these are currently being considered.

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

No new development in this area since last report.

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

R&D space:

The SWBH R&D Director has been meeting with Alan Kenny to plan R&D space in MMH, the Sandwell site and other areas of the Trust post 2018. A significant amount of work needs to done in this domain to ensure that R&D space is fit for purpose.

Research quality:

Internal concerns about the quality of local data collection in the context of a commercial clinical trial running at SWBH led us to request an audit of the trial from the Industry Operations Manager at the West Midlands CRN. This audit highlighted a number of issues including patient follow-up visits not taking place according to the study schedule, study documentation being incomplete and patients being recruited over the age detailed in the study eligibility criteria. This report has been discussed with the Medical Director and has been forwarded to the study's Sponsor. No further patients are being recruited to this study at SWBH and specific measures have been put in place to address issues highlighted in the report in the context of the relevant study. In addition, this has led us to review our internal monitoring and quality assurance processes and a number of approaches are being put in place to reduce future risks:

- We will increase the number of studies at SWBH for which we conduct internal audits and have arranged for external audit training for senior R&D staff to increase the capacity for auditing projects.
- We are reviewing all our Standard Operating Procedures, updating and developing new ones as necessary.
- We have instigated a system of more detailed review of studies prior to approval, including a requirement for a meeting with the study team, to ensure that all feasibility issues have been adequately addressed before local permissions are given.

Research funding:

Core funding from the West Midlands Clinical Research Network (CRN):

Core funding is based on research activity. Our 2015-16 core funding budget was £626,818. Our indicative core funding budget for 2016-17 is £750,273.

Strategic funding from the West Midlands CRN:

- Prior to 2014 we had not been awarded strategic funding.
- In 2014-15 we bid for, and were awarded, £10,000.
- In 2015-16 we bid for £295,921 and were awarded £218,489.
- For 2016-17 we submitted bids for strategic funding for a total of £252,745. Across the West Midlands, the CRN received bids totalling £5.6 million against a strategic fund of £1.048 million (reduced from previous years). I was informed on 25.01.2016 that, of our bids, only one (valued at £35,247) was giving the highest ranking (meaning this amount is almost certain to be funded) with two other (valued at £40,124) being given the second highest ranking (meaning that funding will be allocated if the CRN itself receives additional funding from central resources). In conclusion, the funding we received from the CRN strategic fund will fall significantly in 2016-17 compared to the funding we secured in 2015-16 (£218,489).

Overall CRN funding:

Our overall funding from the CRN is likely to be lower in 2016-17 than it was in 2015-16.

Implications for R&D:

We are currently reviewing our commercial income with the finance team to understand our total income position.

Appendix 1:

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

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

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

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

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

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

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

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

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

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

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

OBJECTIVE 9: To ensuring rigorous governance processes and necessary infrastructure. Specifically (i) The Research Management team will ensure that all research studies are reviewed and set up in accordance with national time lines and delivery of studies is performance managed to ensure adherence to

national recommendations. (ii) We will have increased annual income generated from commercial research and though IP management from £400,000 to £1,000,000 by 2017.

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

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

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

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

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

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

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

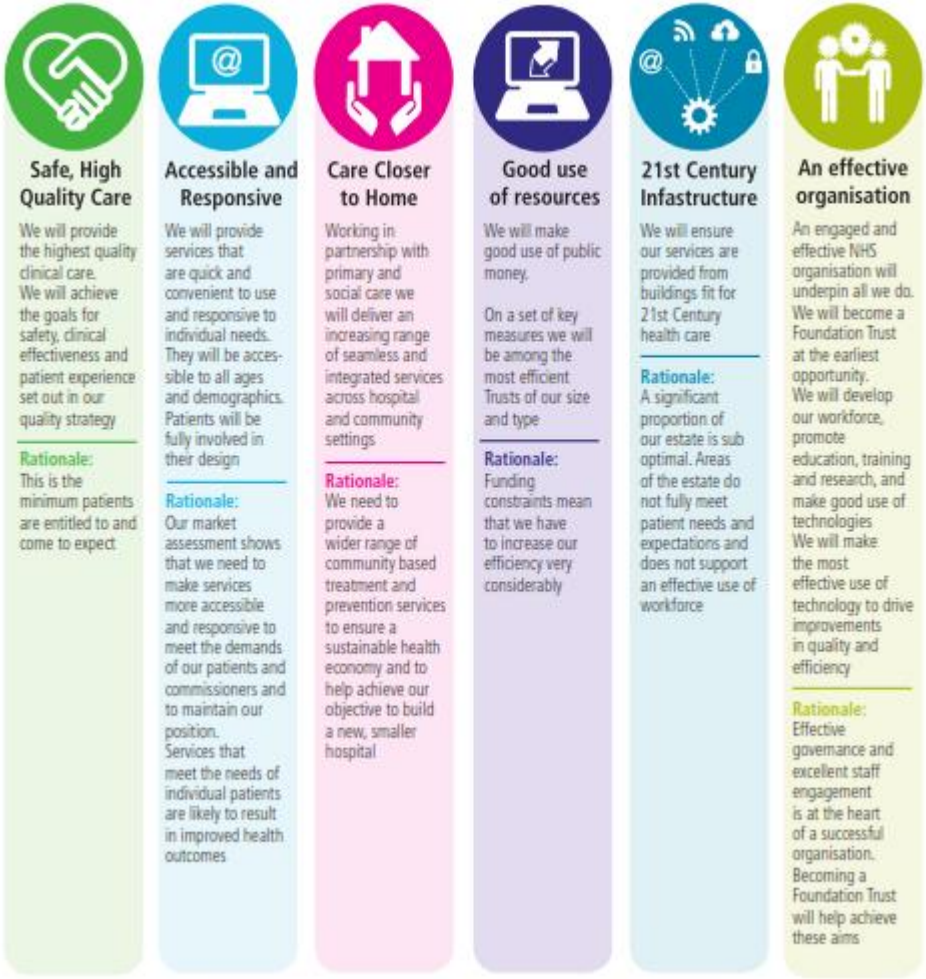
Delivering safe high quality care is at the centre of everything we do. Making care safer and of higher quality is the critical objective of the research we undertake and is why the R&D plan is so important.

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

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

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

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



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

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

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

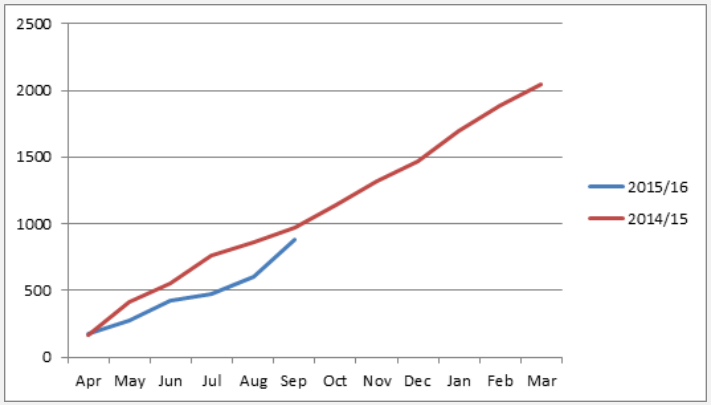
Our **Rheumatologists** have been awarded the Arthritis Research UK Centre of Excellence in the Pathogenesis of Rheumatoid Arthritis (RA), and lead a European Union consortium funded at €5.7M to develop strategies to predict and prevent the development of RA in those at risk. They have identified that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

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

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

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

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

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

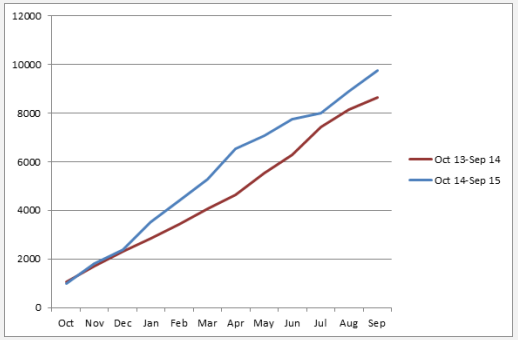
		2,500 patients this year. This enhanced rate of recruitment will be facilitated by: **1. Vacant R&D posts being filled in October / November 2015 giving us access to more delivery staff.** **2. Likely high recruiting clinical studies becoming active in October / November 2015-16.** **This increase activity in 2014-15 and 2015-16 has been achieved in the face of reduced staff resource. The reasons for failing to meet the original target within the R&D plan are described on p12 (Contextualisation).**
OBJECTIVE 2: **Promoting national and international excellence and leadership in clinical research** We will continue to support and develop our areas of research excellence. We will expand our portfolio of research by developing at least two disease areas in which we are national / international leaders.	Researchers at SWBH lead internationally recognised research programmes in several disease areas including: • Atrial fibrillation • Gynaecological malignancies • Inflammatory eye disease • Parkinson's disease • Rheumatoid arthritis • Systemic lupus erythematosus Research carried out at SWBH has: • Led to significant advances in our understanding of disease mechanisms. Enhanced our ability to predict, prevent and treat common diseases	**Over the last year we have achieved considerable success in developing research by securing major national grants in a range of areas including:** • **Behçet's disease:** MRC funding secured for a clinical trial investigating 'Optimal utilisation of biologic drugs in Behçet's Disease: a randomised controlled trial of infliximab vs alpha interferon, with genotyping and metabolomic profiling, towards a stratified medicines approach to treatment'. • **Systemic lupus erythematosus:** MRC funding secured for 'Maximizing SLE therapeutic potential by Application of Novel and Stratified approaches (MASTERPLANS)'. • **Rheumatoid arthritis:** MRC funding secured for **'**Maximising Therapeutic Utility for Rheumatoid Arthritis using genetic and genomic tissue responses to stratify medicines (MATURA)'. • **Gyane-oncology:** NIHR funding secured for 'ROCkeTS -

	associated with major health burdens. • Informed national and international guidelines on disease management.	Refining Ovarian Cancer Test Accuracy Scores' and 'SOCQER-2: Surgery in Ovarian Cancer – Quality of Life Evaluation Research' has been commissioned by NICE. • **Cardiology:** NIHR funding secured for 'CBT-AF: Cognitive Behavioural Therapy to reduce anxiety and depression in patients with atrial fibrillation'. • **Neurology:** Funding secured for 'PD COMM: Lee Silverman Voice Treatment versus standard NHS Speech and Language Therapy in Parkinson's Disease' study'. **Working with Jessica Barlow, Library Services Manager, we have collated data on all research publications from SWBH staff in 2014-15. This exercise will be repeated annually. Moving forward we will capture the extent to which these publications have been cited as a surrogate measure of their impact. This will serve as one of a number of objective measures in relation to Objectives 2 and 3 in our R&D Plan.**
OBJECTIVE 3: **Increasing the breadth of our clinical research portfolio** It is our vision that all patients looked after at the Trust are given the opportunity to take part in clinical research.	Our research portfolio has breadth as well as depth. In addition to disease areas where we are recognised as leaders in the field, we actively contribute to nationally and internationally recognised research across all clinical directorates with active research programmes in areas including:	**We have raised the profile of research amongst Trust staff using a number of strategies including:** • **Promotion of R&D activity in Trust publications including Heartbeat and Innovation and via social media including Twitter.** • **The institution of a regular forum for current and potential Investigators to meet and discuss best practice and the potential for collaborative opportunities.** **We have worked with clinical groups to develop research in areas of historically limited activity. Specifically we have**

	• Dermatology • Diabetes • Gastroenterology • Haematology • Metabolic medicine • Oncology • Paediatrics • Reproductive health • Stroke	**developed new research portfolios in the following specialities:** • **Respiratory medicine** • **Renal medicine** • **Clinical Immunology** • **Anaesthesia & Critical Care**
OBJECTIVE 4: **Increasing the *range of health care professionals* contributing to our clinical research portfolio** We will have promoted the research leadership by Nurses and Allied Health Professionals (AHPs), ensuring that at least three NIHR portfolio adopted studies are led at SWBH by Nurses / AHPs.	Our research portfolio is led predominantly by doctors. There are however several examples of Nurses and Allied Health Professionals (AHPs) conducting research as part of educational projects e.g. MSc projects and PhD training Fellowships.	**We have achieved notable success in promoting research amongst AHPs for example:** • **Mohammed Tallouzi, a Surgical Care Practitioner working in BMEC, has been successful in gaining an NIHR/HEE Clinical Doctoral Research Fellowship.** • **Roanna Burgess, a Consultant Physiotherapist, has been successful in obtaining funding to pursue a Doctoral Research programme between SWBH and the Arthritis Research UK Centre of Excellence in Primary Care at the University of Keele.** • **Neil Smith, a Physiotherapist, has been funded to study for an MRes at Coventry University.**
OBJECTIVE 5: **Translating research into better and safer clinical care** In addition to our current approaches, we will	The National Institute for Health and Clinical Excellence works to facilitate the implementation of evidence based healthcare throughout the NHS and Governance systems at the Trust ensure that guidelines are	**We have contributed to the 'Preventable Incidents, Survival and Mortality Study 2 (PRISM2)' and though this are involved with the development of a national system for mortality reviews.** **We are an active participant in 'Enhanced Peri-Operative Care for High-risk patients (EPOCH) Trial: A stepped wedge cluster randomised trial of a quality improvement intervention for**

continue to work with the CLAHRC-WM to institute changes in clinical practice at the Trust in at least 3 clinical domains. This will improve the quality and safety of the care that we provide to our patients	integrated into clinical care. We have worked with CLAHRC-WM (Collaborations for Leadership in Applied Health Research – West Midlands) to improve the quality of care we provide in relation to our Readmissions project and our 10 out of 10 safety in healthcare project	**patients undergoing emergency laparotomy'.** **Via the CLAHRC, researchers from Warwick Business School have worked with clinicians at SWBH in relation to '*Implementing a 'Patients Know Best', Personal Health Records pilot*'.**
OBJECTIVE 6: **Aligning with the Trust's strategy** The Trust's vision is to be renowned as the best integrated care organisation in the NHS provides an ideal environment within which to strengthen a research programme operating at the interface between secondary care and, for example, primary care and social care. Research themes operating at these interfaces will be supported through close engagement between researchers at the Trust and local partner groupings and organisations. We will have developed a new forum with representation from primary and secondary care within we can develop strategy for research at the primary / secondary care interface. We will host research programmes to:	Several of our current research themes align with the Trust's objective of delivering 'care closer to home' through an integrated service across hospital, intermediate care and community settings.	**A number of examples have developed over the last year which demonstrate innovate ways of working at the primary care / secondary care interface:** • The **Community Rheumatology clinic**, operating within the Vitality Partnership, now recruits patients from primary care directly into research studies operating in secondary care. • The **Cardiology** IMPRESS-AF study now identifies patients directly from primary care to participate in a secondary care based interventional trial.

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

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

from research grants, commercial research and IP management, from £400,000 to £1,000,000.		**Units this year is a result of (i) an increased number of patients recruited (ii) an increased proportion of patients recruited to complex studies.** **In relation to income from commercial research, we achieved just under £600,000 in 2014/15 and are on track to reach £700,000 in 2015/16.**

Contextualisation:

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

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

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

- The **Research Nurse team has been restructured**. We have disestablished the Band 8 Lead Research Nurse post and have replaced it with three Band 7 posts with each Band 7 research nurse managing a smaller pool of R&D delivery staff. The expectation is that this will allow each team to operate in a more efficient way with members of the teams providing more effective cover for studies across the team's portfolio.
- A new forum has been established within which all members of the R&D team meet 2 monthly to review progress towards the Objectives within the R&D plan.
- We have engaged with Dr Hilary Brown (Senior Fellow and Co-Director of Policy, Health Services Management Centre, University of Birmingham) who is conducting a study with R&D staff and local stakeholders exploring the role of the Clinical research nurse and addressing issues of 'productivity',

identifying limiting factors and examining the structures/mechanisms that support research nurses effectively. Data will be made available once the second round of interviews is complete.

- Time sheet data have been collected from R&D staff and are currently being analysed by Lakbir Virk. This will help us to identify examples of excellence in productivity from which we can learn and also areas of weakness that we need to address.

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Financial performance – P09 December 2015**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Finance Director**
AUTHOR:	**Tim Reardon – Associate Director of Finance**
DATE OF MEETING:	**4th February 2016**

EXECUTIVE SUMMARY:

Key messages:

- In month deterioration of headline & underlying performance; I&E remains off plan year to date.
- I&E outlook indicates no meaningful route to plan surplus from matters in SWBH gift to deliver.
- Necessary reliance on significant contingencies. Additional measures mobilised to underpin delivery of best financial result possible consistent with safe care and clean audit opinion.
- Erosion of underlying cash balances consequent on use of contingencies and which will require to be remedied to underpin forward investment programme. No risk to ability to meet current obligations.
- Step improvement in monthly run rate required to secure exit run rate consistent with medium term financial plan. This will not be achieved by P12 and is being addressed through 2016.18 business plan.

Key actions:

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

Key numbers:

- Month deficit £403k being £668k adverse to plan; YTD deficit £(1,224)k being £(2,659)k adverse.
- Forecast surplus £3.8m in line with original financial plan.
- Pay bill £24.4 (vs. £24.4m) in month; Agency spend £1.6m (vs. £1.6m) in month; £13.5m YTD.
- CIP delivery to date £10.3m being £2.0m adverse to TDA plan. Step up in CIP in Q4 required.
- Capex YTD £11.8m being £2.8m below plan. Capital commitments £5.5m.
- Cash at 31st December £33.3m being £7.4m above plan due to timing differences
- New FSRR 3 to date being as plan despite adverse EBITDA performance; forecast 4 now at risk
- Capital Resource Limit (CRL) charge under-shoot £500k on £20.2m plan expected.
- External Finance Limit (EFL) charge forecast at £(0.7)m being consistent with approved EFL.

REPORT RECOMMENDATION:

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

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Good use of resources

PREVIOUS CONSIDERATION:

Performance Management Committee
Finance and Investment Committee

Finance Report

Period 9 2015/16, December 2015

Trust Board
4th February 2016

Contents

Page Title

Finance Report

Summary & Recommendations

Period 9 2015/16

Statutory Financial Duties	Value	Outlook	Note
I&E surplus	£3.8m	X	1
Live within Capital Resource Limit	£20.2m	√	2
Live within External Finance Limit	£(0.7)m	√	3

1. No meaningful route to original plan or TDA stretch surplus from matters within SWBH gift to deliver.
2. Capex control totals clear & to be managed to secure compliance with CRL. IM&T focus of attention.
3. Management of working capital including creditor stretch necessary as P&L delivery reliant on non-cash contingencies.

Outlook

- Actions being progressed to secure best financial out-turn possible consistent with safe services and clean audit opinion.
- Any formal adjustment to plan out-turn requires TDA agreement. National financial position very challenging.
- Exit run-rate significantly adverse to plan compounding 2016.17 financial challenge. Work to resolve on-going.

Financial Performance for the 9 months to 31st December

- I&E deficit of £1,224k being £2,659k behind plan;
- Capital spend of £11.8m, £2.8m behind plan;
- Cash at 31st December £33.3m, being £7.4m more than plan.

Opportunities & risks

The Trust has three specific external risks in total:

- Ante-natal provider to provider tariff improvement.
- Recovery of DTOC fines to local authority.
- Resolution of education contract reduction

The Trust is working with both the TDA and CCG in exploring opportunities for financial improvement. These include fines cap reduction, income recovery and asset valuation. No reduction in services currently proposed.

Recommendation

- Note high level of risk attached with outlook position and implication for 2016.17
- Maintain focus on driving step change in underlying run-rate – planned care income, agency pay reduction, CIP delivery

Finance Report

Performance to date – I&E and cash

Period 9 2015/16

I&E

The key I&E issues are:

- Planned care [elective IP & DC] income below plan levels;
- Premium rate interim staffing spend above plan levels;
- Rate of cost reduction not yet consistent with that required to meet medium term financial plan trajectory

The reported I&E deficit is after the benefit of £8.1m of balance sheet flexibility released to improve the position.

Reserves planned but not spent or accrued to date total £4.7m.

Savings

Progress reported through the Trust's savings management system TPRS continues to deteriorate relative to plan. The concern remains with regard to the delivery of full year plans where significant savings remain to be identified and allocated. Recent forecasts from Groups re CIP achievement confirm this concern.

Capital & Cash

Capital expenditure to date stands at £11.8m against a full year plan of £20.5m. A further £5.5m of firm commitments have been made to date. The revised programme is intended to be managed within the Trust's notified capital resource limit. This is reflected in the cash position, as is payables which continue to reflect disputed payments to NHS suppliers, including those for maternity pathway attendances at other Trusts. Payments due from the local authority for delayed discharges are disputed and so the debtors variance is partially offsetting any benefit on creditors.

Better Payments Practice Code

70% performance for NHS bodies in month brings the YTD down to 84% by value.

Non-NHS performance remains below target at 87% by value. Lack of receipting of orders continues to be a significant impediment to performance.

Financial Sustainability Risk Rating

Rating of 3 year to date consistent with planned rating of 3.

Stretch plan out-turn of 4 at risk due to

Finance Report

I&E – To date & Outlook

Period 9 2015/16

P09 Year to Date	Annual Plan £'000s	CP Plan £'000s	CP Actual £'000s	CP Variance £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s	Plan Outturn £'000s
Patient Related Income	399,654	33,423	32,634	(789)	299,610	295,629	(3,980)	399,654
Other Income	40,742	3,370	3,232	(138)	30,633	30,536	(97)	40,742
Income total	**440,396**	**36,793**	**35,866**	**(927)**	**330,243**	**326,166**	**(4,077)**	**440,396**
Pay	(286,319)	(23,893)	(24,413)	(520)	(214,998)	(220,214)	(5,215)	(286,319)
Non-Pay	(127,471)	(10,837)	(10,565)	272	(97,606)	(91,402)	6,204	(127,471)
Expendiutre total	**(413,789)**	**(34,730)**	**(34,978)**	**(248)**	**(312,605)**	**(311,615)**	**989**	**(413,789)**
EBITDA	**26,606**	**2,063**	**888**	**(1,175)**	**17,639**	**14,550**	**(3,088)**	**26,606**
Non-Operating Expenditure	(21,973)	(1,830)	(1,318)	512	(16,483)	(15,638)	845	(21,973)
IFRIC12	372	31	27	(4)	279	(137)	(416)	372
DH Surplus/(Deficit)	**5,006**	**264**	**(403)**	**(668)**	**1,434**	**(1,224)**	**(2,659)**	**5,006**

In month headline and under-lying position deteriorated.

Out-turn plan shown as stretch target consistent with current reporting to TDA and pending agreement to vary that to a more meaningful out-turn.

On-going reliance on the use of significant contingencies to underpin reported headline performance.

Outlook	Reported YTD £'000s				Mth 10 £'000s	Mth 11 £'000s	Mth 12 £'000s	FY 2015/16 £'000s
Patient Related Income	295,629				34,458	34,738	33,539	397,799
Other Income	30,536				3,365	3,365	4,565	42,033
Income total	**326,166**				**37,822**	**38,102**	**38,104**	**439,831**
Pay	(220,214)				(24,418)	(24,417)	(23,886)	(293,078)
Non-Pay	(91,402)				(10,473)	(11,072)	(10,591)	(123,140)
Expendiutre total	**(311,615)**				**(34,891)**	**(35,488)**	**(34,476)**	**(416,218)**
EBITDA	**14,550**				**2,932**	**2,614**	**3,627**	**23,613**
Non-Operating Expenditure	(15,638)				(1,783)	(860)	(1,460)	(19,568)
IFRIC12	(137)				(15)	(15)	(15)	(246)
DH Surplus/(Deficit)	**(1,224)**				**1,134**	**1,738**	**2,152**	**3,800**

Required delivery in Q4 to secure original plan target surplus as previously reported. This is considered not to be in SWBH gift to secure.

Improvement in run rate to be consistent with medium term financial plan will not be achieved by P12 adding to 2016.17 financial challenge. Remedial plans being addressed through 2016.18 business planning process.

Finance Report

Income Analysis

Period 9 2015/16

PERFORMANCE UP TO December 2015	Activity			Finance		
	Planned	Actual	Variance	Planned £000	Actual £000	Variance £000
Accident and Emergency	167,936	165,020	(2,916)	16,630	15,626	(1,004)
Adult Renal Dialysis	409	176	(233)	50	22	(28)
Community	439,247	438,942	(305)	26,497	26,624	128
Day Cases	31,411	27,129	(4,282)	24,391	21,356	(3,036)
Elective	8,753	6,595	(2,158)	16,202	12,331	(3,870)
Maternity	14,120	14,865	745	13,439	14,097	658
Non-Elective & Emergency	51,433	51,004	(429)	66,809	67,272	462
Occupied Cot Days	8,529	10,069	1,541	4,391	4,576	186
Other Contract Lines	2,388,873	2,450,109	61,236	67,665	67,319	(346)
Outpatient	8,894	7,055	(1,838)	1,700	1,357	(343)
Outpatient FA Multi Professional Non-Consultant Led	126	43	(83)	34	25	(9)
Outpatient FA Single Professional Consultant Led	88,954	92,842	3,888	14,516	15,321	806
Outpatient FA Single Professional Non-Consultant Led	35,744	38,240	2,496	3,325	3,335	10
Outpatient FUP Multi Professional Consultant Led	20,113	13,043	(7,070)	2,516	1,673	(842)
Outpatient FUP Multi Professional Non-Consultant Led	497	454	(43)	24	23	(1)
Outpatient FUP Single Professional Consultant Led	220,651	211,659	(8,992)	18,163	17,405	(758)
Outpatient FUP Single Professional Non-Consultant Led	78,285	83,365	5,080	5,030	5,291	260
Outpatient Procedures	36,368	41,928	5,560	6,729	8,170	1,441
Outpatient Telephone Consultation	9,658	8,820	(838)	218	211	(8)
Other	45,814	51,690	5,877	6,283	6,803	520
Total				**294,613**	**288,839**	**(5,774)**

This table shows the Trust's year to date SLA income performance by point of delivery.
The impact of the shortfall in elective work can be seen in the adverse variance for day cases and elective activity. That these have only been partially offset by additional activity on outpatients and non-elective work underlines the importance of the elective demand and capacity work to the recovery plan.

The variance on total Patient Related Income to date is £(3,770)k.
The difference to SLA income shown above is primarily related to pass through costs of drugs & devices being above plan £1.6m and which are offset by an equivalent variance on non-pay costs.

Finance Report

Pay bill & Workforce

Period 9 2015/16

Paybill & Workforce

- Total workforce of 7,059 WTE [being 58 WTE above plan] including 267 WTE of agency staff.
- Total pay costs in December (including agency workers) were £24.4m [vs. £24.4m previous month] being £0.5m over plan.
- Significant reduction in temporary pay costs required to be consistent with delivery of key financial targets. Focus on improvement in recruitment time to fill and effective sickness management.
- The Trust did not comply with new national agency framework guidance for agency suppliers in December. Shifts procured outside of this are subject to COO approval and is driven by strict commitment to maintaining safe staffing.
- The Trust exceeded the national agency rate cap effected from 23 November 2015. Trust implementation and compliance is subject to granular assurance that there is no compromise to securing safe staffing levels.

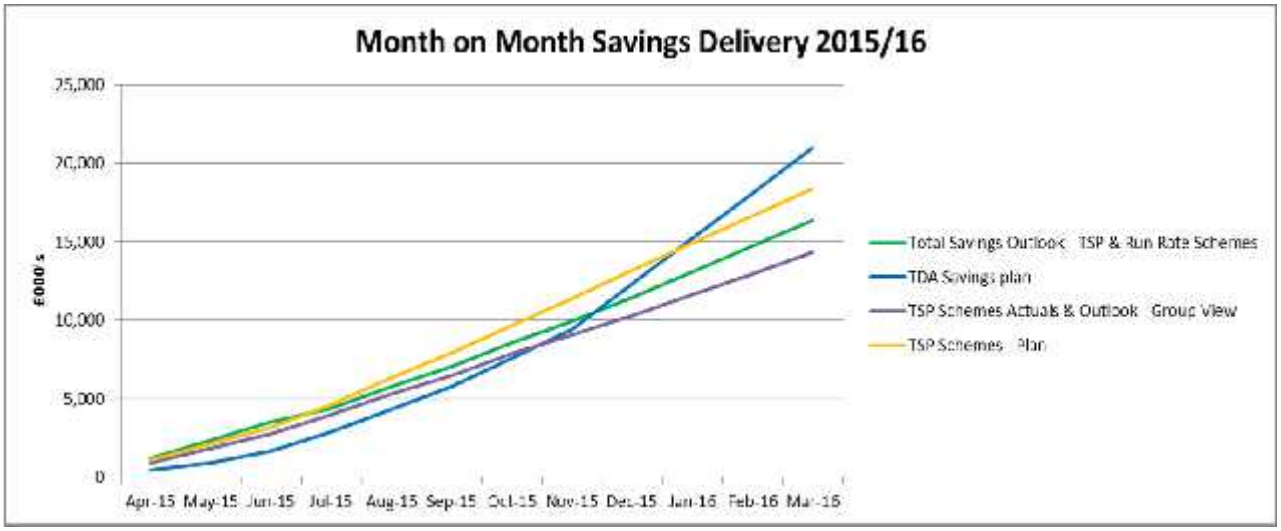
Variance From Plan by Expenditure Type	**Current Period £000**	**Year to Date £000**
	(Adv) / Fav	(Adv) / Fav
Patient Income	(789)	(3,980)
Other Income	(138)	(97)
Medical Pay	(35)	(409)
Nursing	(139)	896
Other Pay	(346)	(5,703)
Drugs & Consumables	(652)	(2,642)
Other Costs	924	8,846
Interest & Dividends	512	845
IFRIC etc adjustments	(4)	(416)
Total	(668)	(2,659)

Pay & workforce	Current period	Previous period	Change in period Value	Change in period %
Pay - total spend	24,413	24,445	-32	0%
Pay - substantive	20,844	20,943	-99	0%
Pay - agency	1,552	1,585	-33	-2%
Pay - bank (including locum)	2,017	1,917	100	5%
WTE - total	7,059	6,884	175	3%
WTE - substantive	6,062	6,069	-7	0%
WTE - agency	267	184	83	45%
WTE - bank (including locum)	731	631	100	16%

Finance Report

CIP achievement

Period 9 2015/16



This chart shows the savings profile in our plan submission to TDA; the plan value of identified TSP savings schemes; the value of those TSP schemes delivered to date and outlook.

The chart also shows a total savings plan from TSP & run rate schemes included in our forecast reported to TDA.

£21m of TSP schemes is necessary to meet the requirements of the trust's plan. Run rate schemes are tracked part of group 'route to balance'.

At P09 [TSP] savings delivery was behind TDA plan with £10.3m of savings delivered against a plan of £12.3m.

TSP savings delivery was, also below the internal plan value of those schemes with £10.3m delivered against a plan of £13.2m.

A group view of the outlook suggests a shortfall in TSP delivery of £6.7m against TDA plan target £21.0m.

This represents a significant deterioration in the group view of TSP savings delivery outlook from that at P05. It also indicates a slight deterioration month on month from P08

Urgent escalation of savings delivery is necessary and in hand.

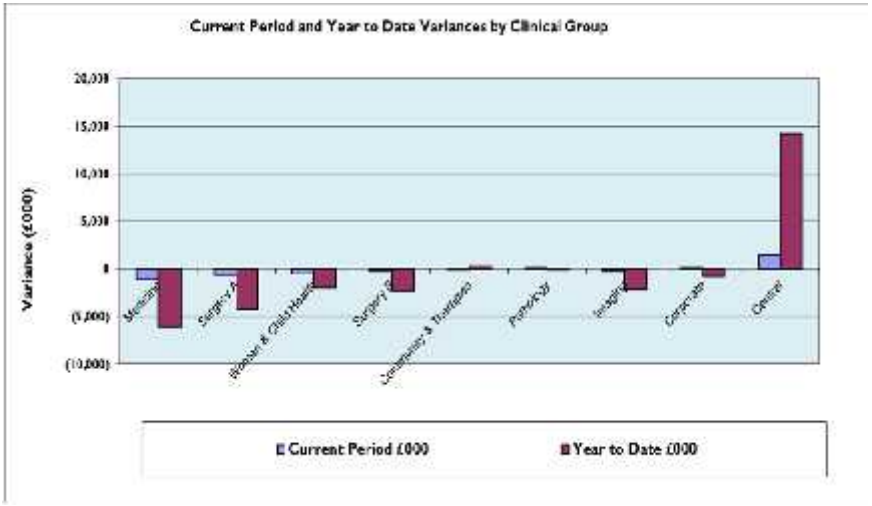
Measurement of success remains delivery of "bottom right" surplus and within that any necessary and sufficient CIPs. Delivery of CIPs to plan is key but not necessarily sufficient to that success.

Finance Report

Group Analysis – Month & YTD

Period 9 2015/16

Group Variances from Plan (Operating income and expenditure)	Current Period £000	Year to Date £000
Medicine	(1,095)	(6,025)
Surgery A	(581)	(4,304)
Women & Child Health	(471)	(2,055)
Surgery B	(275)	(2,283)
Community & Therapies	(12)	346
Pathology	43	(3)
Imaging	(281)	(2,226)
Corporate	45	(749)
Central	1,452	14,211



Performance of Clinical Groups

- **Medicine:** Key risks continue to be medical and nursing agency; delivery of savings plans especially the major scheme around closure of capacity. Delivering winter plan within budget also major risk. Significant CIP Plans value were identified but actual delivery significantly away from plan.
- **Surgery A:** Key risks are, delivery of contract, and delivering CIP target. Demand and Capacity work is forecasting significant improvement against contract. Identification of CIP plans and delivery remains a concern.
- **Women & Child Health:** Settlement of Maternity Pathway forward SLA & historic payments key for the Group. Management of position largely via holding vacancies; workforce plan assuring sustainability & safety.
- **Surgery B:** Intensive work around Demand and Capacity recovery on-going; expectation that significant improvements can be delivered. Significant gap in CIP identification and delivery are also a concern, although work on D&C and delivery of improvements should address significant proportion of these.
- **Community & Therapies'** position includes significant vacancy management as route to CIP savings. workforce plan assuring sustainability & safety.
- **Imaging:** Significant use of Premium Rate Working, contracted out reporting (now ceased) and mobile MRI scanner in order to deliver activity. Use of agency staff remains high. Have been a number of opportunities for improvement identified, and delivery of these vital in order to move toward financial balance.

Corporate Areas

- Pay underspends include December reduced agency are offset by share of SLA underperformance, savings under-delivery and non-pay overspending. Delivery of Demand and Capacity work in clinical Groups will have positive impact on position. Corporate Nursing & Facilities; and Operations remain the two Directorates under most financial pressure.

Central

- Release of balance sheet contingency and impact of deferred / avoided reserves spend.

Finance Report

Capital

Period 9 2015/16

Summary Capital Expenditure: FY 2015/16							
	YTD			Full Year			
Expenditure Category	Flex Plan	Actual	Gap	TDA Plan	Flex Plan	Outlook	Variance
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Estates	9,475	7,689	(1,786)	10,759	12,385	11,885	(500)
Information	1,932	2,203	271	5,100	4,754	4,754	0
Medical equipment	2,831	1,630	(1,201)	3,000	2,990	2,990	0
Contingency	0	0	0	1,294	24	24	0
NHS funded expenditure	**14,238**	**11,522**	**(2,716)**	**20,153**	**20,153**	**19,653**	**(500)**
Donated assets	299	254	(45)	76	348	348	0
Total Expenditure	**14,537**	**11,776**	**(2,761)**	**20,229**	**20,501**	**20,001**	**(500)**

The above table shows the status of the capital programme, analysed by category, at the end of Period 9 together with the latest view of out-turn. IM&T area of focus having regard to VAT treatment of project support costs and timing of key infrastructure expenditure.

CRL undershoot £500k to be delivered to secure capital to revenue transfer opportunity to improve headline I&E surplus. TDA advises that that benefit will not be supported to crystallise locally. Benefit taken nationally.

Finance Report

SOFP

Period 9 2015/16

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION 2015/16

	Balance as at 31st March 2015	Balance as at 31st Dec 2015	TDA Planned Balance as at 31st Dec 2015	Variance to plan as at 31st Dec 2015	TDA Plan as at 31st March 2016	Forecast 31st March 2016
	£000	£000	£000	£000	£000	£000
Non Current Assets						
Property, Plant and Equipment	233,309	235,437	235,665	(228)	246,555	238,898
Intangible Assets	677	510	517	(7)	437	437
Trade and Other Receivables	890	928	908	20	1,011	1,011
Current Assets						
Inventories	3,467	3,400	3,084	316	2,972	2,972
Trade and Other Receivables	16,318	21,893	16,226	5,667	15,966	15,966
Cash and Cash Equivalents	28,382	33,275	25,910	7,365	27,082	27,082
Current Liabilities						
Trade and Other Payables	(45,951)	(63,189)	(47,118)	(16,071)	(53,620)	(48,974)
Provisions	(4,502)	(2,566)	(3,883)	1,317	(3,355)	(3,437)
Borrowings	(1,017)	(1,017)	(1,017)	0	(1,017)	(1,017)
DH Capital Loan	(1,000)	0	0	0	0	0
Non Current Liabilities						
Provisions	(2,986)	(2,931)	(2,363)	(568)	(4,133)	(1,434)
Borrowings	(26,898)	(26,138)	(26,218)	80	(25,881)	(25,881)
DH Capital Loan	0	0	0	0	0	0
	200,689	**199,602**	**201,711**	**(2,109)**	**206,017**	**205,623**
Financed By						
Taxpayers Equity						
Public Dividend Capital	162,210	162,210	162,210	0	162,210	162,210
Retained Earnings reserve	(13,758)	(14,845)	(12,736)	(2,109)	(8,430)	(8,824)
Revaluation Reserve	43,179	43,179	43,179	0	43,179	43,179
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	200,689	**199,602**	**201,711**	**(2,109)**	**206,017**	**205,623**

The table opposite is a summarised SOFP for the Trust including the actual and planned positions at the end of December and the full year. Full year forecast reflects the Trust's decision to revalue Property at 1st April 2015 and this is represented in the variance from plan at 31st March 2016.

The Receivables variance from plan is predominantly related to the aged NHS debt position which is subject to on going negotiations.

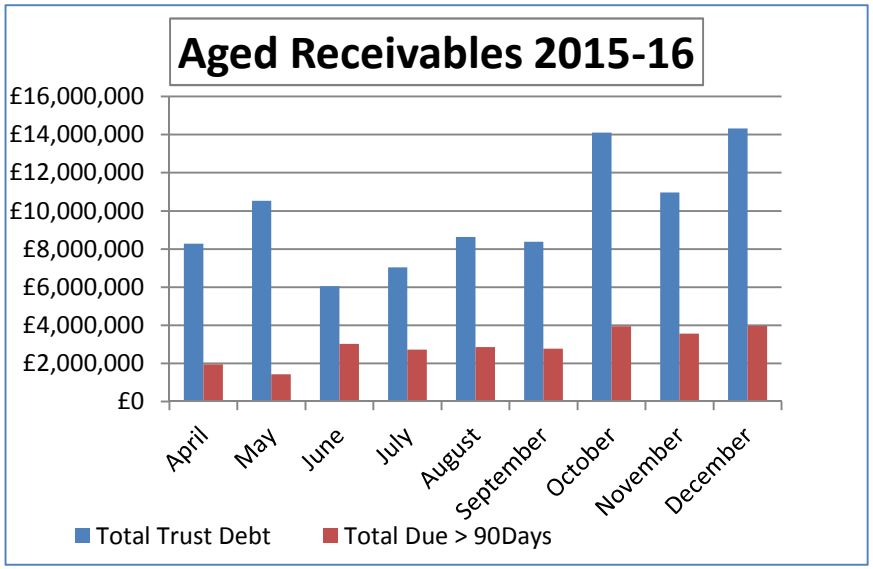
Payables have increased during December that reflects the reduction in payments in the month as the Trust seeks to ensure a robust cash position to support the final 2015/16 I&E position. Progress has been made on addressing the Non-NHS aged creditor profile. Variance from plan also reflects the status of outstanding invoices relating to Maternity Pathways, discussions for which are underway at Executive level.

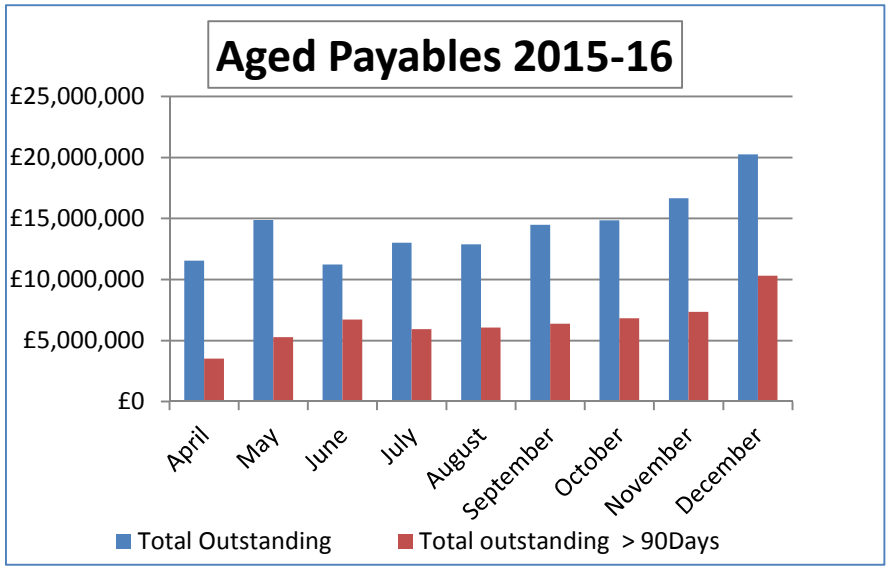
Graphs to represent the profile of Receivables and Payables are shown below.

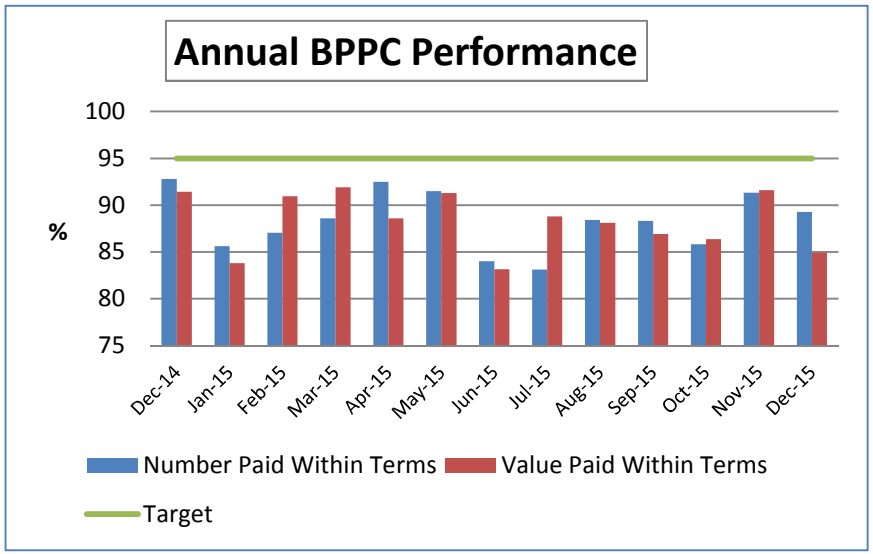
Finance Report

Aged Receivables, Aged Payables, BPPC and Cash Forecast

Period 9 2015/16







Note

- Within aged receivables position shows an increase but includes £4m of invoices raised for Health Education that relate to the MADEL contract for Q4 2015-16, excluding these the overall debt position has decreased. However outstanding debt relating to SLA's with other NHS providers and DTOCs charges with local authorities remain. Discussions for both issues are underway at Executive level.

- BPPC is below target of 95% but reflects consistent performance to date. The main challenges in improving this relate to the trust P2P process and specifically the use of purchase orders, including receipting.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Performance Report
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance
AUTHOR:	Yasmina Gainer, Head Performance Management & Costing
DATE OF MEETING:	4 February 2016

EXECUTIVE SUMMARY:

The report is presented to inform the Committee of the summary performance for the Trust for the period to December 2015.

1) IPR – Summary Scorecard for December Month

Summary Scorecard

Section	Red Rated	Amber Rated	Green Rated	None	Total
Infection Control	2	0	4	0	**6**
Harm Free Care	5	1	6	2	**14**
Obstetrics	2	0	5	6	**13**
Mortality and Readmissions	1	0	0	11	**12**
Stroke and Cardiology	4	0	7	0	**11**
Cancer	1	0	8	4	**13**
FFT. MSA, Complaints	8	2	6	6	**22**
Cancellations	4	1	4	0	**9**
Emergency Care & Patient Flow	6	0	7	7	**20**
RTT	4	0	3	0	**7**
Data Completeness	2	0	8	1	**11**
Staff	10	0	1	12	**23**
Total	**49**	**4**	**59**	**49**	**161**

- December performance has 49 [vs. 47 last month] exceptions (red rated) indicators.
- Relevant recovery plans are overseen through the executive Performance Management Committee.

2) Matters to draw to the Board's attention

Positives

- Improvement in readmission rates which show reduction to 7.3% in month
- Improvement in rapid access chest pain to 94% from 71% & with expectation of full delivery in January
- Improvement in complaints timeliness of handling

Requiring attention

- VTE - one of our baseline care commitments better but requires further improvement – expected January
- Thrombolysis within 60 mins of admission – under-performance in December bucks good track record
- Sickness & absence increase in month to 5.5%; increasing nurse vacancies

REPORT RECOMMENDATION:

The Trust Board is asked to consider the content of this report.
Its attention is drawn to the matters above and commentary at the 'At a glance' summary page.

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

Accept	Approve the recommendation	Discuss
		X

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

Comments:

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

Accessible and Responsive Care, High Quality Care and Good Use of Resources.

PREVIOUS CONSIDERATION:

Operational Management Committee, Performance Management Committee, CLE

Sandwell and West Birmingham Hospitals NHS Trust

Integrated Quality & Performance Report

Month Reported: December 2015

Reported as at: 29/01/2016

Contents

At Glance - December 2015

Infection Control

x3 C. Diff cases reported during the month of December (all in medicine). The number of cases year to date is at 20 against a YTD target maximum of 23 [30 full year].

No cases of MRSA Bacteraemia were reported in December. 2 cases reported year to date versus a target of zero.

MRSA Screening - Elective patients meet target overall (target 80%) across all groups except Medicine which is at 71% elective screening; Non-elective patients meet full screening compliance across all groups.

The incidence of MSSA Bacteraemia (expressed per 100,000 bed days) for the month of December is 10.7 versus the target of 9.42; year to date at 3.7 and in line with target. 2/4 latest months have exceeded target level. Last occurred autumn 2014.

Harm Free Care

Overall Harm Free Care as assessed through the NHS Safety Thermometer indicates a level of Harm Free Care of 94.5% for December beneath the 95.0% operational threshold. This marginal under-performance is persistent month on month.

x75 falls reported in December (49 Acute; 26 Community) with 1 fall resulting in serious injury (Community). No reduction on previous months.

There were 5 cases of avoidable, hospital acquired pressure ulcers reported in December (4 cases in Medicine, 1 case in Surgery A). 4 out of 5 were a grade 3 and 1 case was a grade 2.
Noted significant improvement winter 2015 on winter 2014.

There were 2 serious incidents reported in December (incl 1 fall serious injury).

There were no medication error causing serious harm in December.

There were 9 [vs. 4 last mnth] Open CAS Alerts reported at the end of December, of which none were overdue at the end of the reporting period.

Venous Thromboembolism (VTE) Assessments in December are at 94.1% (target of 95%). The performance levels have been escalated to relevant areas as 4/6 latest months have shown under-performance.
Delivery to target is projected for January as remedial actions deliver.

Obstetrics

The overall Caesarean Section rate for December is 23.1% (vs. 25% target), 25.2% and hence slightly above the target on a cumulative year to date basis.
Elective and Non-Elective rates cumulatively are 8.8% and 16.5% respectively.

Adjusted perinatal mortality rate (per 1000 births) for December is 10.71 being in excess of target rate 8%;
Group consideration of risk. 6/9 months this year delivering within target. The indicator represents an in-month position and which, together with the small numbers involved provides for some natural variation. Nationally this is monitored using a 3 year cumulative trend, based on which the Trust is within normal confidence limits.

Early Booking Assessment (<12 + 6 weeks) - SWBH Specific definition target of 90% has consistently not been met; December delivery 78.6%; performance is consistently delivering to nationally specified targets.

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

Breastfeeding initiation is at 73.16% on a cumulative basis as at quarter 3, below the target of 77% in the last quarter.

Mortality & Readmissions

The Trust overall RAMI for most recent 12-mth cumulative period is 91 (latest available data is as at September).
The RAMI for weekday and weekend each at 92 and 88 respectively and considered within statistical confidence limits.

SHMI measure which includes deaths 30-days after hospital discharge is at 98 for the month of August (latest available data). Consistent with previous months.

Deaths in Low Risk Diagnosis Groups (RAMI) - month of September is at 80. This indicator measures in-month expected versus actual deaths so subject to larger month on month variations.

Crude in-month mortality rates remain similar to previous periods and tracks against established averages.
Mortality review rate in November is only at 79% for the Trust against the internally set target of 90%.

Readmissions (in-hospital) reported at 7.3% for December in-month [8.3% rolling 12 mnths].
For CQC diagnostic group reporting 8.6% rolling 12 months (vs. peer 6.0%).
This indicates an improving trend based on the in-month figures which are linked to recent improvements across the trust.

Stroke Care & Cardiology

Stroke data for December indicates 98% of patients spending >90% of their time on a stroke ward being compliant with the 90% operational threshold (year to date delivery at 92.5%). Sustaining this performance will bring year end performance in line with target for the year.

December admittance to an acute stroke unit within 4 hours remains relatively stable at 82.5% (falling short on 90% local target, but compliant with 80% national target). Year to date delivery at 81.2%. The trust is still striving to improve on this level of performance.

Pts receiving CT Scan within 1 hour of presentation 66.7% in month [73.1% YTD] being compliant with 50% standard.
Pts receiving CT Scan within 24 hrs of presentation has failed to deliver to the 100% target in the month, delivery at 98.2% (99.2% YTD). The service will aim to achieve the target for the year end.

In December patients receiving thrombolysis within 60 minutes of admission was at 80% (vs. 100% last mnth) against a target of 85% - a significant worsening month on month. 84.4% YTD just below target.

For December, Primary Angioplasty Door to balloon time (<90 minutes) and Call to balloon time (<150 minutes) is at 100% (80% targets); both indicators delivering year to date target.

RACP performance for December is at 94.2% (significant improvement from 71.3% previous month following action plans); 5/9 mnths failed standard; impacting therefore the year to date performance which is now at 93.6% (target of 98%).
The service is now looking at improvements across the full pathway, in particular, the GP referral process and is expecting full recovery in January (tracking close to 100%).

Cancer Care

The Trust has met all its national cancer targets in November including the 62-day urgent GP referral to treatment target, with overall performance of 90.3% (vs. 85% target) which is a significant improvement to last month.
x5 breaches in month across tumour-site specialities.
December targets have also been met and therefore meeting Q3 overall.

Internal hospital referrals which are being monitored are below the 90% target and at 87.5% indicating delayed referrals in Gynae.

The projection is that in January the trust will not deliver on all targets (particularly around 2WW from GPs where referrals have increased by c30%); with performance recovering in February and delivery overall for Q4 and thus for the year.

In November, 6 [vs. 13 last month] patients were waiting over 62 days and 2 [8] patients were waiting more than 104 days.
There is now a national focus on this cohort of patients (104 days waiters) and the trust submits detailed patient level information for this indicator.
The longest waiting patient is at 138 days.

Patient Experience - MSA & Complaints

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

FFT is meeting the target in respect of inpatient score, however not against set response rates. Failing the A&E and Outpatients score for December. Low response rates continue in inpatients and A&E.

The number of complaints received for the month is at 83 (avg for this year is 96), with 3 formal complaints.
All have been acknowledged within target timeframes.
The level of responses exceeding agreed dates is at its lowest rate this year at 2.5% in December (4.1% in November) so consistently showing improvement. The oldest complaint on the system is 59 days old.

The Learning Disability indicator is red. The service is on an action plan to ensure compliance is as per latest guidance, and this is being progressed.

Patient Experience - Cancelled Operations

The number of elective operations cancelled at the last minute went up to 1% in month a worsening to last month (0.8% in November) hence failing the target of 0.8%.
The year to date performance is at 0.9% and again just above the required level.

No breaches of 28 days guarantee in December.

39 [vs. 57 last month] of all cancelled patients experienced multiple cancellations in December which is an improvement to previous months.

The number of sitrep cancellations increased in December 40 [vs 33]
There were no urgent cancellations reported in the month of December.

Theatre utilisation is below the target of 85% at a Trust average of 68.9% as at December. Notable the performance in Cathlab is very low due to the new system (Labyrinth) being integrated into trust reporting. The theatre capacity and performance is being managed closer going forward with clear action plans in place.

Emergency Care

The Trust's performance against the 4-hour ED wait target of 91.02% during the month of December.
Performance for Q3 is at 93.12% and hence missing the target of 95%. Performance for Q2 was 94.57% and Q1 at 92.99%. Despite this, the Trust remains one of the top performing A&E departments nationally.

WMAS fineable 30 - 60 minutes delayed handovers at 121 in December (vs 67 last mnth) almost doubling from last month.
Over 60 minutes delayed handovers reported at 8 cases in December (3 cases in November) so here also worsening. WMAS - Handover Delays > 60 mins (% all emergency conveyances) is at 0.18% versus target of 0.02% .

Fractured Neck of Femur - information outstanding at this stage.

Patient out of hours bed moves are showing a reducing trend, but need to follow CQUIN principles which is being actioned and will inform this indicator going forward.

DTOCs are at 2.4% in the month of December (vs. 2% previous month), below the target of 3.5%.

Referral To Treatment

RTT incomplete pathway for December was at 92.01% just meeting the 92% target. This is the only pathway now monitored nationally. The forecast is that incomplete RTT will be met over the next 3 months.

Admitted and non-admitted RTT pathways continue to be monitored & both under-achieved in December as per projections.

At the end of December 2 [vs. 4 last mnth] patients were waiting more than 52 weeks for commencement of treatment; none of these were on the incomplete pathway.

24 Treatment Functions failed the respective RTT pathway performance thresholds for the month of December.
The failing specialities are mainly within Medicine and Surgery A, and are all subject to closely monitored improvement plans.

Diagnostic waits beyond 6 weeks were 0.26% December in-month, remaining well beneath the operational threshold of 1.00%.

Data Completeness

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

The Trust's internal assessment of the completion of valid NHS Number Field within inpatient data sets is below the 99.0% operational threshold, with actual performance (completeness) during December reported as 97.0%. Outpatient, Community and A&E data sets continue to exceed their respective thresholds. Coding for Ethnicity is at 90% versus a target of 90%.

Open Referrals as at November are at are at 228,862 . The trust is following up previous reviews earlier this year, and again assessing the process and policy in respect of this indicator which aims to maintain appropriate levels of open referrals. Progress is being made to improve and embed a robust open referral management process within the Trust. A full roll out of improvements is planned by end of Jan2016.

Staff

PDR overall compliance as at the end of December is at 86.2%.
The Medical Appraisal / Revalidation rate as at December is 86.9% measuring only validated appraisals, not appraisals 'carried out'.
Both indicators are below targets of 95%.

Mandatory Training at the end of December is at 87.1% overall against target of 95%.
Health & Safety mandatory training at 97.6%.

Sickness in the month of December has gone up by 0.5% to 5.5%. Cumulative sickness is at 5.0%. Return to work interviews at 69.9% for the month.

The Trust annualised turnover rate is at 13.6% as at December and static to last month. Specifically, nursing turnover has been recorded at 15% for the month.

Qualified nurse vacancies as at December reported at 293 (267wte LM) implying that we had a greater nursing turnover, which is at 15% as at December, not replenished with new starters.

Nurse Bank & Agency utilisation continues to be high; a high proportion of the filled shifts has been via Bank nurses.

CQUIN

The Trust will be submitting the Q3 returns to CCG and SCG.
The results are being collated and will be reported to set timelines.
Several schemes continue to be challenging in terms of delivery due to system/development issues. Manual audits continue which is a significant effort.

Ext Assessment Frameworks & Data Quality

The TDA Observation & Escalation assessment of the trust remains at 'level 3 - Intervention'.

Data Quality (DQ) - the Performance Committee has agreed to re-visit all IPR indicators in respect of DQ. DQ kitemark assessments have been progressing as part of an ongoing improvement cycle. Detailed action plans are being prepared - all groups need to submit their plans during January which will form part of the Audit Action Tracker.

Summary Scorecard - December (Month)

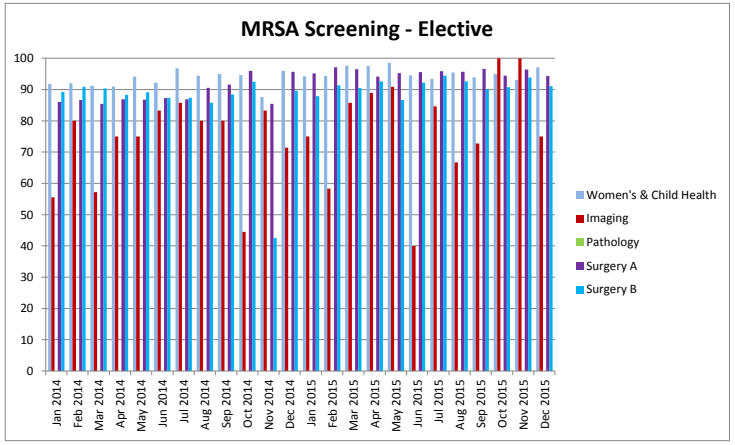
Summary Scorecard

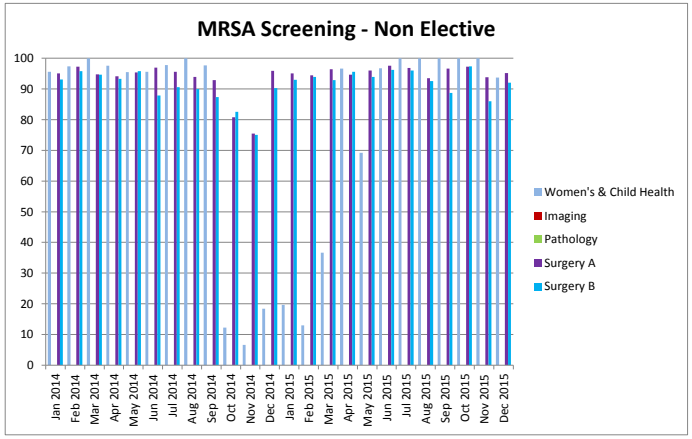
Section	Red Rated	Amber Rated	Green Rated	None	Total
Infection Control	2	0	4	0	6
Harm Free Care	5	1	6	2	14
Obstetrics	2	0	5	6	13
Mortality and Readmissions	1	0	0	11	12
Stroke and Cardiology	4	0	7	0	11
Cancer	1	0	8	4	13
FFT, MSA, Complaints	8	2	6	6	22
Cancellations	4	1	4	0	9
Emergency Care & Patient Flow	6	0	7	7	20
RTT	4	0	3	0	7
Data Completeness	2	0	8	1	11
Staff	10	0	1	12	23
Total	**49**	**4**	**59**	**49**	**161**

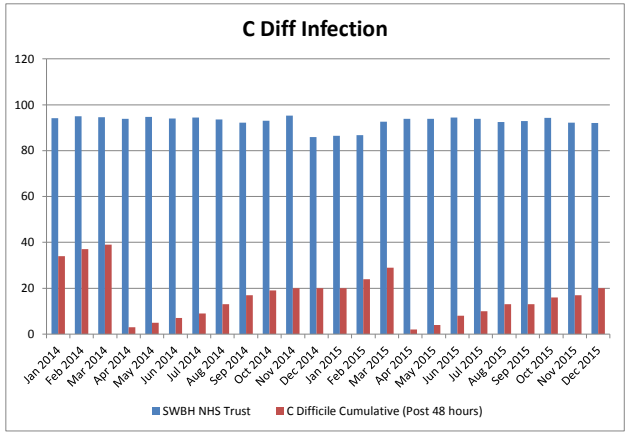
Exceptions are being managed in respective groups and are monitored in Group Reviews and in the Operational Management Committee.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Jul 2014) J A S O N D J F M A M J J A S O N D	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
4			C. Difficile	<= No	30	3		Dec 2015	3	0	0	0					3	20			
4			MRSA Bacteraemia	<= No	0	0		Dec 2015	0	0	0	0					0	2			
4			MSSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9		Dec 2015									10.7	3.7			
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	94.9	95		Dec 2015									10.7	20.1			
3			MRSA Screening - Elective	=> %	80	80		Dec 2015	71	94	91	97					92.5				
3			MRSA Screening - Non Elective	=> %	80	80		Dec 2015	90	95	92	94					92.1				

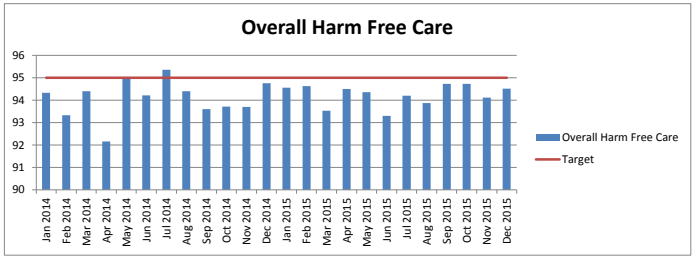


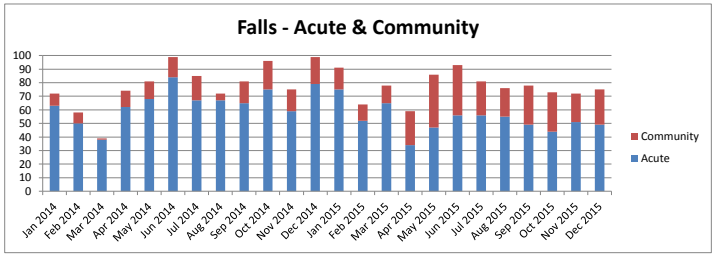


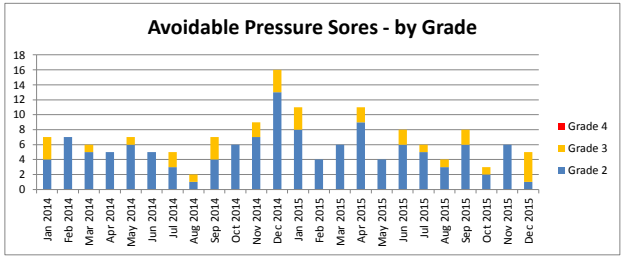


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2014) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8			Patient Safety Thermometer - Overall Harm Free Care	=> %	95	95																			Dec 2015									94.5				
8			Patient Safety Thermometer - Catheters & UTIs	%			0.49	0.42	0.41	0.40	0.25	0.31	0.41	0.40	0.64	0.25	4.00	2.00	1.00	9.00	3.00	3.00	4.00	7.00	Dec 2015									0.58				
8			Falls	<= No	804	67	85	72	81	96	75	99	91	64	78	80	106	90	70	76	78	73	72	75	Dec 2015	35	11	1	0	0	0	26		75	720			
9			Falls with a serious injury	<= No	0	0	1	5	1	1	2	1	1	0	1	1	1	1	5	0	1	2	3	1	Dec 2015	0	0	0	0		0	1		1	15			
8			Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	5	2	7	6	9	16	11	4	6	11	4	8	6	4	8	3	6	5	Dec 2015	4	1	0	0			0		5	55			
3			Venous Thromboembolism (VTE) Assessments	=> %	95	95																			Dec 2015	94.2	94.1	98.6	90.8					94.1				
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	98	98																			Dec 2015	99.7	99.7	100.0	99.6		0.0			99.8				
3			WHO Safer Surgery - brief (% lists where complete)	=> %	95	95																			Dec 2015	99	100	99	98		100			99				
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	85	85																			Dec 2015	98	100	99	98		100			98.773				
9			Never Events	<= No	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	Dec 2015	0	0	0	0	0	0	0		0	3			
9			Medication Errors causing serious harm	<= No	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	Dec 2015	0	0	0	0	-	0	0		0	2			
9			Serious Incidents	<= No	0	0	2	2	1	1	2	3	4	4	6	5	4	7	9	7	5	7	6	2	Dec 2015	0	0	0	1	0	0	1	0	2	52			
9			Open Central Alert System (CAS) Alerts	<= No			5	6	5	5	15	17	10	9	4	8	5	4	8	11	8	7	4	9	Dec 2015									9				
9			Open Central Alert System (CAS) Alerts beyond deadline date	No	0	0	1	0	0	0	4	0	1	0	1	0	3	2	0	1	2	2	0	0	Dec 2015									0				

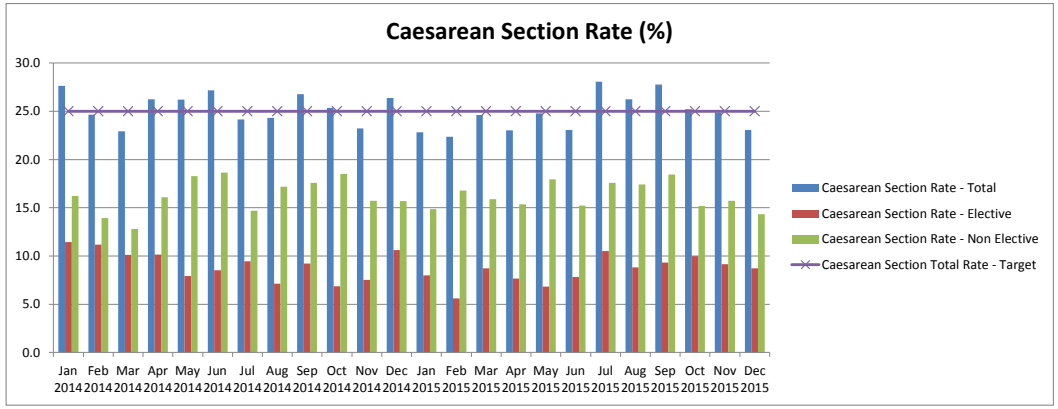


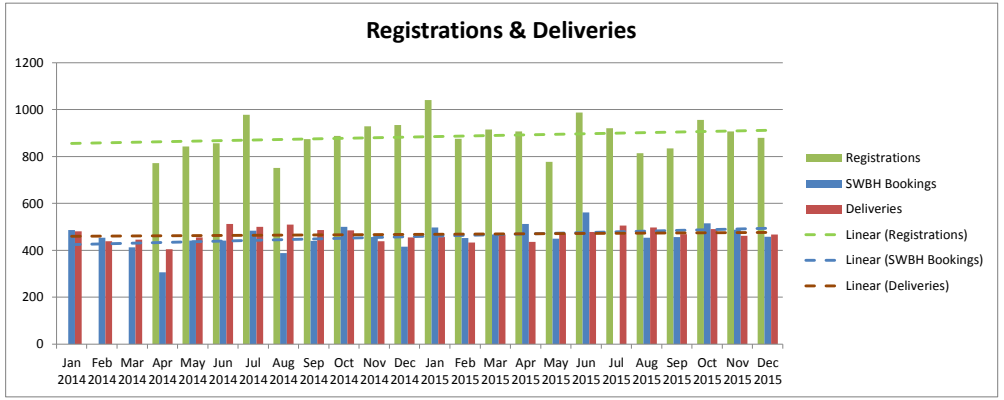




Patient Safety - Obstetrics

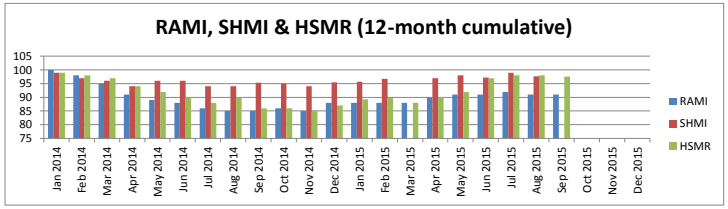
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2014) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			Dec 2015	23.1	25.2			
3			Caesarean Section Rate - Elective	<= %			9	7	9	7	8	11	8	6	9	8	7	8	11	9	9	10	9	9	Dec 2015	8.7	8.8			
3				<= %			15	17	18	19	16	16	15	17	16	15	18	15	18	17	18	15	16	14	Dec 2015	14.3	16.5			
2		d	Maternal Deaths	<= No	0	0																			Dec 2015	0	0			
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Dec 2015	0	20			
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																			Dec 2015	1.07	2.03			
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Dec 2015	10.71				
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	90.0	90.0																			Dec 2015	78.56				
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																			Dec 2015	208.0				
2			Breast Feeding Initiation (Quarterly)	=> %	77.0	77.0	-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		Dec 2015	-	74.22			
2			Puerperal Sepsis and other puerperal infections (variation 1 - ICD10 O85 or O86) (%) -	<= %			1.8	0.9	0.9	0.7	1.5	1.2	1.3	0.5	2.1	2.1	2.1	1.3	1.6	1.6	1.6	1.5	1.3	1.3	Dec 2015	1.35	1.63			
2			Puerperal Sepsis and other puerperal infections (variation 2 - ICD10 O85 or O86 Not O864) (%)	<= %			1.6	0.7	0.3	0.7	1.3	0.8	0.3	0.5	1.5	1.6	1.0	1.3	1.0	1.1	1.3	1.1	1.3	0.3	Dec 2015	0.34	1.16			
2			Puerperal Sepsis and other puerperal infections (variation 3 - ICD10 O85) (%)	<= %			0.4	0.2	0.0	0.0	1.0	0.4	0.0	0.0	1.2	0.7	0.8	0.9	0.2	0.5	0.8	1.1	1.0	0.0	Dec 2015	-	0.66			

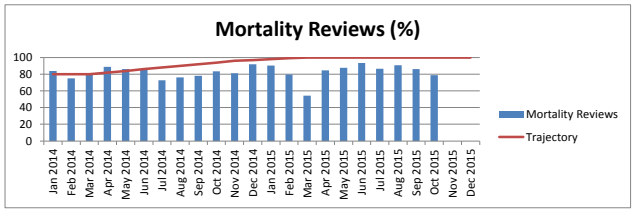


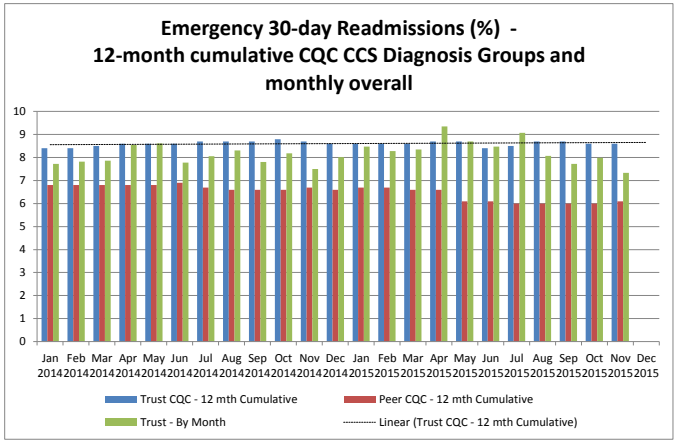


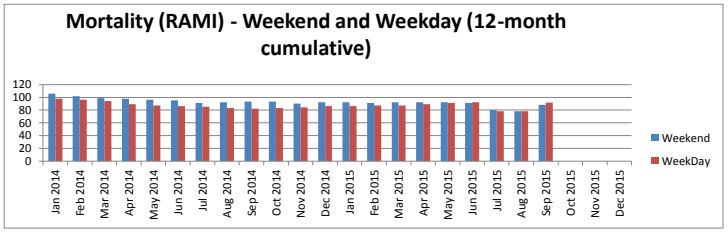
Clinical Effectiveness - Mortality & Readmissions

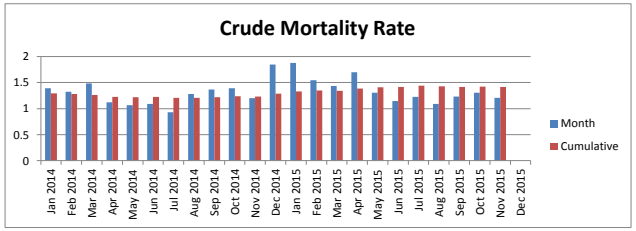
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2014) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	86	85	85	86	85	88	88	88	88	90	91	91	92	91	91	-	-	-	Sep 2015										546			
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	85	83	82	83	84	86	86	87	87	89	91	92	78	78	92	-	-	-	Sep 2015										520			
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	91	92	93	93	90	92	92	91	92	92	92	91	80	78	88	-	-	-	Sep 2015										521			
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	94	94	95	95	94	96	96	97	-	97	98	97	99	98	-	-	-	-	Aug 2015										489			
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			88	90	86	86	85	87	89	90	88	90	92	97	98	98	98	-	-	-	Sep 2015										572.5			
5		C	Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	51	71	89	80	76	111	105	94	93	75	84	53	102	44	80	-	-	-	Sep 2015									80				
3			Mortality Reviews within 42 working days	=> %	90	90																-	-	-	Oct 2015	80	64	0	100					79				
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			0.9	1.3	1.4	1.4	1.2	1.8	1.9	1.5	1.4	1.7	1.3	1.1	1.2	1.1	1.2	1.3	1.2	-	Nov 2015									1.21				
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.2	1.2	1.2	1.2	1.2	1.3	1.3	1.3	1.3	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	-	Nov 2015										1.42			
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			8.1	8.3	7.8	8.2	7.5	8.0	8.5	8.3	8.4	9.4	8.7	8.5	9.1	8.1	7.7	8.0	7.3	-	Nov 2015									7.34				
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			7.9	8.0	8.0	8.0	8.0	8.0	8.1	8.1	8.2	8.2	8.2	8.3	8.4	8.4	8.3	8.3	8.3	-	Nov 2015										8.31			
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			8.7	8.7	8.7	8.8	8.7	8.6	8.6	8.6	8.6	8.7	8.7	8.4	8.5	8.7	8.7	8.6	8.6	-	Nov 2015	-	-	-	-						8.61			





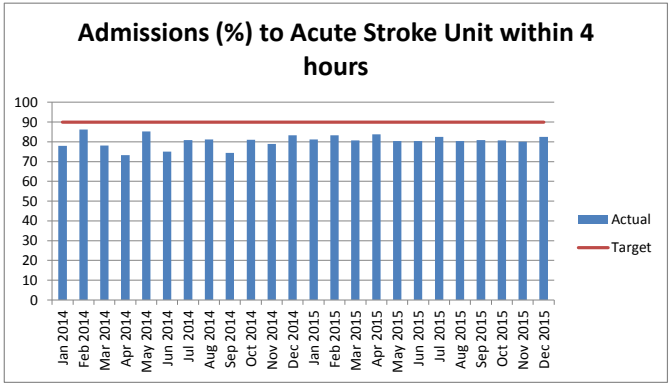


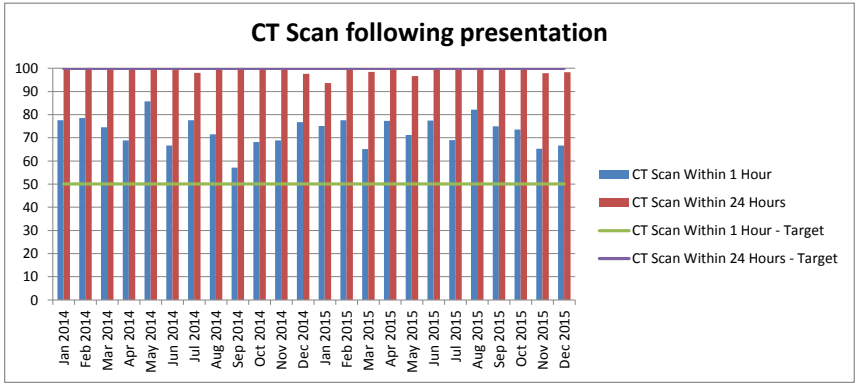


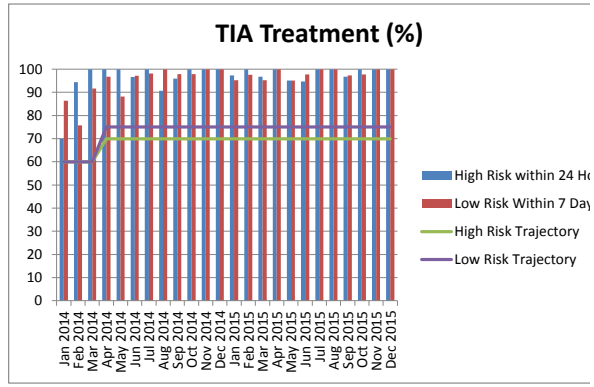


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Jul 2014) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Pts spending >90% stay on Acute Stroke Unit	=> %	90.0	90.0																			Dec 2015	98.0	92.5			
3			Pts admitted to Acute Stroke Unit within 4 hrs	=> %	90.0	90.0																			Dec 2015	82.5	81.2			
3			Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0																			Dec 2015	66.7	73.1			
3			Pts receiving CT Scan within 24 hrs of presentation	=> %	100.0	100.0																			Dec 2015	98.2	99.2			
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			Dec 2015	80.0	84.4			
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0																			Dec 2015	100.0	100.0			
3			TIA (High Risk) Treatment <24 Hours from receipt of referral	=> %	70.0	70.0																			Dec 2015	100.0	98.5			
3			TIA (Low Risk) Treatment <7 days from receipt of referral	=> %	75.0	75.0																			Dec 2015	100.0	98.7			
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0																			Dec 2015	100.0	94.7			
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0																			Dec 2015	100.0	95.6			
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0																			Dec 2015	94.2	93.6			



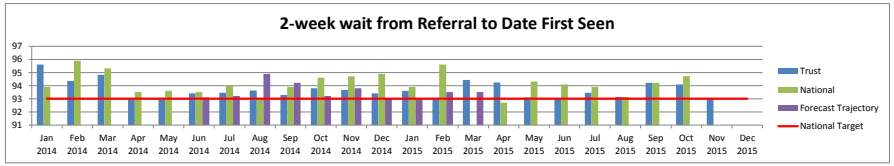


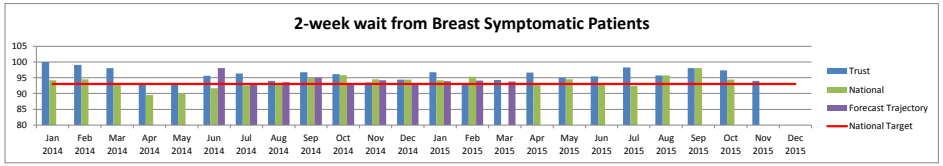


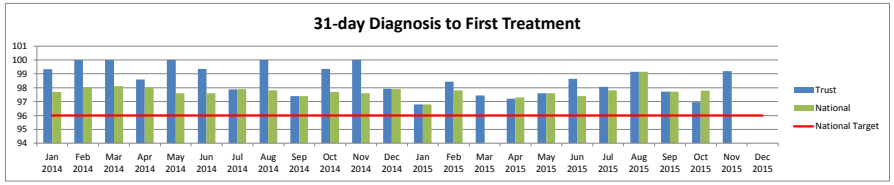
Clinical Effectiveness - Cancer Care

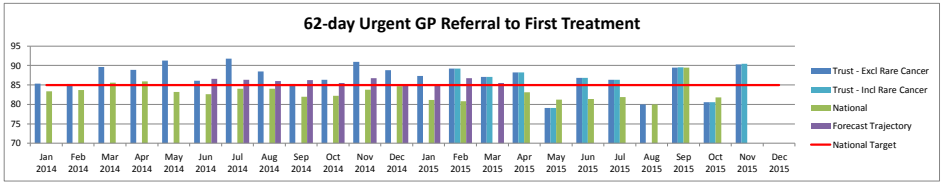
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2014) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
1			2 weeks	=> %	93.0	93.0																		-	Nov 2015	89.9	95.0	95.7	92.3					93.0	93.5			
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		-	Nov 2015		-							94.0	96.4			
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Nov 2015	100.0	98.4	100.0	100.0					99.2	98.0			
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0														N/A				-	Nov 2015									100.0	98.2			
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																		-	Nov 2015									100.0	98.9			
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																		-	Nov 2015									-	0.0			
1			62 Day (urgent GP referral to treatment) Excluding Rare Cancer	=> %	85.0	85.0																		-	Nov 2015	86.8	94.6	0.0	93.8					90.3	85.5			
1			62 Day (urgent GP referral to treatment) Including Rare Cancer	=> %	85.0	85.0	.	.	.	.	.	.	.							.				-	Nov 2015	87.5	94.6	0.0	93.8					90.4	86.2			
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																		-	Nov 2015	0.0	94.4	0.0	50.0					90.0	96.2			
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																		-	Nov 2015	81.0	100.0	100.0	66.7					87.5	90.5			
1			Cancer - Patients Waiting over 62 days	No			-	-	-	-	-	-	-	-	-	-	-	-	0	12	9	13	6	-	Nov 2015	2.5	1.5	1.0	0.5					5.5	39.0			
1			Cancer - Patients Waiting over 104 days	No			-	-	-	-	-	-	-	-	-	-	-	-	4.5	7.0	4.0	8.0	2.0	-	Nov 2015	2.0	0.0	0.0	0.0					2.0	25.5			
1			Cancer - Longest Waiter in days	No			-	-	-	-	-	-	-	-	-	-	-	-	180	147	228	165	138	-	Nov 2015	138	98	104	89					138				

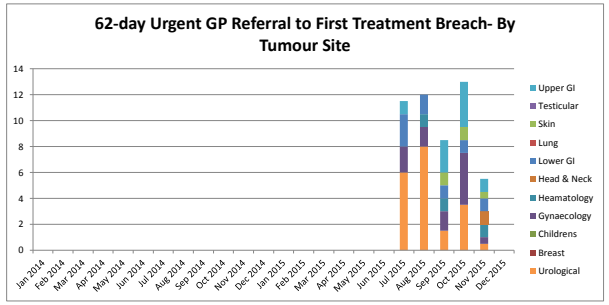
Cancer - Patients Waiting (over 62 days) By Tumour Site				Data Period	Breast	Childrens	Gynae	Haematology	Head & Neck	Lower GI	Lung	Skin	Testicular	Upper GI	Urology	Total
Breaches	No			Nov 2015	0.0	0.0	0.5	1.0	1.0	1.0	0.0	0.5	0.0	1.0	0.5	5.5
Compliance	%			Nov 2015	####	-	93.8	66.7	0.0	88.9	####	95.0	-	75.0	94.7	90.3







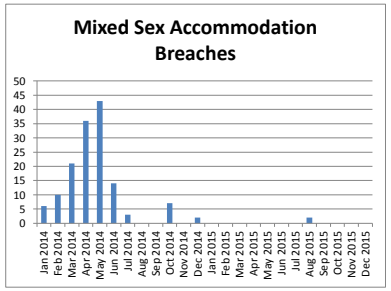


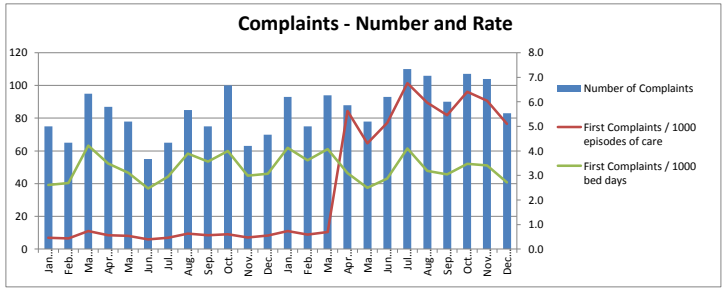


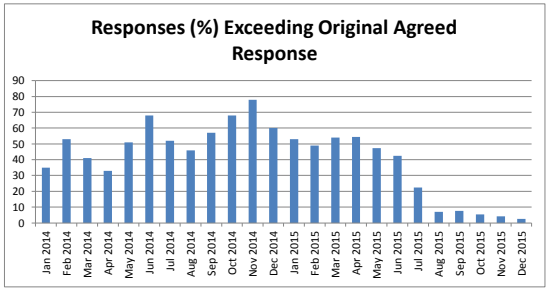
NOTES:

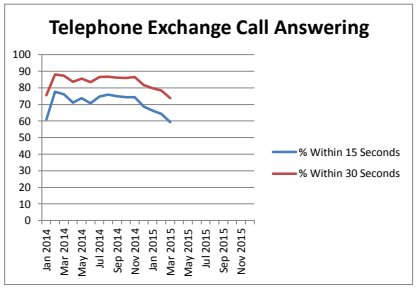
Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2014) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		b	FFT Response Rate - Adult and Children Inpatients (including day cases and community)	=> %	50.0	50.0	41	32	31	28	31	28	33	43	43	29	31	31	28	25	22	27	16	15	Dec 2015									15				
8		a	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95.0	95.0	73	76	74	73	73	69	70	68	72	95	95	95	96	95	95	95	93	96	Dec 2015									96				
8		b	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50.0	50.0	16	17	17	17	18	17	18	21	22	9.9	8.4	7.2	9.4	9.6	7.5	6.8	5.9	5.7	Dec 2015	5.7								5.7				
8		a	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95.0	95.0	47	49	47	48	49	49	50	44	52	79	79	79	84	88	83	80	82	81	Dec 2015	81								81				
8			FFT Score - Outpatients	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	87	86	Dec 2015									86				
8			FFT Score - Maternity Antenatal	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	100	100	Dec 2015									100				
8			FFT Score - Maternity Postnatal Ward	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	97	97	Dec 2015									97				
8			FFT Score - Maternity Community	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	95	98	Dec 2015									98				
13		a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	3	0	0	7	0	2	0	0	0	0	0	0	0	2	0	0	0	0	Dec 2015	0	0	0	0		0	0		0	2			
9			No. of Complaints Received (formal and link)	No			65	85	75	100	63	70	93	75	94	88	78	93	110	106	90	107	104	83	Dec 2015	32	11	17	15	0	1	2	5	83	859			
9			No. of Active Complaints in the System (formal and link)	No			219	258	282	324	359	219	249	266	265	278	225	186	170	174	143	151	145	121	Dec 2015	57	15	21	14	1	0	5	8	121				
9		a	No. of First Formal Complaints received / 1000 bed days	Rate1			2.9	3.9	3.6	4.0	3.0	3.1	4.1	3.6	4.1	3.1	2.5	2.9	4.1	3.2	3.0	3.5	3.4	2.7	Dec 2015	2.1	1.6	27	3					2.72	3.15			
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			0.5	0.6	0.6	0.6	0.5	0.6	0.7	0.6	0.7	5.6	4.3	5.1	6.8	6.0	5.5	6.4	6.0	5.1	Dec 2015	4.6	3.2	12	5			0		5.10	5.65			
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	=> %	100	100	99	99	100	99	100	100	99	98	100	99	100	100	100	100	100	100	100	100	Dec 2015	100	100	100	100	0	100	100	100	100				
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	<= %	0	0	52	46	57	68	78	60	53	49	54	54	47	42	22	7.1	7.7	5.3	4.1	2.5	Dec 2015	0	5.9	4.8	0	0	0	33	0	2				
9			No. of responses sent out	No			138	66	42	35	26	198	59	52	84	56	115	102	129	77	107	101	94	98	Dec 2015	39	15	20	11	1	2	3	7	98				
9			Oldest' complaint currently in system	No			127	133	131	174	161	182	192	213	234	254	188	210	186	208	136	159	47	59	Dec 2015	46	46	57	28	11	0	59	25	59				
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	N	N	N	N	N	N	N	N	No				



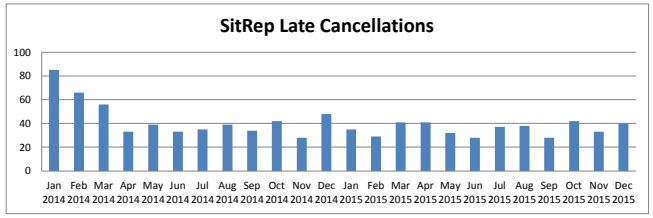


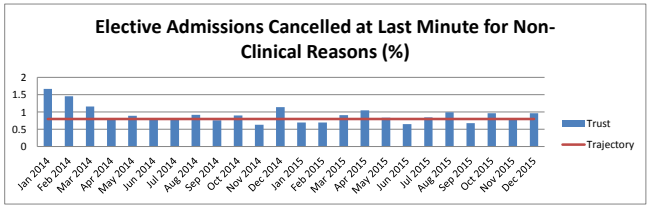


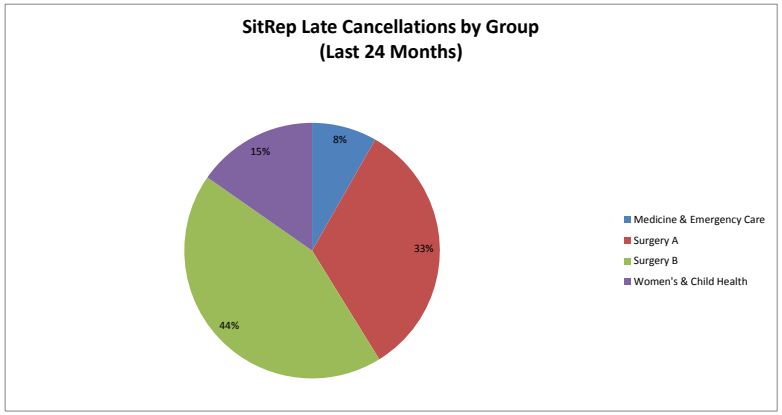


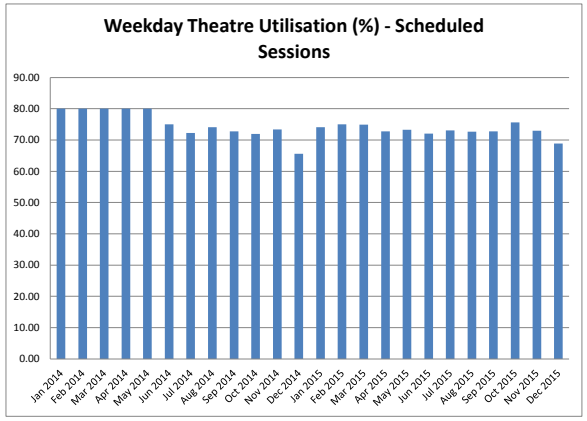
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2014) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2		•	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Dec 2015	-	1.47	1.17	4.23					1.0	0.9			
2		•e•	Number of 28 day breaches	<= No	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	Dec 2015	0	0	0	0					0	1			
2		•e	No. of second or subsequent urgent operations cancelled	<= No	0	0	0	0	0	0	0	1	0	1	1	0	1	0	0	0	0	0	0	0	Dec 2015	0	0	0	0					0	1			
2			No. of Sitrep Declared Late Cancellations	<= No	320	27	36	39	34	42	28	48	36	29	41	41	32	28	37	38	28	42	33	40	Dec 2015	0	16	11	13					40	319			
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	<= No	0	0	0	0	0	0	0	0	0	0	0	0	4	1	0	0	0	0	0	0	Dec 2015	0	0	0	0					0	5			
3			Multiple Cancellations experienced by same patient (all cancellations)	<= No	0	0	-	-	-	-	-	-	-	-	-	46	52	59	46	39	49	50	57	39	Dec 2015	2	19	11	7					39				
3			All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	<= No	0	0	-	-	-	-	-	-	-	-	-	209	204	229	222	211	229	244	238	194	Dec 2015	16	73	72	33					194				
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0																			Dec 2015	31.7	72.2	73.8	72.1					68.9				
2			Urgent Cancellations	<= No	0.0	0.0	-	-	-	-	-	-	-	-	-	11	5	6	0	7	3	9	0	0	Dec 2015	0.0	0.0	0.0	0.0					0	41			



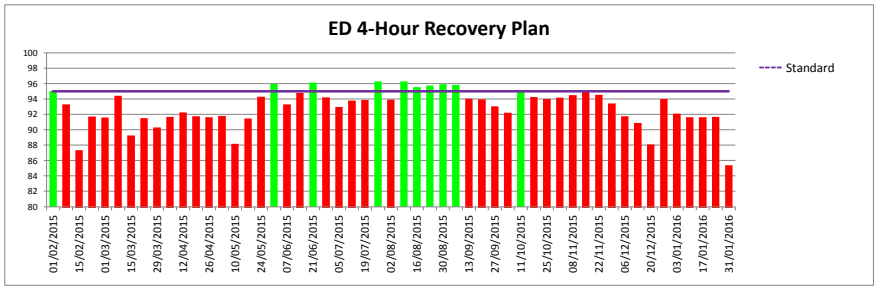


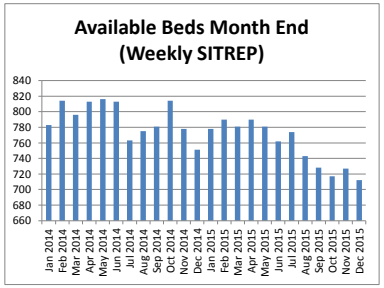


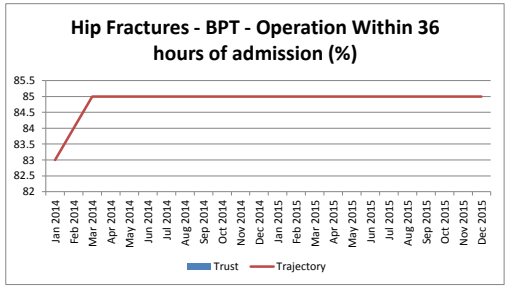


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend	Next Month	3 Months
2			Emergency Care 4-hour waits	=> %	95.00	95.00																			Dec 2015	90.1	90.0	99.2	91.02	93.55			
2			Emergency Care 4-hour breach (numbers)	No			1122	876	1460	1636	1440	2234	1054	1481	1695	1527	1406	1037	1086	741	1138	1106	1103	1715	Dec 2015	796	901	18	1715	10859			
2			Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			Dec 2015	0	0		0	0			
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			Dec 2015	18	16	48	17	17			
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Dec 2015	56	49	115	59	50			
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			Dec 2015	9.00	8.18	####	8.87	7.78			
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Dec 2015	4.40	5.38	1.50	4.49	4.24			
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	145	51	136	219	159	282	185	149	164	43	116	90	72	58	76	93	67	121	Dec 2015	65	56		121	736			
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	8	1	13	21	14	31	7	6	8	9	8	3	3	2	1	1	3	8	Dec 2015	2	6		8	38			
11		•	WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Dec 2015	0.09	0.25		0.18	0.11			
11			WMAS - Emergency Conveyances (total)	No			4278	3994	4067	4193	4168	4470	4001	3829	4182	3981	4214	114	4256	4241	4016	4260	4202	4573	Dec 2015	2189	2384		4573	33857			
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																			Dec 2015	1.0	4.2		2.4	2			
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	<10 per site	<10 per site																			Dec 2015	3	11		14				
2			Delayed Transfers of Care (Acute) - Total Bed Days	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-		-	-			
2			Delayed Transfers of Care (Acute) - Finable Bed Days	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-		-	-			
2			Patient Bed Moves (10pm - 6am) (No.) -ALL	No			606	575	568	603	535	699	544	573	634	567	596	502	545	529	588	601	518	540	Dec 2015				540	4986			
2			Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units	No			297	295	246	306	257	286	214	258	270	237	293	239	240	237	275	261	209	236	Dec 2015				236	2227			
3			Hip Fractures - Operation < 24 hours of admission (%)	=> %	85.0	85.0																		.	Nov 2015				91	68.7			
3			Hip Fractures - Operation < 36 hours of admission (%)	=> %	85.0	85.0																		.	Nov 2015				100	83.6			
			Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85.0	85.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-			

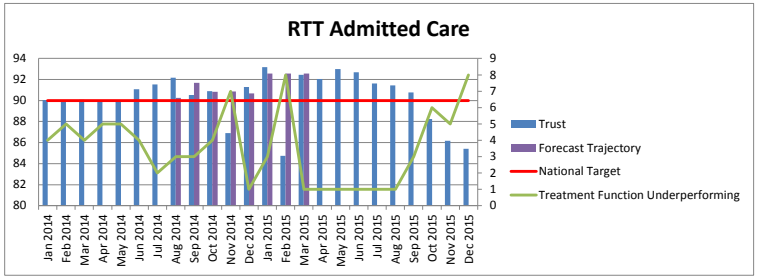


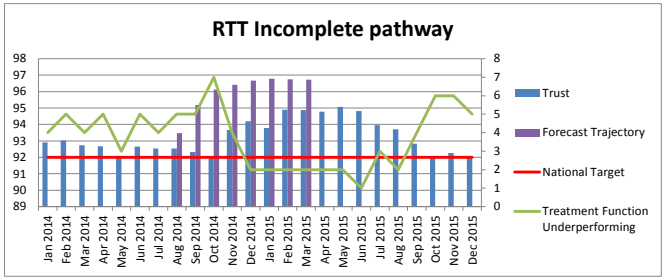


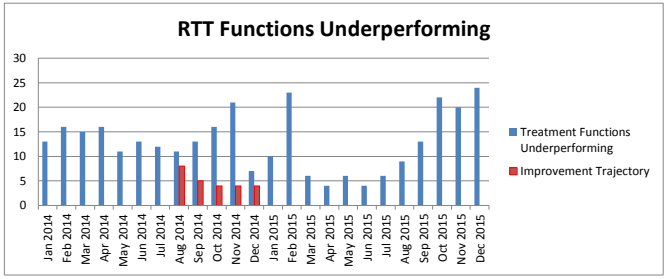


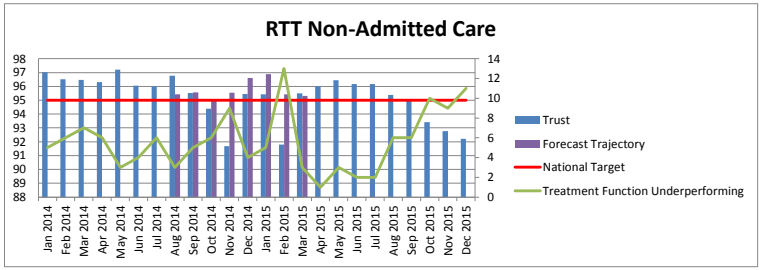
Referral To Treatment

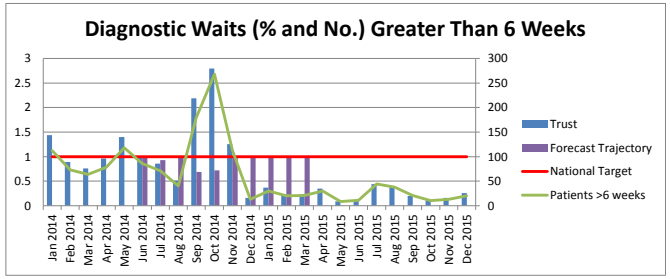
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2014) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2			RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Dec 2015	91.8	71.2	81.9	89.9					85.40				
2			RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Dec 2015	84.5	91.8	95.3	96.4					92.22				
2			RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Dec 2015	91.7	88.9	93.6	96.6					92.01				
2			Patients Waiting >52 weeks	<= No	0	0	3	4	4	3	3	0	4	3	4	1	2	1	3	5	2	4	4	2	Dec 2015	1	0	1	0.0					2				
2			Patients Waiting >52 weeks (Incomplete)	<= No	0	0	2	2	-	3	1	-	1	1	1	-	2	-	2	3	1	2	2	0	Dec 2015	0	0	0	0					0				
2			Treatment Functions Underperforming	<= No	0	0	12	11	13	16	19	8	10	23	6	4	6	4	6	9	13	22	20	24	Dec 2015	8	11	3	1.0					24				
2			Acute Diagnostic Waits in Excess of 6-weeks	<= %	1.0	1.0	0.9	0.5	2.2	3.2	1.1	0.2	0.4	0.2	0.2	0.3	0.1	0.1	0.4	0.4	0.2	0.1	0.2	0.3	Dec 2015	0.1	0.3	0.3	0.0		0.3			0.26				

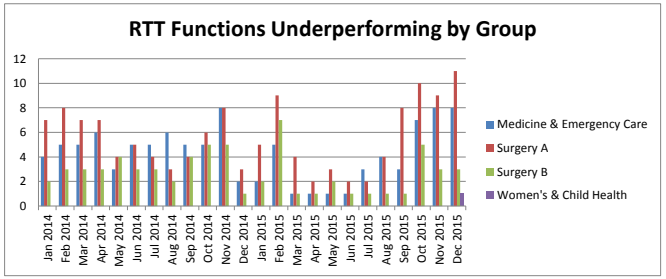










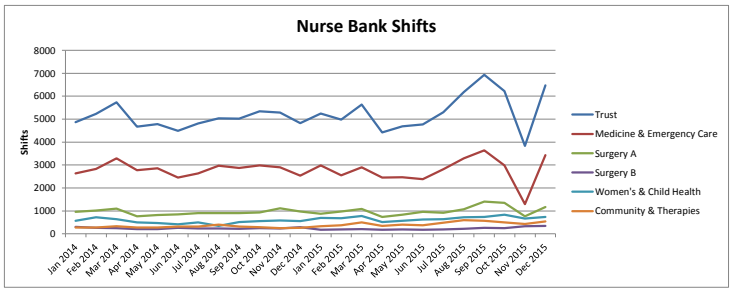


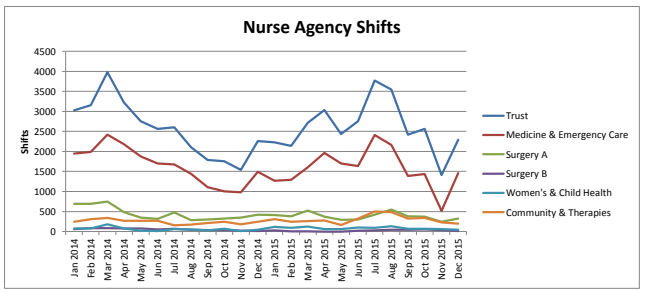
Data Completeness

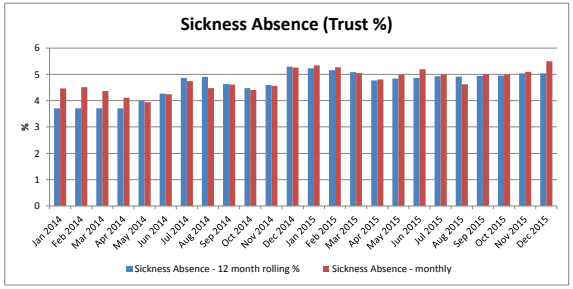
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2014) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Data Completeness Community Services	=> %	50.0	50.0																			Dec 2015								61	61.2				
2			Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Nov 2015									99.4				
2			Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Nov 2015									99.4				
2			Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Nov 2015									99.5				
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=> %	99.0	99.0	95.4	95.2	95.7	95.3	95.7	96.0	96.5	96.9	96.6	96.9	96.6	96.3	96.5	95.8	96.5	97.0	97.4	97.0	Dec 2015									97.0	96.7			
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	=> %	99.0	99.0	99.5	99.4	99.4	99.5	99.5	99.5	99.6	99.6	99.6	99.6	99.6	99.6	99.5	99.4	99.5	99.5	99.5	99.5	Dec 2015									99.5	99.5			
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=> %	95.0	95.0	96.1	96.1	96.2	96.4	96.6	96.2	97.0	96.7	96.8	96.8	96.9	96.9	96.3	96.0	96.7	96.3	97.1	96.8	Dec 2015									96.8	96.7			
2			Ethnicity Coding - percentage of inpatients with recorded response	=> %	90.0	90.0																			Dec 2015									90.0	90.9			
2			Maternity - Percentage of invalid fields completed in SUS submission	<= %	15.0	15.0																			Dec 2015									5.6	5.6			
2			Open Referrals	No			-	-	-	-	-	-	-	-	-	173,131	180,758	183,245	191,411	203,025	208,990	214,841	222,779	228,862	Dec 2015	80,663	42,539	71,194	30,745	3,414	248	59		228,862				

Staff

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Trajectory Month - Amber	Previous Months Trend (since Jul 2014) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
7		b	WTE - Actual versus Plan (FTE)	No				584	626	608	628	674	685	701	732	689	Indicator under Review										Dec 2015													
3		b	PDRs - 12 month rolling	=> %	95.0	95.0	90.0																				Dec 2015	79.1	79.3	80.7	85.8	86.2	67.6	82.6	85.8		86.2			
7		b	Medical Appraisal and Revalidation	=> %	95.0	95.0	90.0									-											Dec 2015	81.4	76.9	75.9	76.7	94.4	96.8	0.0	100.0		86.9			
3		b	Sickness Absence (Rolling 12 Months)	<= %	3.15	3.15	3.8																				Dec 2015	5.4	5.2	3.2	5.8	4.2	4.6	4.9	4.9	5.0	4.9			
3			Sickness Absence (Monthly)	=> %	3.15	3.15	3.8																				Dec 2015	6.2	5.8	3.9	7.0	4.4	4.7	4.6	5.0	5.5	5.06			
3			Return to Work Interviews following Sickness Absence	=> %	100.0	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Dec 2015	64.5	70.1	63.4	66.1	80.1	50.9	82.2	75.6	69.9	65.9			
3			Mandatory Training	=> %	95.0	95.0	90.0																				Dec 2015	82.0	87.7	85.8	83.9	93.4	86.5	90.1	90.6		87.1			
3			Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0	90.0																				Dec 2015	95.9	98.2	94.5	96.3	97.5	97.2	98.9	98.6		97.6			
7		b	Staff Turnover (rolling 12 months)	<= %	10.0	10.0	10.0																				Dec 2015									13.6	13.5			
7			New Investigations in Month	No				5	2	15	3	1	0	3	4	5	8	11	5	8	4	5	10	6	2		Dec 2015	1	0	0	0	0	0	0	1	2				
7			Vacancy Time to Fill	Weeks				18	19	19	20	21	20	20	23	22	23	24	26	25	27	25	23	23	23		Dec 2015									23				
7			Professional Registration Lapses	<= No	0	0	0.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Dec 2015	0	0	0	0	0	0	0	0	0	0			
7			Qualified Nursing Variance (FIMS) (FTE)	No				177	201	200	188	200	228	238	247	263	221	247	288	303	321	320	279	267	293		Dec 2015									293				
			Turnover Rate for Nurses	%				-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	14.6	Dec 2015									15	15			
10			Nurse Bank Fill Rate	=> %	100.0	100.0	100.0	80	77	78	78	82	73	78	78	78	75	81	81	79	80	87	82	90	85		Dec 2015	82.9	82.3	93.5	87.4	100.0	100.0	88.0	99.4	84.7	82.2			
10			Nurse Bank Shifts Not Filled	<= No	0	0	0.0	1087	1802	1370	1036	1440	1727	1716	1432	1487	1532	1378	1073	1612	1423	1207	917	780	1178		Dec 2015	749	232	23	95	0	0	78	1	1178	11110			
10			Nurse Bank Use (shifts)	<= No	46980	3915	3915.0																				Dec 2015	3430	1168	349	734	11	97	544	143	6476	48806			
10			Nurse Agency Use (shifts)	<= No	0	0	0.0																				Dec 2015	1461	322	9	41	36	212	200	10	2291	24229			
10			Admin & Clerical Bank Use (shifts)	<= No	0	0	0.0																				Dec 2015	936	212	97	26	474	113	256	2728	4842	48056			
10			Admin & Clerical Agency Use (shifts)	<= No	0	0	0.0																				Dec 2015	90	69	13	23	0	0	0	178	373	2086			
			Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	0.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	-			
15			Your Voice - Response Rate	No			0.0	-->	18.2	-->	-->	17.4	-->	12.6	12.7	-->	-->	-->	13.9	-->	-->	15.3	-->	-->	12.6		Dec 2015	6	8	14	11	19	21	21	15	12.6				
15			Your Voice - Overall Score	No			0.0	-->	3.68	-->	-->	3.65	-->	3.57	3.55	-->	-->	-->	3.59	-->	-->	3.51	-->	-->	3.57		Dec 2015	3.37	3.31	3.63	3.63	3.79	3.4	3.72	3.58	3.57				







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	CQUIN	Annual Plan Values (000s)	Achieved Values - YTD (000s)	Value at Risk (000s)	Indicator	Trajectory / Notes	Q1	Q2	Q3	Q4	Monthly Trend A	M	J	J	A	S	O	N	D	J	F	M	Comments	Data Period	Year To Date	Trend	Next Month	3 Months
1	National	£646	£323	£0	Acute Kidney Injury	Improvement from previous Quarter	Derive Base Data	Improvement to last Qtr - GP Letter Pilot - Delayed	Improvement to last Qtr - GP Letter Pilot Jan	Improvement to last Qtr	Q1 Met	Q2 Met					●	●	-	-	-	-	December results not confirmed; Delivery expected and manual auditing process needs to continue	Nov-15	●	●	●	●
2	National	£323	£129	£0	Sepsis Screening	Improvement from base to agreed target	Derive Base Data	Target set at 32.5%	Improvement to Target	Improvement to Target	Q1 Met	Q2 Met					●	●	●	-	-	-	In October Patient First implemented . However, system configuration not complete - supplier challenged - October results particularly low at 14% (32%expected) - A&E consultant agreed set December process to ensure Dec month is an improved rate at least. Q3 now met on Dec delivery.	Dec-15	●	●	●	●
3	National	£323	£65	£0	Sepsis Antibiotic Administration	90% by Q4	Establish Audit Mech.	CCG aware - small samples	Work towards 90%	90% Achieved	Q1 Met	Q2 Met					●	●	●	-	-	-	Delivering in Q3	Dec-15	●	●	●	●
4	National	£388	£388	£0	Dementia - Find, Assess, Investigate, Refer & Inform	90% (each of 3 elements) in Q4	Carry fwd from last year	Query with CCG - inform?	Work towards 90%	90% Achieved	Q1 Met	Q2 Met					●	●	●	-	-	-	The 'inform' part of delivery a concern, till discharge letter goes live now not in this financial year. Analysis of eligible patients suggests that 413 letters are to be mailed out to GPs (count at this stage). Information are supporting with PDS (address search and mail merge) to make the task possible.	Dec-15	●	●	●	●
5	National	£65		£0	Dementia - Staff Training	Target tba - Qtly reports to Board	Carry fwd from last year	Work towards 90%	Work towards 90%	90% Achieved	Q1 Met	Q2 Met					●	●	-	-	-	-	December update not received, however so far tracking well with excellent training programme in place.	Nov-15	●	●	●	●
6	National	£194		£0	Dementia - Supporting Carers	Bi-annual reports to Board	Carry fwd from last year	Work towards 90%	Work towards 90%	90% Achieved	Q1 Met	Q2 Met					●	●	-	-	-	-	December update not received, but expected to deliver as per trend	Nov-15	●	●	●	●
7	National	£1,292	£1,163	£0	Improvement in diagnosis recording in HES Data Set of Mental Health presentations	85% in one month	Qly Data Collection	Achieve 85% in one month to complete CQUIN - already achieved in July & August at 99% - maintain performance			Q1 Met	Q2 Met					●	●	●	-	-	-	Scheme was previously declared as delivering, however it appears that codes may have been used incorrectly. A review is on its way to pick up delivery for Jan and remaining months of the year.	Dec-15	●	●	●	●
8	Local	£330	£330	£0	Community Therapies - Dietetics Community Communication with GPs	Deliver outstanding actions from 14 / 15	One data submission at end of Q2				Met												Delivered fully	Dec-15	●			
9	Local	£672	£142	£0	Reduce Number of Ward Transfers experienced by patients with Dementia	Agree improvement trajectory from base	Derive Base Data	Improvement Required	Improvement Required	Improvement Required	Q1 Met	Q2 Met					●	●	●	-	-	-	Q3 overall has not reduced to previous quarter which is the CCG criteria. However, bearing in mind winter pressures this is still a good outcome	Dec-15	●	●	●	●
10	Local	£672	£493	£0	Reduce Number of Out Of Hours Patient Transfers	Agree improvement trajectory from base	Derive Base Data	Improvement Required	Improvement Required	Improvement Required	Q1 Met	Q2 Met					●	●	●	-	-	-	Q3 delivery is lower than previous quarter hence delivered as per criteria.	Dec-15	●	●	●	●
11	Local	£1,163	£475	£0	Safeguarding	Carry Forward from last year	Report to Board (Pat Story)	Report to Board (Pat Story)	Report to Board (Pat Story)	Report to Board (Pat Story)	Q1 Met	Q2 Met					●	●					December update not received, however expected to fully deliver sa per current trend.	Nov-15	●	●	●	●
12	Local	£400	£0	£0	Falls Medication	Baseline now agreed Q2	Not active Q1	Not active Q2	Baseline agreed		Not Active						-	-					Starting after Q2, delivery expected in Q4	Nov-15		●	●	●
13	Spec.	£118	£59	£118	Reduce Number of Consultant-Led Follow Up OP Attendances	Implement plans to & monitor FUN ratio	Formulate Plans	Sign Off of Plans	Monitor & Improve	Monitor & Improve	Q1 Met	Q2 Met					●	●	●	-	-	-	Plan required and sign off by Medical Director / COO - lack of clarity in respect of delivery of activity.	Dec-15	●	●	●	●
14	Spec.	£118	£59	£0	HIV - Reducing Unnecessary CD4 Monitoring	90% pts have no more than 1 CD4 count in 9m	Qtly Data Collection	Qtly Data Collection	Qtly Data Collection	Qtly Data Collection	Q1 Met	Q2 Met					●	●	●	-	-	-	Tracking well.	Dec-15	●	●	●	●
15	Spec.	£118	£59	£118	Haemoglobinopathy Networks - develop partnership working, define pathways and protocol	Publish agreed care p'ways and protocols	Set Up initial network meet				Q1 Met	Q2 Met					●	●	●	-	-	-	Network meetings have resumed in January and update expected at the end of the month.	Dec-15	●	●	●	●
16	Spec.	£118	£59	£0	Breast Cancer - help patients make more informed choices regarding treatment	Provision of anon. pt. Datasets	Derive Base Data	Qtly Data Collection	Qtly Data Collection	Qtly Data Collection	Q1 Met	Q2 Met					●	●	●	-	-	-	Tracking well.	Dec-15	●	●	●	●
17	Spec.	£118	£59	£0	Bechet's Disease (Highly Specialised Service) - set up clinical outcome collaborative workshop	Submit Quarterly return	Qtly Data Collection	Qtly Data Collection	Qtly Data Collection	Qtly Data Collection	Q1 Met	Q2 Met					●	●	●	-	-	-	Tracking well.	Nov-15	●	●	●	●

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	CQUIN	Annual Plan Values (000s)	Achieved Values - YTD (000s)	Value at Risk (000s)	Indicator	Note	Trajectory		Previous Months Trend										Data Period	Comments	Year To Date	Trend	Next Month	3 Months
							Year	Month	A	M	J	J	A	S	O	N	D	J	F	M							
17	Public Health	£94	£0	£0	Breast Screening - improvement in uptake	Annual Report			Q1 Met			Q2 Met			●	●	●	-	-	-	Dec-15	13 out of 14 GPs taking part; all have shown improvements and many at desired improvement target of 5% uptake. GPs not taking part shown deterioration; **MD to write to non-participating GPs**	●	●	●	●
18	Public Health	£42	£11	£32	Bowel Screening - improvement in uptake	Annual Report			Q1 Met			Q2 Met			●	●	●	-	-	-	Dec-15	Patient letter gone out, but 6mths period in which to attend screening so results - uptake unlikely, count of uptake due on 5th February.	●	●	●	●
19	Public Health	£154	£77	£0	Maternity and Health Visiting Services - Integrated working	Implement Shared Assessment Framework			Q1 Met			Q2 Met			●	●	●	-	-	-	Dec-15	BadgerNet used to facilitate sharing	●	●	●	●

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

The Trust is reporting on Q3 performance at the end of January which is being prepared . Both Q1 and Q2 full funding payments have been achieved.

Highlights - Quarter 3 Reporting Period (December 2015) ...

Overall, the majority of schemes are delivering and are managed extremely well. Delays in system developments have caused large workaround and CQUIN leads and other staff have displayed significant effort on working around this.

Risks ...

Schemes to focus on for the last three months are at the highest risk of non-delivery and hence non-payment:

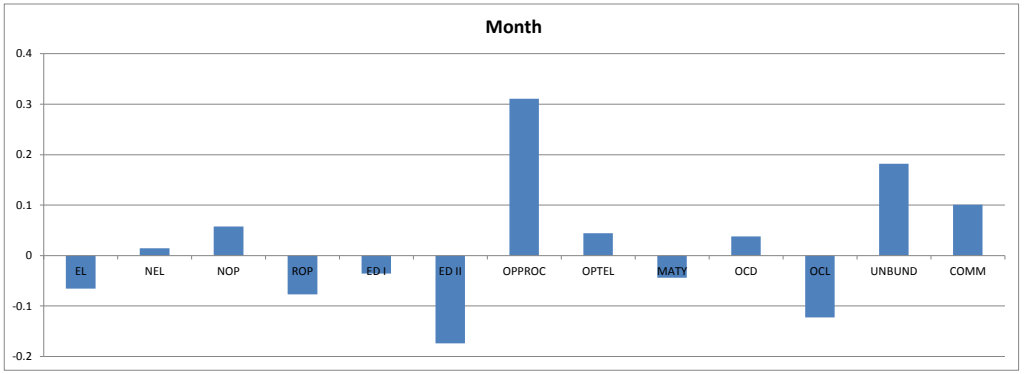
- Mental Health Diagnosis codes in A&E, previously declared as delivering but on review below target
- AKI manual auditing continuous until the discharge letter is developed, now expected in February.
- Sepsis A was of concern as Oct and Nov month slipped below target delivery. This was mainly in relation to expected system developments not being in place. A manual audit was put in place in December to salvage delivery which has been achieved. It is uncertain though if CCG will expect only one month delivery in the quarter.
- Other schemes not able to report for in December lack reporting discipline rather than failure to deliver, but an up to date position has not been received.

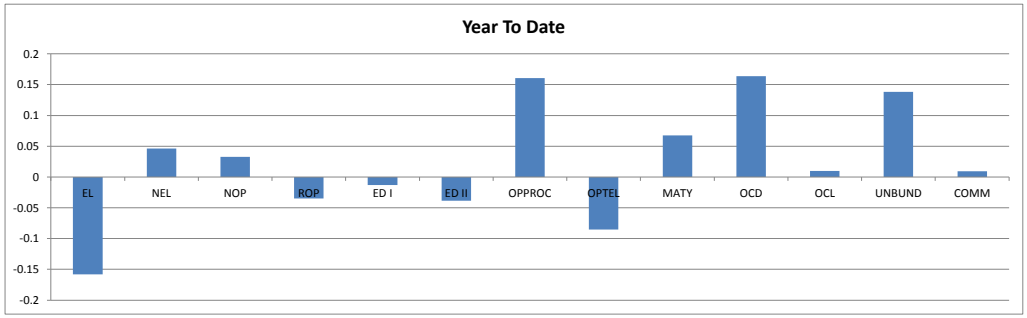
Projections - Quarter 4 ...

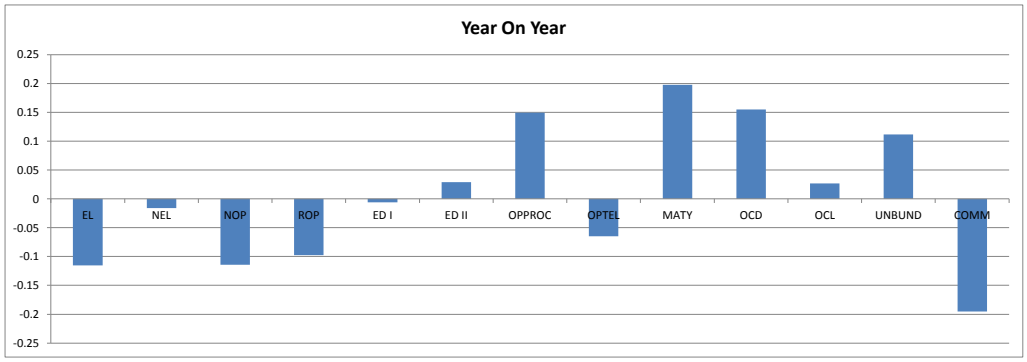
- The above highlights the risk across a couple of major schemes, however it is expected that each scheme will deliver full year.
- Specialised schemes have fallen behind target milestones for a number of reasons, some outside of trust control, so the likelihood is that some will not be payable on a full annual basis. We are yet to discuss with SCG the outcome for these.
- The CQUIN leads have to work intensively against those schemes

Activity Summary

Data up to December 2015







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

Adverse variances to plan in elective and outpatient care are being addressed through the demand and capacity work being led by the Chief Operating Officer.
The plan focusses on maintaining underlying contract plan levels of activity during Q3 and Q4 through daily reporting of booked admitted and non-admitted activity and management challenge of differences from target.

There has been some movement in point of delivery activity since plans were set with plans set as daycase procedures but now recorded in the outpatient setting. Outpatient procedures continue to perform well in month 9 however daycases have continued to slide from their improved performance in October, and elective procedures continue to show significant adverse variance.

Unplanned admissions in total continue to over perform year-to-date however this includes under performance in long stay emergency payments being offset by short stay tariff and non-emergency activity, and our emergency departments continue to underperform – particularly at the City site.

Maternity activity levels remain similar to the average seen so far this year however in December we have seen lower levels of standard and intermediate pathways with a slight increase for complex pathways.

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

Finance Summary

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (O N D J F M A M J J A S O N D J F M)	RAG	Data Period	Group (M A W B C P I CO)	Month	Year To Date	Trend	Next Month	3 Months
						100 200 300 400 500 600 700 800								
18		f	Bottom Line Income & Expenditure position - Forecast compared to plan £m	£0.0			GREEN	Dec-15		£0.000				
18		f	Bottom Line Income & Expenditure position - Year to Date Actual compared to plan £m	£0.0	£0.0		RED	Dec-15	#REF! ### ### ### ### ### ### ###		-£2.658			
18		f	Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan	£0.0	£0.0		AMBER	Dec-15	-0.8 -2.4 -0.1 -0.6 0.2 0.1 0.3 -1.4		-£1.998			
18		f	Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan	£0.0			RED	Dec-15	-0.3 -3.2 -0.4 -0.6 0.1 0.0 0.6 -2.2		£0.000			
18		f	Forecast underlying surplus / deficit compared to plan	£0.0			GREEN	Dec-15			£0.000			
18		f	Forecast year end charge to capital resource limit	£22.8			GREEN	Dec-15		£19.653				
18		f	Is the Trust forecasting permanent PDC for liquidity purposes?	No			GREEN	Dec-15		£0.000				
18		b	Temporary costs and overtime as % total paybill	2.6%	2.6%		RED	Dec-15	11.6% 4.8% 1.8% 2.2% 9.0% 0.4% 7.9% 3.5%	6.4%	6.1%			
18			Financial Sustainability Risk Ratings from M6 (Continuity of Services Risk Ratings for M3 to M5)	3			GREEN	Dec-15			3.0			

MONTHLY: PASTE IN TDA KEY METRICS PAGE TO THIS FILE

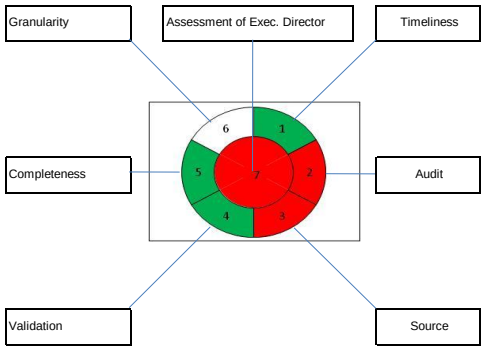
Legend

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

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

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

Data Quality - Kitemark



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

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

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

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

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		EC	AC	SC					
Patient Safety - Inf Control	C. Difficile	<= No	30	3																			Dec 2015	1	2	0	3	18			
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Dec 2015	0	0	0	0	2			
Patient Safety - Inf Control	MRSA Screening - Elective (%)	=> %	80	80																			Dec 2015	87	90	31	71.2				
Patient Safety - Inf Control	MRSA Screening - Non Elective (%)	=> %	80	80																			Dec 2015	91	88	94	90.5				
Patient Safety - Harm Free Care	Falls	<= No	0	0	42	44	41	67	50	66	63	42	52	43	47	42	39	41	40	41	41	35	Dec 2015	11	15	9	35	369			
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	1	4	1	1	2	0	1	0	1	1	0	1	5	0	1	1	2	0	Dec 2015	0	0	0	0	11			
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	3	0	5	3	6	7	10	1	1	8	3	6	2	0	6	2	3	4	Dec 2015	0	4	0	4	34			
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Dec 2015	94.1	81.5	96.9	94.2				
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			Dec 2015	100.0	100.0	98.0	99.7				
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			Dec 2015	99	0	0	99.4				
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.0																			Dec 2015	98	0	0	97.6				
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Dec 2015	0	0	0	0	0			
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	Dec 2015	0	0	0	0	2			
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Dec 2015	0	0	0	0	29			
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98																	-	-	Oct 2015	75	79	88	80				
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			10.2	11.0	10.7	10.0	8.9	9.6	10.7	10.0	10.5	11.7	10.5	10.3	11.5	10.7	9.7	9.6	8.6	-	Nov 2015				8.6				
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			9.6	9.8	9.9	10.0	10.0	9.9	10.1	10.1	10.2	10.3	10.3	10.3	10.4	10.4	10.3	10.3	10.3	-	Nov 2015					10.4			

Medicine Group

Section	Indicator		Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		EC	AC	SC					
Clinical Effect - Stroke & Card	Pts spending >90% stay on Acute Stroke Unit (%)	=> %	90.0	90.0																		-	Nov 2015		95.2		95.2	91.9			
Clinical Effect - Stroke & Card	Pts admitted to Acute Stroke Unit within 4 hrs (%)	=> %	90.0	90.0																		-	Nov 2015		80.0		80.0	81.1			
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																		-	Nov 2015		65.2		65.2	73.9			
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.0																		-	Nov 2015		97.8		97.8	99.3			
Clinical Effect - Stroke & Card	Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																		-	Nov 2015		100.0		100.0	85.0			
Clinical Effect - Stroke & Card	Stroke Admissions - Swallowing assessments (<24h) (%)	=> %	98.0	98.0																			Dec 2015		100.0		100.0	100.0			
Clinical Effect - Stroke & Card	TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=> %	70.0	70.0																		-	Nov 2015		100.0		100.0	98.2			
Clinical Effect - Stroke & Card	TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=> %	75.0	75.0																		-	Nov 2015		100.0		100.0	98.5			
Clinical Effect - Stroke & Card	Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=> %	80.0	80.0																			Dec 2015		100.0		100.0	94.7			
Clinical Effect - Stroke & Card	Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			Dec 2015		100.0		100.0	95.6			
Clinical Effect - Stroke & Card	Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			Dec 2015		94.2		94.2	93.6			
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Nov 2015			89.9	89.9				
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Nov 2015			100.0	100.0				
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Nov 2015			86.8	86.8				
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	0	1	4.5	4.5	2.5	-	Nov 2015	-	-	2.50	2.50	13			
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	0	0	3	4	2	-	Nov 2015	-	-	2.00	2.00	9			
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	62	97	228	165	138	-	Nov 2015	-	-	138	138				
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0	0	0	0	0			
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			28	32	36	48	18	31	30	36	38	41	35	41	53	36	29	43	42	32	Dec 2015	19	6	7	32	352			
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			106	130	131	156	149	93	106	126	117	112	104	87	90	74	58	65	65	57	Dec 2015	34	9	14	57				
Pt. Experience - FFT,MSA,Comp (Group Sheet Only)	Oldest' complaint currently in system (days)	No			127	133	131	174	161	182	188	209	230	250	188	210	186	208	136	159	43	46	Dec 2015	46	32	39	46				

Medicine Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate EC	AC	SC	Month	Year To Date	Trend	Next Month	3 Months
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Dec 2015	-	-	-	-				
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0.0	0.0	0.0	0	0			
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	7	3	2	5	4	1	0	0	9	8	1	2	4	7	0	0	1	0	Dec 2015	0.0	0.0	0.0	0	23			
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	50	61	54	57	60	62	61	49	48	54	60	46	47	45	33	54	35	32	Dec 2015	0.0	0.0	31.7	31.7				
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	1	2	5	0	0	1	1	0	0	Dec 2015	0.00	0.00	0.00	0.00	10			
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95.0	95.0																			Dec 2015	90.1	90.0	Site S/C	90.0	92.8			
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			907	736	1201	1390	1181	1913	940	1242	1412	'	'	'	'	'	'	'	'	'	Mar 2015	1361	4	47	1412	13511			
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0																			Dec 2015	0.0	0.0	Site S/C	0	0			
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.0	15.0																-	-	-	Sep 2015	16.0	16.0	Site S/C	16	17			
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60.0	60.0																-	-	-	Sep 2015	43.0	55.0	Site S/C	50	57			
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			Dec 2015	9.0	8.2	Site S/C	8.6	8.2			
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Dec 2015	4.4	5.4	Site S/C	4.9	4.6			
Emergency Care & Pt. Flow	WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	145	51	136	219	159	282	185	149	164	43	116	90	72	58	76	93	67	121	Dec 2015	65	56		121	736			
Emergency Care & Pt. Flow	WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	8	1	13	21	14	31	7	6	8	9	8	3	3	2	1	1	3	8	Dec 2015	2	6		8	38			
Emergency Care & Pt. Flow	WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Dec 2015	0.09	0.25		0.17	0.11			
Emergency Care & Pt. Flow	WMAS - Emergency Conveyances (total)	No			4278	3994	4067	4193	4168	4470	4001	3829	4182	3981	4214	114	4256	4241	4016	4260	4202	4573	Dec 2015	2189	2384		4573	33857			
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			Dec 2015	0.0	93.0	91.0	91.8				
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			Dec 2015	0.0	85.0	84.2	84.5				
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			Dec 2015	0.0	93.2	90.9	91.7				
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	1	1	Dec 2015	0	0	1	1				
RTT	Treatment Functions Underperforming	<= No	0	0	5	6	5	5	7	2	2	6	1	1	1	1	3	4	3	7	8	8	Dec 2015	0	2	6	8				
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Dec 2015	0	0.1	0	0.07				

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		EC	AC	SC					
Data Completeness	Open Referrals	No			'	'	'	'	'	'	'	'	'	60,571	63,010	62,950	66,143	70,955	72,441	75,035	78,201	80,663	Dec 2015	23,389	17,537	39,737	80663				
Staff	WTE - Actual versus Plan	No			151	166	160	166	197	232	242	244	176	200	200	219	236	262	261	217	214	208	Dec 2015	98.5	50.8	54.4	208				
Staff	PDRs - 12 month rolling (%)	=> %	95.0	95.0																			Dec 2015	79.19	77.38	82.67		84.9			
Staff	Medical Appraisal and Revalidation	=> %	95.0	95.0										-									Dec 2015	81.82	82.14	80.56		83.6			
Staff	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15																			Dec 2015	5.12	5.82	5.22	5.43	4.98			
Staff	Sickness Absence - In month	<= No	3.15	3.15	-	-	-	-	-	-	-	-	-	-	-								Dec 2015	6.69	7.33	3.25	6.23	5.75			
Staff	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-	-	-	-	-	-		-	-								Dec 2015	66.1	69.4	43.2		61.27			
Staff	Mandatory Training (%)	=> %	95.0	95.0																			Dec 2015	82.9	81.8	80.93		82.7			
Staff	New Investigations in Month	No			2	1	2	1	0	0	1	2	2	2	1	1	2	1	3	0	0	1	Dec 2015	0	0	1	1				
Staff	Nurse Bank Fill Rate %	=> %	100	100	'	'	'	'	'	'	'	'	72	2528	3008	2311	3287	3019	4330	2700	1185	3654	Dec 2015				83				
Staff	Nurse Bank Shifts Not Filled (number)	<= No	0	0	-	-	-	-	-	-	-	-	1031	1136	1055	771	1146	977	811	594	217	749	Dec 2015				749				
Staff	Nurse Bank Use	<= No	34560	2880																			Dec 2015				3430	24734			
Staff	Nurse Agency Use	<= No	0.00	0.00																			Dec 2015				1461	14666			
Staff	Admin & Clerical Bank Use (shifts)	<= No	0.00	0.00																			Dec 2015				936	8730			
Staff	Admin & Clerical Agency Use (shifts)	<= No	0.00	0.00																			Dec 2015				90	506			
Staff	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-			
Staff	Your Voice - Response Rate (%)	No			-->	9	-->	-->	9	-->	-->	6	-->	-->	-->	6	-->	-->	6	-->	-->	6	Dec 2015	6.0	5.0	10.0	6.0				
Staff	Your Voice - Overall Score	No			-->	3.76	-->	-->	3.76	-->	-->	3.57	-->	-->	-->	3.49	-->	-->	3.45	-->	-->	3.37	Dec 2015	3.44	3.56	3.10	3.37				

Surgery A Group

Section	Indicator	Measure	Trajector Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate A	B	C	D	Month	Year To Date	Trend	Next Month	3 Months
Patient Safety - Inf Control	C. Difficile	<= No	1																			Dec 2015	0	0	0	0	0	2			
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0																			Dec 2015	0	0	0	0	0	0			
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80																			Dec 2015	94.3	99.1	88.4	0	94.3				
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80																			Dec 2015	94.6	95.2	96.7	100	95.2				
Patient Safety - Harm Free Care	Falls	<= No	0	8	3	9	9	6	6	0	4	4	5	9	5	4	2	4	2	6	11	Dec 2015	9	2	0	0	11	48			
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	Dec 2015	0	0	0	0	0	1			
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	1	1	0	0	4	0	0	2	0	0	1	1	1	2	1	1	1	Dec 2015	1	0	0	0	1	8			
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0																			Dec 2015	96.1	89.3	92.7	99	94.1				
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0																			Dec 2015	99.9	100	98.7	100	99.7				
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0																			Dec 2015	100	100	100	0	100.0				
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0																			Dec 2015	100	100	100	0	100.0				
Patient Safety - Harm Free Care	Never Events	<= No	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	Dec 2015	0	0	0	0	0	2			
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0	0	0	0	0	0			
Patient Safety - Harm Free Care	Serious Incidents	<= No	0																			Dec 2015	0	0	0	0	0	6			
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	98.0																	-	-	Oct 2015	33	75	100	100	64.3				
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	<= %		6.5	6.3	5.7	6.6	6.3	6.4	7.3	7.0	6.4	7.7	8.2	7.9	7.3	7.8	7.8	7.3	7.4	-	Nov 2015					7.4				
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	<= %		6.8	6.7	6.6	6.7	6.6	6.7	6.7	6.8	6.7	6.8	6.8	6.8	6.9	7	7.21	7.3	7.4	-	Nov 2015						7.0			

Surgery A Group

Section	Indicator	Measure	Trajector Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate A	B	C	D	Month	Year To Date	Trend	Next Month	3 Months
Clinical Effect - Cancer	2 weeks	=> %	93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Nov 2015	95.6		92.9		94.96				
Clinical Effect - Cancer	2 weeks (Breast Symptomatic)	=> %	93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Nov 2015	94.0				94				
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Nov 2015	98.0		100.0		98.44				
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Nov 2015	94.4		94.7		94.55				
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No		-	-	-	-	-	-	-	-	-	-	-	-	0	10	3	5	2	-	Nov 2015	-	-	-	-	1.5	18			
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No		-	-	-	-	-	-	-	-	-	-	-	-	4	6	1	2	0	-	Nov 2015	0	-	0	-	0	13			
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No		'	'	'	'	'	'	'	'	'	'	'	'	180	147	173	124	98	'	Nov 2015	98	-	98	-	98				
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	3	0	0	0	0	2	0	0	0	0	0	0	0	2	0	0	0	0	Dec 2015	0	0	0	0	0	2			
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No		8	19	15	13	13	7	15	9	16	16	8	16	16	15	15	18	18	11	Dec 2015	3	6	2	0	11	133			
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No		34	39	49	57	78	53	45	40	45	46	27	32	23	26	23	23	24	15	Dec 2015	4	7	4	0	15				
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No		118	99	109	133	143	171	192	213	234	254	97	157	108	122	125	27	47	46	Dec 2015	37	39	46	28	46				
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	1.9	-	3.07	0.55	1.47				
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	Dec 2015	0	0	0	0	0	1			
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	6	16	10	18	6	33	11	13	17	12	10	8	21	13	13	17	8	16	Dec 2015	8	0	7	1	16	118			
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	77	76	78	75	77	71	78	79	75	78	78	79	80	78	77.87	78	78	72	Dec 2015	66.3	80.7	71.0	80.0	72.17				
Pt. Experience - Cancellations	Urgent Cancelled Operations	No		-	-	-	-	-	-	-	-	-	2	0	0	0	7	2	8	0	0	Dec 2015	0	0	0	0	0	19			
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No		119	52	103	118	94	121	43	108	127	'	'	'	'	'	'	'	'	'	Mar 2015	66	53	8	0	127	1166			
Emergency Care & Pt. Flow	Hip Fractures - Operation < 24 hours of admission (%)	=> %	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Nov 2015		90.9			90.9	68.7			

Surgery A Group

Section	Indicator	Measure	Trajector Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate A	B	C	D	Month	Year To Date	Trend	Next Month	3 Months
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0																			Dec 2015	74.4	57.0	85.7	0.0	71.2				
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0																			Dec 2015	94.5	91.7	83.1	0.0	91.8				
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0																			Dec 2015	91.6	85.8	90.2	0.0	88.9				
RTT	Patients Waiting >52 weeks	<= No	0	2	4	2	1	2	0	3	1	2	1	0	0	0	2	1	1	0	0	Dec 2015	0	0	0	0	0				
RTT	Treatment Functions Underperforming	<= No	0	4	3	4	6	7	4	5	8	4	2	3	2	2	4	8	10	9	11	Dec 2015	5	3	3	0	11				
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0																			Dec 2015	0.4	0.0	0.0	0.0	0.29				
Data Completeness	Open Referrals	No		-	-	-	-	-	-	-	-	-	32,829	34,523	35,269	36,991	39,612	40,315	40,565	41,714	42,539	Dec 2015	15,668	12,762	11,016	3,093	42539				
Staff	WTE - Actual versus Plan	No		78	71	71	71	76	66	62	70	70	88	97	103	110	120	122.1	116	107	112	Dec 2015	28.3	25	36.9	17.1	111.9				
Staff	PDRs - 12 month rolling	=> %	95.0																			Dec 2015	73.5	71.7	86.7	78.1		85.7			
Staff	Medical Appraisal and Revalidation	=> %	95.0										-									Dec 2015	100	92.3	83.3	68.3		84.5			
Staff	Sickness Absence - 12 month rolling (%)	<= %	3.15																			Dec 2015	5.0	5.0	5.8	4.7	5.2	5.2			
Staff	Sickness Absence - In Month	<= No	3.15	-	-	-	-	-	-	-	-	-	-	-								Dec 2015	8.1	4.6	6.0	5.3	5.8	5.3			
Staff	Return to Work Interviews (%) following Sickness Absence	=> %	100	-	-	-	-	-	-	-	-		-	-								Dec 2015	67.4	46.6	79.2	73.3	70.1	64.6			
Staff	Mandatory Training	=> %	95.0																			Dec 2015	85.7	81.0	90.5	88.8		88.7			
Staff	New Investigations in Month	No		0	0	2	0	1	0	1	1	2	3	3	1	2	1	0	3	0	0	Dec 2015	0	0	0	0	0				
Staff	Nurse Bank Fill Rate	=> %	100.0	-	-	-	-	-	-	-	-	76	71	80	82	76	76	85.77	85	86	82	Dec 2015					82.31	81			
Staff	Nurse Bank Shifts Not Filled	<= No	0	-	-	-	-	-	-	-	-	335	313	247	197	347	303	272	220	117	232	Dec 2015					232	2248			
Staff	Nurse Bank Use	<= No	826																			Dec 2015					1168	9197			
Staff	Nurse Agency Use	<= No	0																			Dec 2015					322	3248			
Staff	Admin & Clerical Bank Use (shifts)	<= No	0																			Dec 2015					212	1808			
Staff	Admin & Clerical Agency Use (shifts)	<= No	0																			Dec 2015					69	344			
Staff	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00					-	-			
Staff	Your Voice - Response Rate	No		-->	11	-->	-->	11	-->	-->	9	-->	-->	-->	10	-->	-->	10	-->	-->	8	Dec 2015	9	5	4	9	8				

Surgery A Group

Surgery B Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate O	Directorate E	Month	Year To Date
Patient Safety - Inf Control	C. Difficile	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0	0	0	0
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0	0	0	0
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	75	97	91.1	
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	88.9	93.9	92.1	
Patient Safety - Harm Free Care	Falls	<= No	0	0	2	0	0	0	0	1	1	0	0	0	0	2	1	0	0	1	2	1	Dec 2015	1	0	1	7
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0	0	0	0
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0	0	0	0
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	98.9	98	98.6	
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98	98	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	100	100	100	
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	99.4	100	99.48	
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	99.4	100	99.48	
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0	0	0	0
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0	0	0	0
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0	0	0	0
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	97	-	-	●	-	-	-	-	-	N/A	N/A	N/A	N/A	●	N/A	●	N/A	-	-	Oct 2015	0	0	0	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			4.9	4.6	4.0	4.9	4.9	5.0	2.9	4.5	5.5	5.7	4.4	3.4	5.7	3.6	5.3	5.0	4.4	-	Nov 2015			4.4	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			4.8	4.8	4.8	4.8	4.8	4.8	4.7	4.5	4.5	4.5	4.6	4.6	4.6	4.5	4.7	4.7	4.6	-	Dec 2015				4.6

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Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate O	Directorate E	Month	Year To Date
Clinical Effect - Cancer	2 weeks	=> %	93	93																		-	Nov 2015		95.7	95.7	
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96	96						-										#DIV/0!		-	Nov 2015		100	100	
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85	85			-													#DIV/0!		-	Nov 2015		0	0.0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	0	0	0	0	1	-	Nov 2015	-	1	1	1
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	-	Nov 2015	-	0	0	0
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	62	51	62	0	104	-	Nov 2015	-	104	104	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0	0	0	0
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			10	11	8	12	11	14	14	12	16	14	9	6	15	15	16	18	18	17	Dec 2015	16	1	17	128
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			34	37	36	37	47	33	35	35	36	39	35	17	17	22	19	24	25	21	Dec 2015	19	2	21	
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No			103	129	98	63	138	109	102	123	144	164	135	102	126	148	83	106	34	57	Dec 2015	21	57	57	
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Dec 2015	0.48	2.56	1.17	
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0	0	0	0
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	16	14	16	12	11	7	24	11	8	15	17	16	10	14	8	19	15	11	Dec 2015	3	8	11	125
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85	85	74.5	72	73.6	72	73	68	74.1	72	75.2	73.3	71.4	73.1	73.9	70.5	73.6	75	75.1	73.8	Dec 2015	75.8	68.5	73.79	
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	0	0	1	0	0	0	0	0	0	Dec 2015	0	0	0	1
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95	95																			Dec 2015	99.2		99.2	99.1
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			13	26	29	10	27	25	8	8	39	-	-	-	-	-	-	-	-	-	Mar 2015	29	10	39	290
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0	-	-	-	-	-	-	-	-											Dec 2015	0		0	0
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15																-	-	-	Sep 2015	14		14	14
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																-	-	-	Sep 2015	17		21	20
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5	5																			Dec 2015	11		10.95	4.75

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Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5	5																	Dec 2015	1.5		1.5	1.75

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Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate O	Directorate E	Month	Year To Date
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90	90																			Dec 2015	78.5	89.3	81.9	
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95	95																			Dec 2015	95.5	94.7	95.3	
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92	92																			Dec 2015	93.6	93.6	93.6	
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	2	2	1	0	0	1	1	0	1	0	3	2	1	3	3	1	Dec 2015	1	0	1	
RTT	Treatment Functions Underperforming	<= No	0	0	3	2	4	5	5	1	2	7	1	1	2	1	1	1	1	5	3	3	Dec 2015	1	2	3	
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1	1																			Dec 2015	0	0.32	0	
Data Completeness	Open Referrals	No			-	-	-	-	-	-	-	-	-	58,186	60,484	61,192	63,016	65,129	66,371	67,982	70,005	71,194	Dec 2015	59,930	11,264	71194	
Staff	WTE - Actual versus Plan	No			33	32	28	30	27	30	32	29	28.5	35.3	35.1	46.6	43.1	49.7	57.2	58	59.1	61.1	Dec 2015			61.1	
Staff	PDRs - 12 month rolling	=> %	95	95																			Dec 2015	76.6	93.4		86.1
Staff	Medical Appraisal and Revalidation	=> %	95	95										-									Dec 2015	84	25	75.9	89.5
Staff	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Dec 2015	3.43	2.44	3.16	3.2
Staff	Sickness Absence - In Month	<= %	3.15	3.15	-	-	-	-	-	-	-	-	-	-	-								Dec 2015	3.57	5.15	3.86	3.56
Staff	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-	-	-	-	-	-		-	-								Dec 2015	56	77.2	63.41	54.62
Staff	Mandatory Training	=> %	95	95																			Dec 2015	83.4	92.3		86.44
Staff	New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	Dec 2015			0	
Staff	Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	-	-	-	-	100	99	99.6	98.4	98.2	96.9	96	97	97.6	93.5	Dec 2015			93.5	97.11
Staff	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	-	-	-	-	1	2	1	3	4	7	13	7	27	23	Dec 2015			23	87
Staff	Nurse Bank Use	<= No	2796	233																			Dec 2015			349	2154
Staff	Nurse Agency Use	<= No	0	0																			Dec 2015			9	236
Staff	Admin & Clerical Bank Use (shifts)	<= No	0	0																			Dec 2015			97.0	1129.0

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Staff	Admin & Clerical Agency Use (shifts)	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015			13.0	206.0
Staff	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-
Staff	Your Voice - Response Rate	No			-->	17	-->	-->	17	-->	-->	14	-->	-->	-->	12	-->	-->	15	-->	-->	14	Dec 2015	7	31	**14**	
Staff	Your Voice - Overall Score	No			-->	3.52	-->	-->	3.52	-->	-->	3.54	-->	-->	-->	3.59	-->	-->	3.63	-->	-->	3.63	Dec 2015	3.56	3.73	**3.63**	

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Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		G	M	P	C					
Patient Safety - Inf Control	C. Difficile	<= No	0	0																			Dec 2015	0	0	0	0	0	0			
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Dec 2015	0	0	0	0	0	0			
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.00	80.00																			Dec 2015	97				97.1				
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80.00	80.00																			Dec 2015	0	94			93.8				
Patient Safety - Harm Free Care	Falls	<= No	0	0	0	1	0	0	0	0	0	0	0	1	2	1	0	1	2	0	1	0	Dec 2015	0	0	0	0	0	8			
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0	0	0	0	0	0			
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	0	0	2	0	0	0	2	0	0	0	0	0	1	0	0	0	0	Dec 2015	0	0	0	0	0	1			
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Dec 2015	99	84			90.8				
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			Dec 2015	99	100			99.6				
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			Dec 2015	98	100			98.0				
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.00																			Dec 2015	98	100			98.0				
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Dec 2015	0	0	0	0	0	1			
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Dec 2015	0	0	0	0	0	0			
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Dec 2015	0	0	1	0	1	10			

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		G	M	P	C					
Patient Safety - Obstetrics	Caesarean Section Rate - Total	<= %	25.0	25.0																			Dec 2015		23			23.1	25.2			
Patient Safety - Obstetrics	Caesarean Section Rate - Elective	%			9	7	9	7	8	11	8	6	9	8	7	8	11	9	9	10	9	9	Dec 2015		8.7			8.7	8.8			
Patient Safety - Obstetrics	Caesarean Section Rate - Non Elective	%			15	17	18	19	16	16	15	17	16	15	18	15	18	17	18	15	16	14	Dec 2015		14			14.3	16.5			
Patient Safety - Obstetrics	Maternal Deaths	<= No	0	0																			Dec 2015		0			0	0			
Patient Safety - Obstetrics	Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Dec 2015		0			0	20			
Patient Safety - Obstetrics	Admissions to Neonatal Intensive Care	<= %	10.0	10.0																			Dec 2015		1.1			1.1	2.0			
Patient Safety - Obstetrics	Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Dec 2015		11			10.7				
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	90.0	90.0																			Dec 2015		79			78.6				
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0																			Dec 2015		208			208.0				
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100.0	97.0	-						-				N/A			N/A	N/A		-	-	Oct 2015	100	0	0		100.0				
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			6.2	6.4	5.5	7.2	6.8	7.2	6.6	7.4	6.9	7.4	6.9	7.1	7.1	4.4	4.5	6.4	5.9	-	Nov 2015					5.9				
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.4	6.4	6.4	6.5	6.5	6.6	6.5	6.6	6.7	6.7	6.7	6.8	6.9	6.7	6.6	6.6	6.5	-	Nov 2015						6.7			
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Nov 2015	92		0		92.3				
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Nov 2015	100				100.0				
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Nov 2015	94				93.8				
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	0	1.5	1.5	4	0.5	-	Nov 2015	0.5	-	0	-	0.5	7.5			
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	1	1	0	2	0	-	Nov 2015	0	-	0	-	0	4			
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	123	130	98	146	89	-	Nov 2015	89	-	0	-	89				

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		G	M	P	C					
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0				0	0			
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			11	8	8	8	12	7	11	9	11	7	9	14	14	12	10	9	10	15	Dec 2015	6	5	4	0	15	100			
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			21	24	29	29	33	12	21	27	32	28	28	20	18	17	13	13	13	14	Dec 2015	0	0	0	0	14				
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No			52	66	87	104	123	151	52	73	94	113	128	96	50	57	57	27	24	28	Dec 2015	22	18	26	28	28				
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Dec 2015	5.8		-		4.2				
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0				0	0			
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	7	6	6	7	7	7	1	5	7	6	4	2	2	4	7	6	9	13	Dec 2015	13				13	53			
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	83	78	76	77	77	80	77	78	79	76	78	74	75	76	79	76	76	72	Dec 2015	72	-			72.1				
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	8	3	0	0	0	0	0	0	0	Dec 2015	0	-	0	-	0	11			
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			18	14	30	23	36	82	5	30	16	-	-	-	-	-	-	-	-	-	Mar 2015	8	0	8	0	16	300			
RTT	RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Dec 2015	90				89.9				
RTT	RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Dec 2015	96				96.4				
RTT	RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Dec 2015	97				96.6				
RTT	Patients Waiting >52 weeks	<= No	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0				0				
RTT	Treatment Functions Underperforming	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	Dec 2015	1				1				
RTT	Acute Diagnostic Waits in Excess of 6-weeks	<= %	0.1	0.1																			Dec 2015	0				0.0				

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate G	M	P	C	Month	Year To Date	Trend	Next Month	3 Months
Data Completeness	Open Referrals	No			'	'	'	'	'	'	'	'	'	19,676	20,814	21,841	23,178	25,152	26,342	27,705	29,256	30,745	Dec 2015	8,635	15,874	6,227	9	30745				
Staff	WTE - Actual versus Plan	No			67	81	61	60	59	66	67	68.6	66.9	67.9	70.8	87.2	95.8	111	96.6	85.7	82.5	98.9	Dec 2015	26	57	16	0	98.9				
Staff	PDRs - 12 month rolling	=> %	95.0	95.0																			Dec 2015	86	83	92	0		87.7			
Staff	Medical Appraisal and Revalidation	=> %	95.0	95.0										-									Dec 2015	68	82	85	0		87.9			
Staff	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Dec 2015	5.2	6.5	4.4	10	5.8	5.6			
Staff	Sickness Absence - in month	<= %	3.15	3.15	-	-	-	-	-	-	-	-	-	-	-								Dec 2015	6.1	7.9	5.4	0	7.0	5.9			
Staff	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-		-	-								Dec 2015	70	65	68	43	66.08	60.2			
Staff	Mandatory Training	=> %	95.0	95.0																			Dec 2015	89	81	88	87		84.2			
Staff	New Investigations in Month	No			2	0	0	0	0	0	0	1	1	1	3	2	2	1	1	1	1	0	Dec 2015	0	0	0	0	0				
Staff	Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	-	-	-	-	90	93.6	95.4	91.9	93.9	90.9	94.7	94.2	96.1	87.4	Dec 2015					87.4	93.2			
Staff	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	-	-	-	-	81	37	35	53	50	68	51	48	394	95	Dec 2015					95	93			
Staff	Nurse Bank Use	<= No	6852	571																			Dec 2015					734	6019			
Staff	Nurse Agency Use	<= No	0	0																			Dec 2015					41	682			
Staff	Admin & Clerical Bank Use (shifts)	<= No	0	0																			Dec 2015					26	542			
Staff	Admin & Clerical Agency Use (shifts)	<= No	0	0																			Dec 2015					23	121			
Staff	Medical Staffing - Number of instances when junior rotas not fully filled	0	0																													
Staff	Your Voice - Response Rate	No			-->	12	-->	-->	12	-->	-->	9	-->	-->	-->	13	-->	-->	12	-->	-->	11	Dec 2015	15	5	17	13	11				
Staff	Your Voice - Overall Score	No			-->	3.65	-->	-->	3.65	-->	-->	3.53	-->	-->	-->	3.66	-->	-->	3.64	-->	-->	3.63	Dec 2015	3.7	3.7	3.6	3.5	3.6				

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
			Year	Month	1	1	3	2	3	8	5	3	1										G	M	P	C					
WCH Group Only	HV (C1) - No. of mothers who receive a face to face AN contact with a HV at =>28 weeks of pregancy	No			-	-	-	-	-	-	-	-	-	17	26	56	97	124	118	111	-	-	Oct 2015				111	111	549			
WCH Group Only	HV (C2) - % of births that receive a face to face new birth visit by a HV =<14 days	=> %	95.0	95.0	-	-	-	-	-	-	-	-	-	82.6	81	86.7	88.3	87.9	90.7	-	-	-	Sep 2015				91	90.7	87.83			
WCH Group Only	HV (C3) - % of births that receive a face to face new birth visit by a HV >days	%			-	-	-	-	-	-	-	-	-	17	15.9	8.8	5.87	9.69	9.04	-	-	-	Sep 2015				9	9.04	9.29			
WCH Group Only	HV (C4) - % of children who received a 12 months review by 12 months	=> %	95.0	95.0	-	-	-	-	-	-	-	-	-	59.2	61.7	71.1	77.7	82	87.4	92.3	-	-	Oct 2015				92	92.29	81.43			
WCH Group Only	HV (C5) - % of children who received a 12 months review by the time they were 15 months	%			-	-	-	-	-	-	-	-	-	88.4	78.8	77.3	86.7	86.1	84.5	91	-	-	Oct 2015				91	91.02	86.23			
WCH Group Only	HV (C6i) - % of children who received a 2 - 2.5 year review	=> %	95.0	95.0	-	-	-	-	-	-	-	-	-	85.1	80.2	91.4	89.8	82	92.9	95.1	-	-	Oct 2015				95	95.14	89.09			
WCH Group Only	HV (C6ii) - % of children who receive a 2 - 2.5 year review using ASQ 3	%			-	-	-	-	-	-	-	-	-	76.9	71.5	78.3	79.2	70	84.7	83.2	-	-	Oct 2015				83	83.24	77.38			
WCH Group Only	HV (C7) - No. of Sure Start Advisory Boards / Children's Centre Boards witha HV presence	=> No	100	100	-	-	-	-	-	-	-	-	-	1	1	1	1	1	1	1	-	-	Oct 2015				1	1	7			
WCH Group Only	HV (C8) - % of children who receive a 6 - 8 week review	=> %	95.0	95.0	-	-	-	-	-	-	-	-	-	74	74.3	79.1	83.5	94	93	96.5	-	-	Oct 2015				97	96.52	89.17			
WCH Group Only	HV - % of infants for whom breast feeding status is recorded at 6 - 8 week check	=> %	100	100	-	-	-	-	-	-	-	-	-	63.3	65.3	65	77.7	88.5	83.1	80.2	-	-	Oct 2015				80	80.15	79.39			
WCH Group Only	HV - % of infants being breastfed at 6 - 8 weeks	%			-	-	-	-	-	-	-	-	-	38.7	38.7	38.7	33.6	31.4	32.3	27.6	-	-	Oct 2015				28	27.58	32.45			
WCH Group Only	HV - % HV staff who have completed mandatory training at L1,2 or 3 in child protection in last 3 years	=> %	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Oct 2015				-	-	-			
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 10 - 14 day developmental check	No			-	-	-	-	-	-	-	-	-	-	-	-	347	397	333	-	-	-	Sep 2015				333	333	1077			
WCH Group Only	HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 10 - 14 day developmental check	=> %	100	100	-	-	-	-	-	-	-	-	-	88	87.2	85.8	92.3	98.5	86	-	-	-	Sep 2015				86	86.05	91.27			
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check	No			-	-	-	-	-	-	-	-	-	-	-	-	359	374	340	365	-	-	Oct 2015				365	365	1438			
WCH Group Only	HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check	=> %	100	100	-	-	-	-	-	-	-	-	-	74.1	80.9	79	99.7	95.4	94.7	####	####	####	Dec 2015				0	0	92.63			
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check	No			-	-	-	-	-	-	-	-	-	-	-	-	315	340	275	321	-	-	Oct 2015				321	321	1251			
WCH Group Only	HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check	=> %	100	100	-	-	-	-	-	-	-	-	-	76.2	68.8	66.3	98.4	95.8	81.1	####	####	####	Dec 2015				0	0	86.86			
WCH Group Only	HV - movers into provider <1 year of age to be checked =<14 d following notification to HV service	No			-	-	-	-	-	-	-	-	-	0	0	0	84	31	27	42	-	-	Oct 2015				42	42	184			
WCH Group Only	HV - all untested babies <1 year of age will be offered NBBS screening & results to HV.	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-	-			

Pathology Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate					Month	Year To Date	Trend	Next Month	3 Months
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		HA	HI	B	M	I					
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Dec 2015	0	0	0	0	0	0	0			
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 2015	-	-	-	-	-	-	-			
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 2015	-	-	-	-	-	-	-			
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	0	-	-	-	-	-	Nov 2015	-	-	-	-	-	-				
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			0	1	1	3	0	2	3	1	5	0	2	3	0	2	0	1	2	0	Dec 2015	0	0	0	0	0	0	10			
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			1	2	3	6	5	5	8	7	6	4	6	5	2	3	0	2	2	1	Dec 2015	1	0	0	0	0	1				
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No			27	46	68	92	111	90	96	117	138	73	92	27	23	18	0	25	4	11	Dec 2015	11	0	0	0	0	11				
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Dec 2015	-	-	-	-	-	-	-			
Data Completeness	Open Referrals	No			-	-	-	-	-	-	-	-	-	1,700	1,743	1,808	1,870	1,957	3,276	3,293	3,318	3,414	Dec 2015	1,334	1	1,600	0	479	3,414				
Staff	WTE - Actual versus Plan	No			32	29	27	25	27	27	24	16	16	20.4	22.8	32.5	34	33.7	40.3	40.1	39.2	38.2	Dec 2015	3.2	3.6	14.5	2	3.2	38				
Staff	PDRs - 12 month rolling	=> %	95.0	95.0																			Dec 2015	81.5	84.2	85.2	91.7	93.3		91.18			
Staff	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Dec 2015	100	100	100	75	100		88.89			
Staff	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Dec 2015	4.7	1.39	4.53	3.23	6.46	4.15	4.29			
Staff	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Dec 2015	5.7	0.5	5.3	4.3	8.5	4.42	3.84			
Staff	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Dec 2015	79.3	93.6	82.2	92.4	100	80.1	79.6			
Staff	Mandatory Training	=> %	95.0	95.0																			Dec 2015	88.2	96.4	93.9	93.8	98.7		95.2			
Staff	New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	Dec 2015	0	0	0	0	0	0				
Staff	Admin & Clerical Bank Use (shifts)	<= No	0	0																			Dec 2015						474	4679			
Staff	Admin & Clerical Agency Use (shifts)	<= No	0	0																			Dec 2015						0	0			
Staff	Your Voice - Response Rate	No			-->	31	-->	-->	31	-->	-->	12	-->	-->	-->	21	-->	-->	24	-->	-->	19	Dec 2015	15	28	12	26	57	19				
Staff	Your Voice - Overall Score	No			-->	3.74	-->	-->	3.74	-->	-->	3.76	-->	-->	-->	3.69	-->	-->	3.58	-->	-->	3.79	Dec 2015	3.64	3.73	3.77	3.75	4.14	3.79				

Imaging Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate DR	IR	NM	BS	Month	Year To Date	Trend	Next Month	3 Months
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0	0	0	0	0	0			
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0	0	0	0	0	0			
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	<= No	0	0	1.0	1.0	-	-	1.0	3.0	1.0	1.0	-	-	2.0	2.0	2.0	1.0	1.0	1.0	-	-	Nov 2015					-				
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	=> %	0	0	3.0	4.0	4.0	4.0	5.0	7.0	8.0	9.0	9.0	9.0	11.0	12.0	13.0	13.0	14.0	15.0	14.0	-	Nov 2015						4.42			
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Nov 2015			65.2		65.22	73.94			
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.00	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Nov 2015			97.8		97.83	99.3			
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 2015	-	-	-	-	-	-			
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 2015	-	-	-	-	-	-			
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	0	-	-	-	-	-	-	Nov 2015	-	-	-	-	-				
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0	0	0	0	0	0			
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			3	3	0	4	2	2	3	2	1	0	4	3	5	8	4	1	2	1	Dec 2015	1	0	0	0	1	28			
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			8	5	5	8	10	8	9	7	5	0	5	5	7	11	7	3	2	0	Dec 2015	0	0	0	0	0				
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No			59	30	52	76	72	75	83	75	96	123	102	27	24	43	62	29	3	0	Dec 2015	0	0	0	0	0				
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Dec 2015	-	-	-	-	-	-			
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			32	34	49	50	52	45	41	49	51	-	-	-	-	-	-	-	-	-	Mar 2015	51	0	0	0	51	513			
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0.3				0.3				
Data Completeness	Open Referrals	No			-	-	-	-	-	-	-	-	-	132	148	151	173	178	198	208	231	248	Dec 2015	248	0	0	0	248				
Staff	WTE - Actual versus Plan	No			13	22	14	16	15	21	21	33	34	41	46	58	59	56	50	48	45	40	Dec 2015	20	0.2	3.3	7.2	40.1				
Staff	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	61.3	92.3	77.8	87.3		77.6			
Staff	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	-	●	●	●	●	●	●	●	●	Dec 2015	100	0	100	75		95.8			
Staff	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	3.2	5.6	2.4	5.7	4.57	4.63			
Staff	Sickness Absence - in month	<= %	3.15	3.15	-	-	-	-	-	-	-	-	-	-	-	●	●	●	●	●	●	●	Dec 2015	3.7	1.4	0.8	6.2	4.66	4.36			
Staff	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	●	-	-	●	●	●	●	●	●	●	●	Dec 2015	51.2	95.2	74.4	21.3	50.9	46.2			
Staff	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	83.6	91.1	89.3	89.5		87.0			
Staff	New Investigations in Month	No			0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015					0				
Staff	Nurse Bank Use	<= No	288	24	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015					97	767			
Staff	Nurse Agency Use	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015					212	2167			
Staff	Admin & Clerical Bank Use (shifts)	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015					113	1528			
Staff	Admin & Clerical Agency Use (shifts)	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015					0	0			
Staff	Your Voice - Response Rate	No			-->	33	-->	-->	33	-->	-->	18	-->	-->	-->	19	-->	-->	24	-->	-->	21	Dec 2015	18	0	61	11	21				
Staff	Your Voice - Overall Score	No			-->	3.73	-->	-->	3.73	-->	-->	3.28	-->	-->	-->	3.41	-->	-->	3.11	-->	-->	3.40	Dec 2015	3.3	0	3.8	3.9	3.4				

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		AT	IB	IC					
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.0	80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0	0	0	0				
Patient Safety - Harm Free Care	Falls	<= No	0	0	13	4	14	20	17	21	22	16	13	30	47	37	25	27	29	29	21	26	Dec 2015	1	25	0	26	271			
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1	Dec 2015	0	1	0	1	3			
Patient Safety - Harm Free Care	Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	2	1	1	1	3	5	2	1	3	3	1	1	3	2	0	0	2	0	Dec 2015	0	0	0	0	12			
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0	0	0	0	0			
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0	0	0	0	0			
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2015	0	1	0	1	5			
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2015	0	0	0	0	0			
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			0	5	2	5	1	1	2	1	1	0	1	2	1	3	5	4	4	2	Dec 2015	1	1	0	2	22			
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			3	8	8	10	12	3	4	3	6	0	7	6	4	5	7	5	5	5	Dec 2015	2	2	1	5				
Pt. Experience - FFT,MSA,Comp	Oldest complaint currently in system (days)	No			75	38	60	64	81	75	61	82	103	158	0	99	118	140	10	21	40	59	Dec 2015	0	16	59	59				

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		AT	IB	IC					
Staff	WTE - Actual versus Plan	No			45	61.8	65	67	71	75	76	72.2	77.4	174	92.8	77.3	85.3	87.7	114	124	103	105	Dec 2015	8	64.4	32.1	104.5				
Staff	PDRs - 12 month rolling	=> %	95.0	95.0																			Dec 2015	87.7	75	86.4		86.7			
Staff	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Dec 2015	3.51	5.74	4.75	4.92	5.14			
Staff	Sickness Absence - in month	<= %	3.15	3.15	-	-	-	-	-	-	-	-	-	-	-								Dec 2015	3.19	5.54	4.53	4.63	4.37			
Staff	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-		-	-								Dec 2015	95.3	82.1	77.6	82.16	80.23			
Staff	Mandatory Training	=> %	95.0	95.0																			Dec 2015	93.4	86.9	91.2		89.3			
Staff	New Investigations in Month	No			0	0	0	0	0	0	0	0	0	1	3	0	0	0	0	0	4	0	Dec 2015				0				
Staff	Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	-	-	-	-	93	89.5	94.2	89.2	89	89.7	92.2	90.6	95.6	88	Dec 2015	-	-	-	87.98	90.78			
Staff	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	-	-	-	-	36	41	31	46	72	62	56	48	19	78	Dec 2015	-	-	-	78	453			
Staff	Nurse Bank Use	<= No	5408	451																			Dec 2015				544	4238			
Staff	Nurse Agency Use	<= No	0	0																			Dec 2015				200	2842			
Staff	Admin & Clerical Bank Use (shifts)	<= No	0	0																			Dec 2015				256	2225			
Staff	Admin & Clerical Agency Use (shifts)	<= No	0	0																			Dec 2015				0	0			
Staff	Your Voice - Response Rate	No			-->	32	-->	-->	32	-->	-->	28	-->	-->	-->	26	-->	-->	31	-->	-->	21	Dec 2015	30	21	18	21				
Staff	Your Voice - Overall Score	No			-->	3.88	-->	-->	3.88	-->	-->	3.76	-->	-->	-->	3.77	-->	-->	3.68	-->	-->	3.72	Dec 2015	3.63	3.7	3.82	3.72				

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		AT	IB	IC					
Community & Therapies Group Only	DVT numbers	=> No	730	61	39	33	70	35	42	47	54	53	55	56	53	67	64	78	59	44	-	-	Oct 2015				44	421			
Community & Therapies Group Only	Therapy DNA rate OP services	<= %	9	9	10.6	10.5	11.3	12	13.6	12	12.3	13.9	12.9	13.3	12	14.5	10.7	9.85	10.5	11.4	11	10.5	Dec 2015				10.5	11.5			
Community & Therapies Group Only	FEES assessment	<= No	100	8	4	4	5	5	3	2	14	1	2	0	2	0	0	-	-	-	-	-	Jul 2015				0	2			
Community & Therapies Group Only	ESD Response time	<= Hr	48	48									-	-	-	-	-	-	-	-	-	-	Feb 2015				0	0			
Community & Therapies Group Only	STEIS	<= No	0	0	0	1	0	0	0	1	0	0	-	-	-	0	0	0	0	1	0	1	Dec 2015				1	2			
Community & Therapies Group Only	Rapid response to AMU, RRTS	<= mins	60	60	73	68	81	79	82	86	79	98	-	-	-	-	-	-	-	-	-	-	Feb 2015				98	864			
Community & Therapies Group Only	Avoidable weight loss	<= %	20.0	20.0	0	0	0	0	0	9	0	0	8	0	25	20	0	-	-	-	-	-	Jul 2015				0.0	11.8			
Community & Therapies Group Only	Green Stream Community Rehab response time for treatment (days)	<= No	11.0	11.0	16.1	15.6	17.1	14.3	12.3	13.1	9.5	12.1	13.7	16	14	11	15	15	12	15	-	-	Oct 2015				15	98			
Community & Therapies Group Only	DNA/No Access Visits	%			-	3	1	1	1	1	1	1	-	-	-	-	6	1	1	-	1	1	Dec 2015				0.72				
Community & Therapies Group Only	Falls Assessments - DN service only	%			-	72	58	49	45	45	62	54	65	47	55	50	46	44	43	42	41	46	Dec 2015				46.17				
Community & Therapies Group Only	Pressure Ulcer Assessment - DN service only	%			-	73	61	50	48	46	63	57	65	51	55	51	48	44	43	44	33	48	Dec 2015				48.05				
Community & Therapies Group Only	Healthy Lifestyle Assessments - DN Service only	%			-	61	54	48	39	43	58	54	36	47	57	45	37	37	37	36	67	-	Nov 2015				67				
Community & Therapies Group Only	At risk of Social Isolation Referrals to 3rd sector DN service only	%			-	46	75	67	57	65	95	77	-	-	-	-	50	75	50	63	63	-	Nov 2015				62.5				
Community & Therapies Group Only	MUST Assessments - DN Service only	%			-	9	11	10	11	10	19	18	-	22	22	24	21	23	23	23	23	26	Dec 2015				26.44				
Community & Therapies Group Only	Incident Rates - per 1000 charge	Rate1			-	4	5	5	4	4	5	4	-	4	5	5	4	4	-	-	-	-	Aug 2015				4.4				
Community & Therapies Group Only	Dementia Assessments - DN Service only	%			-	72	62	55	52	51	61	62	-	46	56	40	48	45	50	43	50	29	Dec 2015				29.01				
Community & Therapies Group Only	48 hour inputting rate	%			-	91	83	81	85	86	89	83	-	87	89	92	91	94	90	90	94	94	Dec 2015				93.81				

Corporate Group

Section	Indicator	Measure	Trajectory				Previous Months Trend														Data Period	Directorate							Month	Year To Date	Trend	Next Month	3 Months
			Year		Month		J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		CEO	F	W	M	E	N	O				
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No					5	6	5	7	6	6	15	5	6	5	7	8	6	15	11	13	8	5	Dec 2015	1	1	0	1	0	1	1	5	78			
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No					12	13	21	21	25	12	21	16	18	14	12	14	9	16	16	16	9	8	Dec 2015	1	1	0	1	0	2	3	8				
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No					77	99	121	106	104	104	123	145	138	158	99	121	53	24	27	29	27	25	Dec 2015	-	-	-	-	-	-	-	25				
Staff	WTE - Actual versus Plan	No					176	162	183	194	203	168	175	200	220	260	267	110	99.6	103	100	92.2	89.3	97.8	Dec 2015	9.7	3.2	-12.7	17.4	-2.4	47.3	35.3	97.8				
Staff	PDRs - 12 month rolling	=> %	95.0	90.0	95.0	90.0																			Dec 2015	88	62	77	78	96	91	82		86.9			
Staff	Medical Appraisal and Revalidation	=> %	95.0	90.0	95.0	90.0									-							#DIV/0!			Dec 2015			95					100.0	100			
Staff	Sickness Absence - 12 month rolling	<= %	3.15	3.75	3.15	3.75																			Dec 2015	2.59	2.62	3.54	3.30	3.27	5.92	5.47	4.90	4.77			
Staff	Sickness Absence - in month	<= %	3.15	3.75	3.15	3.75	-	-	-	-	-	-	-	-	-	-	-								Dec 2015	3.04	3.62	3.90	2.17	6.07	6.33	4.12	4.95	4.80			
Staff	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.00	100.0	100.00	-	-	-	-	-	-	-	-		-	-								Dec 2015	82.1	65.9	43.7	85.7	51.2	83.3	75.7	75.6	72.6			
Staff	Mandatory Training	=> %	95.0	90.0	95.0	90.0																			Dec 2015	94	93	93	92	95	89	91	90.6	90			
Staff	New Investigations in Month	No					1	0	5	0	0	0	1	0	0	1	0	1	2	1	1	5	0	1	Dec 2015	0	0	0	0	0	1	0	1				
Staff	Nurse Bank Use	<= No	1088	1088.00	91	91.00																			Dec 2015								143	1654			
Staff	Nurse Agency Use	<= No	0	0.00	0	0.00																			Dec 2015								10	306			
Staff	Admin & Clerical Bank Use (shifts)	<= No	0	0.00	0	0.00																			Dec 2015	-	-	-	-	-	-	-	2728	27415			
Staff	Admin & Clerical Agency Use (shifts)	<= No	0	0.00	0	0.00																			Dec 2015	-	-	-	-	-	-	-	178	909			
Staff	Your Voice - Response Rate	No					-->	24	-->	-->	21	-->	-->	15	-->	-->	-->	16	-->	-->	19	-->	-->	15	Dec 2015	67	24	25	20	15	9	10	15				
Staff	Your Voice - Overall Score	No					-->	3.60	-->	-->	3.49	-->	-->	3.48	-->	-->	-->	3.50	-->	-->	3.46	-->	-->	3.58	Dec 2015	3.65	3.44	3.77	3.76	3.59	3.47	3.35	3.58				

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:	4th February 2016

EXECUTIVE SUMMARY:

1.1 This report is an update on safe nurse staffing December 2015 data.

1.2 The daily checking of nurse staffing data has been used to provide this report and provides a realistic picture of staffing on the wards with the exception of maternity and children's wards. Corrective actions have been implemented; these will be checked prior to the next board meeting.

1.3 The bank module is being tested and initial reports produced from the system, it is the intention to use the bank module to help produce the data in the future taking out the manual counting which is the current strength.

REPORT RECOMMENDATION:

To receive an update at the March Trust Board meeting
To support the manual, daily checking of nurse staffing as the means of collecting the necessary information to make the national submission.

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 UPDATE

Report to Trust Board on 4th February 2016

1 EXECUTIVE SUMMARY

1.1 This report is an update on nurse staffing data collected for December 2015.

1.2 The daily data check on nurse staffing has continued and forms the basis of this report.

1.3 This data provides better assurance about what is happening shift by shift on all acute adult in-patient wards and assessment units across the trust.

1.4 The data for maternity and children's continues to have problems although the wards have the right nu

2 DECEMBER DATA UPDATE

The average fill rates across the trust which includes permanent, bank and agency staff for all shifts is above 92%. There were some operational pressures through December with some additional beds opened. We have maintained safe staffing across all the acute medical surgical wards within the agreed staffing parameters. This has meant that staff have been deployed between wards and some between hospitals. The children's wards are not fully using the bank module on the e-rostering system consequently the data shows gaps in the numbers which is not reflecting the staff on duty, this has been corrected by the team going forward but may not be evident in the data for another month. All areas have continued with recruitment events to fill vacancies with some success.

Testing the bank module has continued and is proving to be a useful tool in the bank office as they are now able to challenge temporary staffing requests if there is no gap on the rota. Some test reports have been produced from the system, amendments are being made to these and the next step will be to use the reports with Group Directors as part of the accountability challenges in relation to nurse staffing.

3 RECOMMENDATION

The Board are requested to receive this update and agree to publish the data on our public website.

Chief Nurse continues to work with the information team to produce consistent and assured data in relation to ward nurse staffing.

Colin Ovington, Chief Nurse

27th January 2016

Appendix 1 – staffing data

	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 Dec 2015	Percentage night time fill rate during Dec 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during Dec 2015	Percentage night time fill rate during Dec 2015
Medicine & Emergency care	D5	City	13	5	5	5	98.7%	97.5%	1	1	0	91.9%	0.0%
	D7	City	19	3	3	3	98.1%	98.1%	1	1	0	100.0%	0.0%
	D11	City	21	3	3	3	101.6%	100.0%	2	2	1	104.8%	103.4%
	D12	City	10	2	2	2	109.7%	96.8%	1	1	1	95.2%	96.9%
	D15	City	24	3.5	3.5	3	122.6%	127.3%	2	2	1	98.3%	103.2%
	D16	City	21	3	3	3	110.9%	99.0%	2	2	1	101.5%	103.4%
	D26	City	21	3	3	3	101.6%	100.0%	2	2	1	119.4%	119.4%
	AMU 1	City	41	10	10	10	93.5%	95.2%	4	4	4	86.3%	74.6%
	AMU 2	City	19	5	5	5	91.2%	84.1%	1	1	1	104.7%	84.6%
	PR4	Sandwell	25	7	7	7	95.9%	96.3%	3	3	3	92.0%	97.1%
	PR5	Sandwell	34	5	5	4	99.6%	99.2%	3	3	2	90.4%	96.6%
	NT4	Sandwell	28	4	4	4	92.0%	86.2%	3	3	3	94.1%	95.7%
	LY 4	Sandwell	34	5	5	4	93.2%	91.9%	3	3	2	99.2%	112.9%
	temporary ward LY2	Sandwell	29	4	4	4	96.3%	100.0%	4	4	2	128.8%	100.0%
	N5	Sandwell	15	5	5	2	100.7%	100.0%	1	1	1	100.0%	100.0%
	AMU A	Sandwell	32	11	11	11	98.4%	97.2%	4	4	3	99.4%	105.4%
	AMU B	Sandwell	20	3.5	3.5	3	96.8%	100.0%	3	3	3	132.3%	90.4%

	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 Dec 2015	Percentage night time fill rate during Dec 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during Dec 2015	Percentage night time fill rate during Dec 2015
Surgery A	D21	City	23	4	4	2	94.4%	100.0%	2	2	2	97.2%	88.6%
	D17	City	19	4	4	2	92.3%	96.8%	2	2	2	95.7%	100.0%
	SAU	SGH	14	5+1 on mid shift	6	4	91.9%	93.5%	2	2	1	82.2%	77.5%
	temporary move L5	SGH	20	6	6	4	93.9%	98.9%	3	3	2	100.3%	116.6%
	P2	SGH	20	5	5	3	93.5%	99.0%	4	4	3	90.8%	96.8%
	N3	SGH	33	5	5	3	88.4%	100.0%	4	4	3	101.2%	104.3%
	L3	SGH	33	5	5	3	85.2%	89.2%	4	4	3	90.3%	108.7%
	CCS	City		Staff flexed to the dependency/number of patients in the units			93.4%	98.2%	Staff flexed to the dependency/number of patients in the units			87.7%	102.6%
	CCS	SGH					85.6%	93.2%				132.3%	87.1%

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during Dec 2015	Percentage night time fill rate during Dec 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during Dec 2015	Percentage night time fill rate during Dec 2015
Community & Therapies	Henderson	RH	24	3	3	2	91.9%	100.0%	3	3	3	93.5%	93.5%
	Elisa Tinsley	RRH	24	3	3	2	89.8%		3.5	3.5	2.5	96.8%	
	D43	City	24	6	6	4	100.0%	100.0%	5	5	2	100.0%	119.4%
	Leasowes	RH	20	3	3	2	66.9%	100.0%	3	3	2	114.4%	94.6%

	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 Dec 2015	Percentage night time fill rate during Dec 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during Dec 2015	Percentage night time fill rate during Dec 2015
Surgery B	Eye ward	City	10	2	2	2	96.8%	95.1%	1	1	0	84.1%	80.0%

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during Dec 2015	Percentage night time fill rate during Dec 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during Dec 2015	Percentage night time fill rate during Dec 2015
Womens & Children's	L G	SGH	14	3	3	2	94.3%	86.9%	1	1	1	58.8%	38.7%
	L1	SGH	26	5	5	4	94.7%	58.0%	3	3	2	44.0%	62.0%
	D19	City	8	3	3	2	74.7%	42.6%	1	1	0	66.7%	0.0%
	D27	City	18	4	3	2	78.8%	75.8%	2	2	1	78.2%	58.1%
	Maternity	City	42	6	5	4	100.7%	69.9%	4	4	2	92.6%	84.0%

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Information Governance Toolkit
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Mariola Smallman, Head of Risk Management
DATE OF MEETING:	4 February 2016

EXECUTIVE SUMMARY:

This report provides an update on the Trust's position against the 2015-16 Health and Social Care Information Centre (HSCIC) Information Governance (IG) Toolkit standards.

- **Appendix A** contains the IG Toolkit summary

REPORT RECOMMENDATION:

The Board is asked to **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:

Aligned to BAF, quality and safety agenda and requirement for Information Governance HSCIC self-assessment submission.

PREVIOUS CONSIDERATION:

Audit and Risk Committee January 2016

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Information Governance

Report to the Trust Board on 4 February 2016

1. EXECUTIVE SUMMARY

1.1 This report provides an update on the Trust's position against the 2015-16 Health and Social Care Information Centre (HSCIC) Information Governance (IG) Toolkit standards. The Trust's overall score for the 2014-15 self-assessment submission was 74%; the aim set for 2015-16's self-assessment submission is to achieve 85% (the deadline is 31 March 2016).

2. BACKGROUND

2.1 Information Governance is to do with the way organisations process or handle information and includes patient, staff and corporate information.

2.2 The IG toolkit is commissioned by the Department of Health and is developed / maintained by the HSCIC. The IG Toolkit is a set of standards (45 of which apply to Acute Trusts), which the Trust is required to carry out an annual self-assessment of compliance. The standards are broadly group into the following themes:

- IG management
- Confidentiality and Data Protection
- Information Security
- Clinical Information
- Secondary Use
- Corporate Information

3. IG TOOLKIT THEMES

3.1 **IG management**

The ongoing IG work programme components are delivered through a number of specialist executive and operational committees and groups (Informatics Committee, OMC, RMC, Information Governance Group, EPRR, HRSC, L&D, etc.). During 2015-16 quarterly meetings have been held with the Chief Executive and Senior Information Risk Owner (SIRO – this role is fulfilled by the Director of Governance) IG training continues to be available through a variety of mechanisms. The IG webpages and Connect policies and procedures web pages include a wide variety of IG related materials and staff in IG, Risk and IT provide advice and support as required.

3.2 **Confidentiality and Data Protection**

Information sharing systems and processes are in place to ensure third party agreements meet Data Protection and Confidentiality requirements. Work is ongoing to improve data capture of information flows and how patients are informed about how the Trust may use their data. The

standards also relate to subject access requests, for which there is an established policy and procedure. The Medical Director continues to fulfil the Caldicott Guardian role for the Trust.

3.3 **Information security**

Informatics colleagues are working on the Trust wide IT infrastructure and security project. This work includes updates to the network, software and security as well as working closely with the EPRR lead, who is liaising with directorates to further test and develop local business continuity measures. Informatics colleagues maintain a record of all IT systems, which is updated on an ongoing to basis to capture current information about asset owners, criticality, information security and resilience, etc. These standards also relate to the Trust's SmartCard and Registration Authority responsibilities.

3.4 **Clinical Information**

The majority of these standards relate to data quality assurances (use of NHS number, pseudonymisation, audit, traceability, etc.), which is managed by Information / BIU, medical records and clinical audit.

3.5 **Secondary Use**

These standards largely relate to data quality, external reviews and audits and how the Trust has utilised this information to bring about improvements.

3.6 **Corporate Information**

Corporate information standards relate to staff and corporate records but do not include patient records. The standards include corporate information procedures and audit as well as Freedom of Information requests processing.

3.7 **IG related incidents**

IG and IT related incidents continue to be monitored and corporately followed-up where required, e.g. CDA failure and cryptolocker. IG / IT incidents are managed and investigated as per standard incident reporting procedures. As at writing there are no open incidents awaiting a decision from the Information Commissioner's Office regarding any enforcement action.

3.8 **IG risks**

IG risks are reported and managed according the Trust's standard risk management policy and procedure. IG risks can be identified across any work programme / department in the Trust as well as overarching strategic risks, such as the IT infrastructure stabilisation programme, which features on the Trust Risk Register (alongside others) that are monitored by The Board on a monthly basis.

4. IG TOOLKIT 2015-16 SELF-ASSESSMENT

4.1 The 2015-16 annual IG Toolkit self-assessment submission deadline is 31st March 2016. **Appendix A** provides:

- a summary of the standards
- level of attainment to be achieved for 2015-16 with a comparison of 2014-15
- where applicable Internal Audit review findings*

4.2 Many of the themes do not change year on year. Scoring is based on three levels, with evidence requirements set out within each level of each standard. **Level 1** evidence is typically basic documentation and responsibilities are clearly defined; **Level 2** is typically where policies and procedures are fully implemented and for some that audits have been acted on; **Level 3** is typically where actions following audits and other improvement activities have been fully implemented and that monitoring arrangements can be evidenced to ensure compliance and effectiveness of policy/procedures.

4.3 *An annual Internal Audit review of a selection of standards is also carried out. In previous years the Internal Audit review has been carried out during quarter 4; during 2014-15 this was brought forward to quarter 3 to ensure any actions can be completed well before the 31 March 2016 deadline. **Appendix B** includes a summary of actions identified by the quarter 3 Internal Audit review.

5. QUARTER 4, 2015-16 ONGOING ACTIONS

5.1 Specialist executive and operational committees and groups (Informatics Committee, OMC, RMC, Information Governance Group, EPRR, HRSC, L&D, etc.) will continue to progress actions as identified in the Internal Audit Review and /or ongoing work programmes to achieve the agreed levels for the 2015-16 IG Toolkit submission.

5.2 A summary of key areas of improvement progressed during 2015-16 include:

- Extensive IT infrastructure and software investment, which is an ongoing work programme;
- Trust-wide QIHD IG corporate theme in September 2015, which helped over 800 staff increase their awareness and meet their mandatory training requirement;
- "IG Month" campaign in November 2015, which included key messages, posters, quiz and launch of several IG and IT related policies, procedures and guidance;
- Updated tools to collate Trust-wide information on data transfers and IG risks.

5.3 A key area of focus for quarter 4 remains IG toolkit standard 112 in relation to mandatory training. A concerted effort involving all levels of staff, including support from the Chief Executive and Director of Workforce and Organisation Development, will target areas of non-compliance to meet the required levels of staff trained (95%).

6. RECOMMENDATION(S)

6.1 The Board is recommended to:

- **NOTE** the contents of the report.

Kam Dhami, Director of Governance

4 February 2015

Appendix A: IG Toolkit summary

Req't Ref Number	Description	Evidence Summary	Team / Person Responsible	Accountable Lead	Attainment Level 2015-16 Aim	2014-15 Final Submission
101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	IG Policies; Assigned IG responsibility in JDs; IG related committee ToRs and minutes, IG development plan, framework review and sign off.	Loretta Bradley	Kam Dhami	3	3
105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Comprehensive IG related policies, evidence of policy-approval and sign off, staff communications and awareness about policies, IG development plan, annual review of framework and IG development plan	Loretta Bradley	Kam Dhami	3	3
110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Contracts and data processing agreements in place stating IG requirements, examples of clauses; list of contractors involved in data processing identified; third party contract checks carried out.	Justin Mitchell / Craig Higgins	Tony Waite	2	2
111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	Contracts containing IG compliance requirements, staff comms about IG responsibilities – staff bulletin, policies, training materials, etc. Spot checks on staff compliance with IG and monitoring; incident reports.	Lesley Barnett	Raffaella Goodby	3	3
112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Documented responsibility for leading IG training agenda, TNA to include recommended role based IG training, documented and owned actions regarding training, training materials, reports of annual training compliance for staff. Evidence of 95% compliance across all staff (annual mandatory training requirement). IA review (Q3) follow-up from previous audit: evidence not at Level 2 minimum – plan to address shortfall in progress	Jim Pollitt	Raffaella Goodby	3	2
200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and	Caldicott Guardian in place, role is documented. Documented evidence of Caldicott performance and training and plan, which is signed off (IG Devt Plan). Informatics Committee and IGG ToR and minutes.		Roger Stedman	3	3

Appendix A: IG Toolkit summary

Req't Ref Number	Description	Evidence Summary	Team / Person Responsible	Accountable Lead	Attainment Level 2015-16 Aim	2014-15 Final Submission
	experience which meet the organisation's assessed needs					
201	Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users	Responsibility for ensuring staff are informed of their responsibilities regarding confidentiality. Staff guidance and awareness materials; Confidentiality and DP policy, signed off by senior level.	Loretta Bradley	Kam Dhami	3	2
202	Personal information is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	Assigned responsibility for documenting information sharing processes. Approved guidelines for staff, made available. Confidentiality and DP policy. Information Sharing procedures. Patient feedback incorporated.	Loretta Bradley	Kam Dhami	3	2
203	Individuals are informed about the proposed uses of their personal information	Patient information which is made available to patients. Evidence staff are informed about the patient resources. Plan to improve patient info regarding their personal data and access to it. IA review (Q3) management action: evidence not at level 2 minimum – plan to address shortfall in progress	Linda Pascall / Loretta Bradley	Colin Ovington	3	2
205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Documented approved procedures for handling subject access requests and assigned responsibility. Staff awareness of responsibilities. Procedure is implemented; targets are being met.	Kelly Trimble	Kam Dhami	3	3
206	There are appropriate confidentiality audit procedures to monitor access to confidential personal information	Documented, approved procedures with assigned responsibility for monitoring and auditing access to confidential information, made available throughout the organisation. Procedures are implemented, staff are monitored and action is taken where there are breaches. Completed risk assessments for paper records, Data Protection and Confidentiality policy and IS Policy. Confidentiality Audit Procedures. Incident Reporting / SI	Sarah Cooke	Roger Stedman	2	2

Appendix A: IG Toolkit summary

Req't Ref Number	Description	Evidence Summary	Team / Person Responsible	Accountable Lead	Attainment Level 2015-16 Aim	2014-15 Final Submission
		procedure.				
207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Information sharing protocols and agreements are in place and approved.	Loretta Bradley	Kam Dhami	3	3
209	All person identifiable data (PID) processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Annual data flow mapping survey carried out and high risks, e.g. data flows outside UK identified and reviewed for safe transfer. Results have been signed off/ approved. IA review (Q3) follow-up from previous audit: evidence not at Level 2 minimum – actions in progress to ensure compliance.	Loretta Bradley	Kam Dhami	2	2
210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Documented procedures for introduction of new and changing information assets and responsibility for this is formally assigned. All applicable staff are informed.	Lee King	Alison Dailly	2	2
300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Assigned Information Security role/ responsibility, documented plan for Information Security Assurance reported to SIRO and supported by appropriately trained staff.	Lee King	Alison Dailly	2	2
301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Formally documented and approved Information Risk Assessment and Management Programme. Information Security Risks reviewed / updated and monitored.	Lee King	Alison Dailly	2	2
302	There are documented information security incident / event reporting and	Approved procedures for reporting, investigating and managing information security events which have been	Loretta	Kam Dhami	3	3

Appendix A: IG Toolkit summary

Req't Ref Number	Description	Evidence Summary	Team / Person Responsible	Accountable Lead	Attainment Level 2015-16 Aim	2014-15 Final Submission
	management procedures that are accessible to all staff	communicated to staff. Contracts and agreements with partners contain clear reporting requirements.	Bradley			
303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Board or senior committee assigned overall responsibility for RA which is documented. RA policy / procedures approved by senior management.	Sarah Cooke	Alison Daily	2	2
304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Signed off Smartcard plan/ procedure – regarding staff awareness of Ts&Cs of usage. RA manager JD (assigned responsibility), IS policy referencing Smartcard use. Audit reports for monitoring Smartcard compliance regarding usage and disabling access.	Sarah Cooke	Alison Daily	3	2
305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Assigned responsibility for defining and documenting requirements for both system and user access controls. System Level Security Policy. Associated access management procedures such as user registration and deregistration including temporary access. Information Security policy.	Martin Evans	Alison Daily	2	2
307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	SIRO in place appropriately trained. Updated Information Asset register. Documented risk findings from IAR reported to SIRO. Regular risk reviews of information assets carried out.	Loretta Bradley / Lee King	Kam Dhami / Alison Daily	3	2
308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Data flows identified. Risks addressed where risks identified. Risks appropriately escalated. Log of all data sharing and transfer agreements.	Loretta Bradley	Kam Dhami	3	2

Appendix A: IG Toolkit summary

Req't Ref Number	Description	Evidence Summary	Team / Person Responsible	Accountable Lead	Attainment Level 2015-16 Aim	2014-15 Final Submission
309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Documented approved strategy and associated programme. All business critical systems identified and supported with BCPs. All IAOs analysed effect of disruption on their assets and linked to risk register/ reported to SIRO. Staff made aware of BCP requirements. Example system level security policies. Updated Information Asset Register are evidenced. DR arrangements documented.	Matthew Dodd	Rachel Barlow	2	2
310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	Infrastructure plan. Documented and approved procedures and controls based on risk assessment results to prevent disruption/ interruption of information assets. Summary of risk assessment findings.	Lee King	Alison Dailly	2	2
311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	Information Assets reviewed and where those identified vulnerable to malicious code it has been addressed through SLSPs. The measures have been implemented (shown through anti virus SoP and reports from AV software.	Lee King	Alison Dailly	2	2
313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Information Security Policy. Identified controls are implemented. A network security policy has been produced for each ICT network and approved by the SIRO (IS Policy as evidence). ICT networks asset owners have reviewed risks and controls. (Breast screening SLSP and risk assessment, infrastructure risk assessment, CLE minutes evidenced). Controls have been approved by SIRO.	Lee King	Alison Dailly	2	2
314	Policy and procedures ensure that mobile computing and teleworking are secure	Documented approved procedures for mobile working, log kept of all authorised staff and where permissions are removed, staff are informed of responsibilities, robust remote access solutions are in place.	Lee King	Alison Dailly	2	2
323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Existence of Information Asset Register that includes all assets that comprise or hold personal data with accountable owner, plan to capture any missing assets, risk assessments have been carried out and technical safeguards are in place for assets. IA review (Q3) finding: evidence meets level 2	Lee King	Alison Dailly	2	2

Appendix A: IG Toolkit summary

Req't Ref Number	Description	Evidence Summary	Team / Person Responsible	Accountable Lead	Attainment Level 2015-16 Aim	2014-15 Final Submission
		minimum				
324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	A plan for implementing pseudonymisation and anonymisation for secondary uses is in place, processes have been implemented.	Matthew Maguire	Rachel Barlow	2	2
400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Information Quality and Records Managers/Officers roles assigned, approved documented strategies for information quality and records management identifying required support for necessary work, senior corporate responsibility identified, all staff appropriately trained.	Matthew Maguire	Rachel Barlow	2	2
401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Process is in place to ensure all new systems comply with NHS number requirements and old systems where problems exist with implementation are addressed.	Matthew Maguire	Rachel Barlow	2	2
402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Responsibility has been assigned, approved documented procedures in place, reports are received by a senior committee, procedures are available to all relevant staff, staff are trained, reconciliation is performed as required.	Matthew Maguire	Rachel Barlow	2	2
404	A multi-professional audit of clinical records across all specialties has been undertaken	A clinical records audit process is documented and in place, all relevant staff are informed of their responsibilities regarding clinical record keeping.	Simon Parker	Kam Dhami	3	3
406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	Documented and approved procedures in place to monitor the availability of paper health/care records, action taken where issues identified.	Trish Kehoe	Rachel Barlow	3	3
501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as	All key service user information systems incorporate national NHS and/or care definitions and values. Validation programmes are built in to systems and are kept up-to-date and cannot be switched off/ overridden, local system documentation is regularly reviewed and updated.	Matthew Maguire	Rachel Barlow	2	2

Appendix A: IG Toolkit summary

Req't Ref Number	Description	Evidence Summary	Team / Person Responsible	Accountable Lead	Attainment Level 2015-16 Aim	2014-15 Final Submission
	standards develop	Responsibility is assigned, Job descriptions, updated training materials, reports and minutes provided as evidence.				
502	External data quality reports are used for monitoring and improving data quality	An approved process for using external data quality reports for monitoring data quality in place with assigned accountability, process available to all relevant staff, external DQ reports received and issues addressed, senior management kept informed of DQ report use and issues. Evidenced by DQ policy, JDs, DQ reports and minutes to evidence review of reports and actions agreed. IA review (Q3) management action: evidence not at level 2 minimum – plan to address shortfall in progress	Matthew Maguire	Rachel Barlow	2	2
504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	Assigned responsibility, approved procedures in place, relevant staff have been trained, issues are identified and addressed and monitored and reviewed over time. Job descriptions, DQ Policy, minutes, training materials, reports, trend analysis as evidence. IA review (Q3) finding: evidence meets level 2 minimum.	Matthew Maguire	Tony Waite	2	2
505	An audit of clinical coding, based on national standards, has been undertaken by a NHS Classifications Service approved clinical coding auditor within the last 12 months	Documented procedures annual audit of clinical coding in place. Audit programme undertaken and, accuracy levels meet minimum standards. Annual clinical coding audit required and evidence of action completion where identified.	Matthew Maguire	Rachel Barlow	3	2
506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	Responsibility is assigned, an approved audit plan is in place, staff are advised regarding accuracy, accuracy reported to Board/ senior management committee.	Matthew Maguire	Rachel Barlow	2	2
507	The Completeness and Validity check for data has been completed and passed	Responsibility is assigned for the checks. Requirement for the checks is documented in the DQ policy. Checks have been carried out to required standard. Agreed improvement plan in place. Results are reported to the relevant committee.	Matthew Maguire	Rachel Barlow	2	2

Appendix A: IG Toolkit summary

Req't Ref Number	Description	Evidence Summary	Team / Person Responsible	Accountable Lead	Attainment Level 2015-16 Aim	2014-15 Final Submission
508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	Responsibility is assigned, an approved strategy is in place, staff are informed and engaged. DQ policy, results shared with staff and results showing staff engagement is evidenced.	Matthew Maguire	Rachel Barlow	2	2
510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	TNA and Training plan is in place. Staff training evidenced.	Matthew Maguire	Rachel Barlow	3	3
601	Documented and implemented procedures are in place for the effective management of corporate records	Responsibility is assigned. Documented approved policy/ procedures for Corporate Records Management which have been implemented and staff informed.	Duncan Whitehouse	Kam Dhami	3	2
603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	FOI responsibilities assigned. Procedures are published and accessible and provided to staff. There is existence of a publications scheme and legal requirements are being met. Job description, training and awareness materials, assurance reports, publication scheme, request log.	Duncan Whitehouse	Kam Dhami	3	3
604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	Responsibility is assigned, approved plan is in place, audit completed, actions have been identified and addressed.	Duncan Whitehouse	Kam Dhami	3	2

Appendix B: Internal Audit Review Summary of Actions

Req't Ref	Standard	Actions for management	Implementation date	Responsible owner
112	Information Governance awareness and mandatory training procedures are in place and all staff are trained (95% compliance required)	Work has already begun on ensuring that the Trust fully complies.	31st March 2016	Associate Director of Education, Learning and Development
203	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	Since the review additional evidence has been uploaded. The remaining action is on track and once uploaded will meet Level 2 requirements.	31st March 2016	Information Governance Manager / Deputy Chief Nurse
301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Since the Internal Audit Review additional evidence has been uploaded to ensure full compliance.	22nd January 2016	Chief Information Officer
502	External data quality reports are used for monitoring and improving data quality	Since the review some evidence has been uploaded, although the Level 2 standard has not yet been achieved.	31st March 2016	Head of Information / BIU
209	All person identifiable data (PID) processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Since the review the revised Data Flow Mapping survey has been issued. As at writing over 50 responses received. A review of all responses will be carried out to identify any overseas transfers and whether these meet legal requirements.	31st March 2016	Information Governance Manager / Head of Risk Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Complaints & PALS report: 2015/16 quarter 3
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Karen Beechey, Head of PALS & Complaints
DATE OF MEETING:	4th February 2016

EXECUTIVE SUMMARY:

This report sets out details of Complaints and PALS enquiries received between October and December (Quarter 3).

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

In this quarter, it is reported that the complaints activity has increased, and shows that 93% of complaints have been managed within their target date. Themes and outcomes remain consistent with previous quarters and shows a continued focus on lessons learned, 'action tracking' and quality responses that are caring, transparent, timely and responsive to the needs of complainants.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
✓		✓

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

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

Comments:

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

Safe, high quality care
Improve and heighten awareness of the need to report and learn from complaints.

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Complaints and PALS Report

2015/16: Quarter 3

COMPLAINTS MAKING A DIFFERENCE

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

What we were told	Our response	The difference
Patient had cataract surgery on 1 June 2015 and got a follow up appointment on 11 August 2015 but only due to her persistence. Complainant unhappy that systems were not in place to ensure timely follow up appointments.	To ensure this does not happen again, plans are under-way to have a central booking team responsible for booking appointments (including those required within the community) and therefore provide a more streamlined service for patients.	Unacceptable delays in follow up will not occur for patients, and will reduce the inconvenience of patients having to chase their own appointments.
A carer from the residential home who accompanied the patient requested that their care be transferred to Russell Hall Hospital. It was agreed and a transfer form was completed. This was NOT at the request of the family and NOK was not asked. On three occasions, the family have requested to change the patient's address for appointment letters to the daughter's address, as the family have been unaware of appointments. Pt is 90 years old and suffers with dementia and therefore is not able to attend appointments on his own. The patient was discharged from the consultant as per the request of a carer and the hospital should not have acted on the carer's instructions.	Apology offered for the Trust's inflexible administrative systems. We confirmed that we have now changed the patient's address details to that of his daughter's address. Changes have been put in place across the medical secretarial teams and these systems are being audited by our Patient Administration Managers. The patient's care will now remain at BMEC.	Elderly and vulnerable patients will be supported by the most appropriate care giver including family and communication with families will be improved, reinforcing trust and improving outcomes for the patient.
The patient's solicitors requested his records from Legal Services on 24 August2015, and they were delayed beyond the 40 day time frame given for Subject Access Requests. The	We have recently changed the way Subject Access Requests are managed and have introduced a database to identify at what stage they are at in the process and this in turn has made it much easier to	The new data base will ensure that anyone enquiring about the status of their request will be given accurate information, as well as supporting the team to manage these requests within the appropriate

What we were told	Our response	The difference
complainant also received conflicting information from a member of the team, and was not happy with their attitude.	update enquirers with more accuracy and to manage requests. In relation to the concern about the attitude of a member of the Legal Services team, and apology was offered and professionalism discussed with them, and the team as a whole.	timeframe, which is also now achieved in 93% of the case.
Patient had an appointment for an echocardiogram on 8 December 2015 at 9.45am. He spoke to the receptionist and apologised for being 20 minutes late but the receptionist advised that he could not be seen and did not want to know why he was late. The patient was concerned that the attitude of the receptionist influenced the decision not to allow the patient	The receptionist apologised as it was not intentional to appear rude and unhelpful. Reasons as to why the appointment could not go ahead were explained. The appointment letter has now been amended to ensure that this is clearer for patients who may be running late.	Patients are informed via their appointment letters, that if they are late, then their appointment will need to be rearranged. By advising all patients of this potential, they will be aware that this is potential and be better prepared for this outcome.
Patient is complaining about the new booking in system, feeling that we are in breach of confidentiality as when booking in for an appointment the patient's personal details come up on the screen and can be read by anyone nearby. Patient was told that there was no other method of recording attendance. Patient wants to know the justification of why there is such a disregard of the Data Protection Laws.	Apologies and explanations offered, including the benefits of the self-check in system. Privacy lines have now been affixed in front of check in kiosks to ensure privacy is maintained, and was implemented as a result of the this complaint, and other patient feedback.	
Patient was in surgery for a knee replacement. Before going into surgery she was given half the antibiotics by syringe (the other half to be administered once in theatre). The Anaesthetist picked up the wrong syringe and injected the patient with the wrong medication, resulting in an	This incident was raised under the Trust Incident Reporting process and was fully discussed at the September anaesthetic governance meeting to raise awareness and prevent a repeat. Emergency drugs are now kept separately from other drugs, such as antibiotics, interruptions in the anaesthetic	The risk of the likelihood of such an event has been significantly reduced, which in turn has improved patient safety.

What we were told	Our response	The difference
unexpected admission to the Critical Care Unit.	room do not occur during drug administration.	
Patient complained that they had 2 appointments for cardiology cancelled due to no doctor being available.	Apologies offered to the patient. The complaint has been discussed with the team involved who agreed a formal escalation process whereby any patients that are cancelled more than once by the Trust are offered an expedited appointment under an alternative clinician if agreeable with the patient. Furthermore to avoid any booking errors relating to clinicians not being available we have administered a 'flexible registrar' system whereby if the original clinician is unavailable for any reason then a speciality doctor is always on hand to ensure patients are seen in clinic and not turned away.	Waiting times for appointments will be reduced, and where unavoidable cancellations occur, and then patients who have experienced this will be prioritised, ensuring that they still feel valued.

COMPLAINTS AND PALS: 2015/16

Quarter 3 data highlights

1.	The **total number of PALS concerns registered was 634**, down by 23. Strategy and Governance, and Imaging saw the most significant decrease, with Surgery B seeing an increase concerns particularly around appointment. (page 21)
2.	The **total number of Complaints logged was 261,** a decrease of 66 complaints across the quarter compared to Q2 2015/16. 26 of these were withdrawn by the complainant at some point during the quarter leaving 235 to manage. There were 7 more complaints made in October 2015 compared to October 2014, 18 more complaints made in November 2015 compared to November 2014, and 1 more made in December 2015 compared to December 2014. (page 7)
3.	The **total number of compliments collected for Q3 2015/16 was 220** compared to 285 in Q2 2015/16 and 358 in Q1 2015/16. It is now clear that the collection method is not supporting accurate data reporting, and a new method of collection is scheduled to be trialled in Women and Child Health in Q4 2015/16 and Q1 2016/17. (Appendix 11 page 39)
4.	The a**verage number of days taken to resolve complaints saw a decrease by a further of 15.17 days from 44.65** (Q2 2015/16) down to 29.48 (Q3 2015/16). This decrease continues to be attributed to the resolution of fewer older complaints as well as a higher proportion of newer complaints being managed within their target dates and is set to stabilise as the case load is now managed within an average of 30 working days. (page 11)
5.	**Complaints per 1000 bed days have decreased** when compared to the previous quarter, with an average rate of 3.0 of against 3.4 in the previous quarter. This rate is lower than for the same period last year when the Q3 2014/15 rate was 4.5. This decrease has contributed to a continued downward trend over the last 7 quarters. (page 8)
6.	**When looking at the complaints rate per 1000 FCE it is still Surgery B that has the highest complaints rate at 11.5** (an increase on last quarter's 9.5) all other groups seeing a decrease in rate. Woman and Child Health still has the lowest and whilst they had seen a steady increased from 2.5 in Q3 2014/15, to 4.6 in Q2 2015/16, it is now back down to 3.6 in this quarter. (page 9)
7.	**'Not Upheld' complaints made up 27% of closed complaints a**gainst 24% in Q2 2015/16 and 24% in Q1 2016/16 and 26% in Q4 2014/15, but with no emerging trends in terms of Groups or themes. (page 18)
8.	**The three themes** that emerged out of complaints this quarter remain the same as the previous four quarters and are **Attitude of Staff, Clinical Care and Appointments**. Medicine still has the highest percentage of complaints across these categories at 42%. (page 14)
9.	**Reopened cases totalled 53 with 2 of those re opened due to not all the issues being answered in our first response (4%)**. This compares to 40 reopened with 4 where not all issues were addressed in Q2 2015/16 and 49 reopened with 7 where not all issues were addressed in Q1 2015/1 and 44 reopened where 5 where not all issues were addressed in Q4 2014/15. There has been a reduction in the % of those reopened where not all issues were addressed, from 22% in for the same quarter last year, Q3 2014/15, down to 11% in Q4 2014/15, a slight increase to 14% in Q1 2015/16 and back down to 10% in Q2 2015/16. (page 19)
10.	**There were 13 new PHSO enquiries** of the Trust in this quarter, and 2 previous enquiries were closed off. This is the most significant increase of PHSO cases seen this year, details of the cases are detailed in the report. (pages 20)
11.	The **new Complaints satisfaction survey was launched** this quarter. The **response rate was slightly low at 12.1%** but the results were improved in some of the areas of complaints management surveyed. The results for overall well-handled went from 45% in Q1 2015/16 to 69% in Q3 2015/16 and being kept informed went from 34% in Q1 2015/16 to 77%. 85% of respondents also found the response easy to understand in Q3 2015/16 as opposed to 58% in Q1 2015/16. (page 12)
12.	There is no disproportionality the number of complaints made by (or on behalf of) either Pakistani patients (at 8% complaints vs 11% local population) but **Black Caribbean patients featured as making up a higher proportion of complainants than that of the population as a whole**. (at 13% complaints vs 6% local population). (page 14)

COMPLAINTS AND PALS: Q2 2015/16

Index

INTRODUCTION

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

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

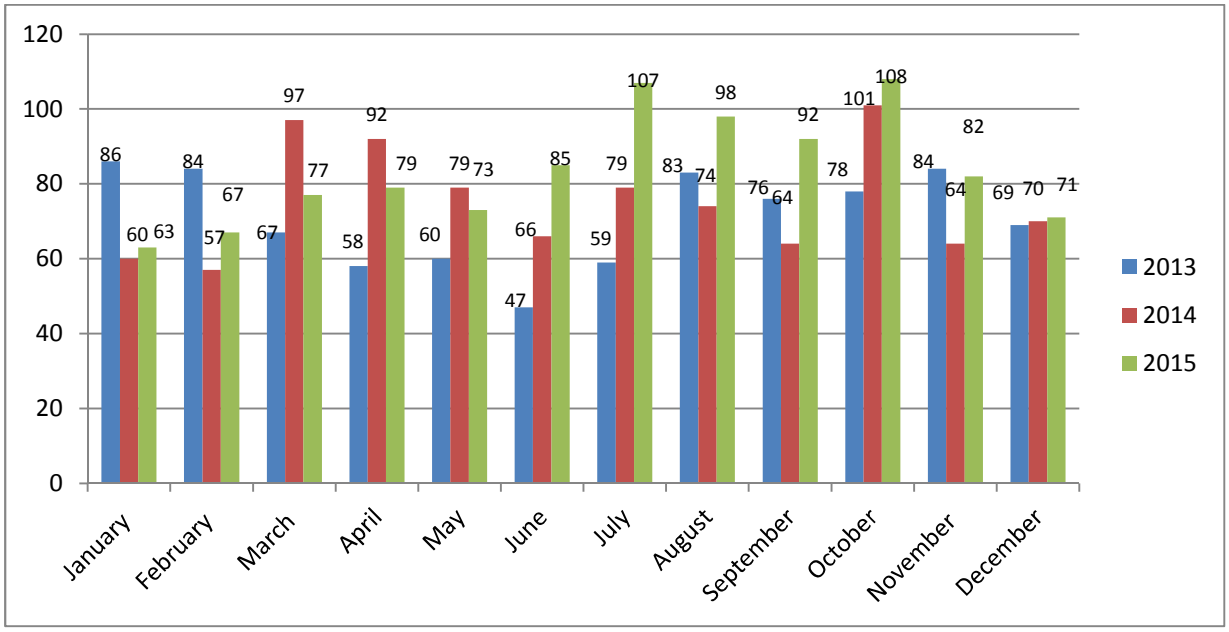
COMPLAINTS

1. Complaints Management

1.1 Total received

The total number of complaints received by the Trust financial year to date is 795, against 689 for the same period in 2014/15. The total number of complaints received in Q3 2015/16 was 261 compared to 297 in Q2 2015/16 and 237 in Q1 2015/16. In the same period the previous year, Q3 2014/15 235 complaints were received, 26 less. When broken down by month, year on year, there were 7 more complaints made in October 2015 compared to October 2014, 18 more made in November 2015 compared to November 2014 and 1 more complaint made in December 2015 compared to December 2014. It should also be noted that 26 complaints were withdrawn in this quarter, 5 less than in the previous quarter leaving 272 actively managed this quarter.

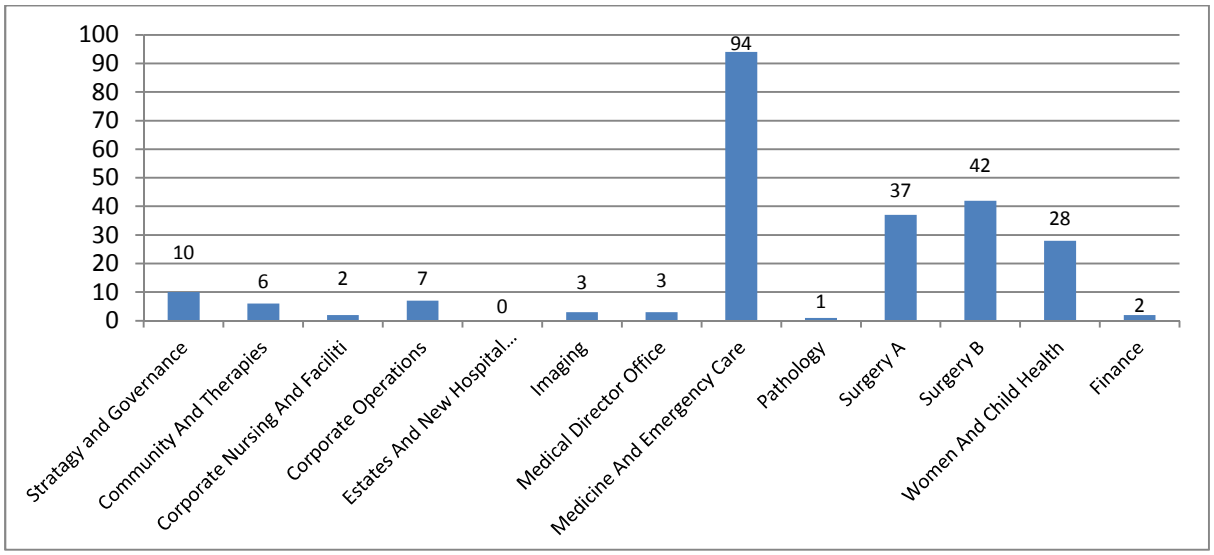
Q3 2015/16 complaints received by month



1.2 Complaints by Clinical Group

When analysing the complaints received in Q3 2015/16, by Clinical Group and Corporate Directorate, Medicine continue to receive the most complaints. **Appendix 1a** shows how these figures compare over the last 4 quarters. **Appendix 1b** shows how this is broken down by ward (where applicable).

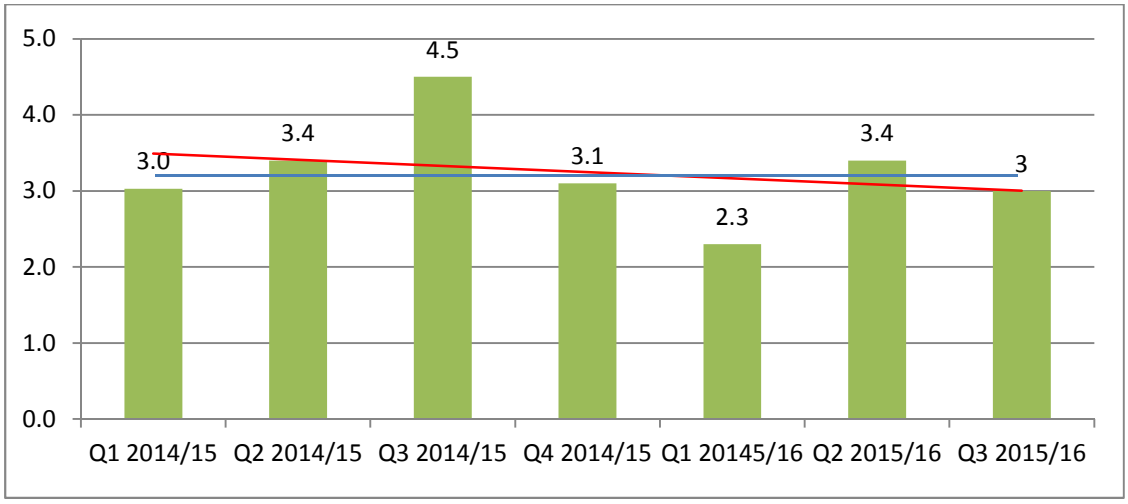
Q3 2015/16 complaints received by Clinical Group/ Corporate Direcotrate



1.3 Complaints by 1000 bed days

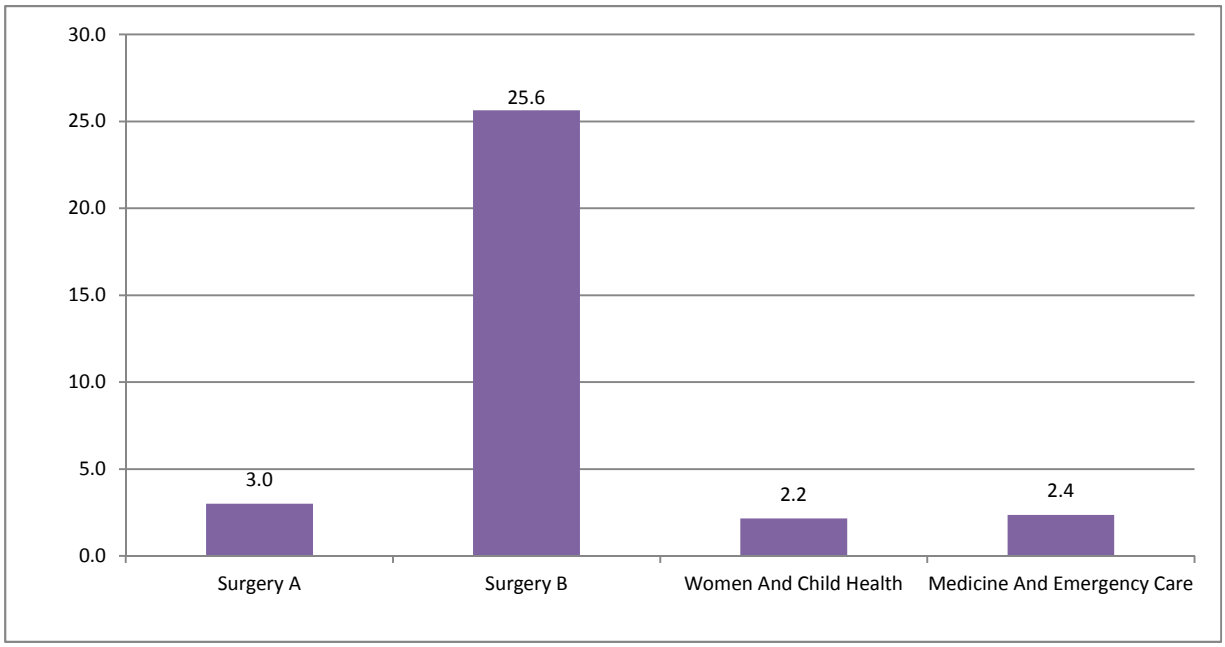
The complaints rate, calculated as complaints per 1000 bed days for Q3 2015/16 is lower than the previous quarter at 3.0 against 3.4 for Q2 2015/16. The trend line is still downward. The 12 month rolling average has decreased to 3.2 against 3.3 when last reported. The trend line is shown in red and the rolling average is shown in blue.

Complaint rate over last 6 quarters showing trend and average



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

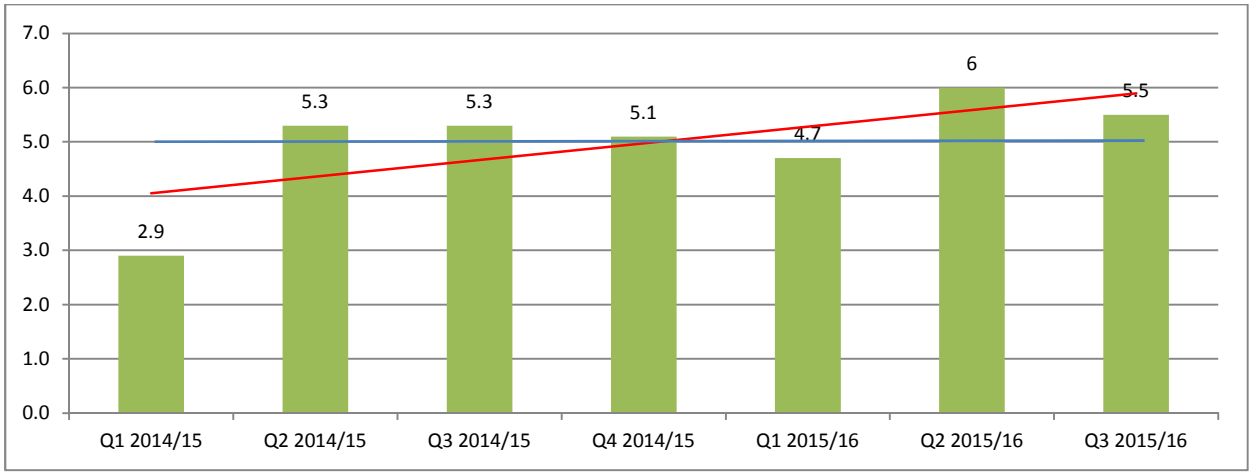
Complaint rate per 1000 bed days for Q3 2015/16 by Clinical Group



1.4 Complaints received per 1000 FCE (Finished Consultant Episodes)

To more accurately compare which Clinical Group is receiving the most complaints, it is important to represent these not just as numbers of complaints, but as a proportion of the patients that have received care in these areas. This then puts these numbers into context. By comparing the numbers of complaints with FCE we can gauge better whether one service or another is attracting more dissatisfaction and once understood, drill down further into what aspect of that service needs to improve. This analysis was only applied to the largest of the Clinical Groups, as they contribute to 86% of the complaints. This is an increase of 7% from the 79% proportion from Q2 2015/16.

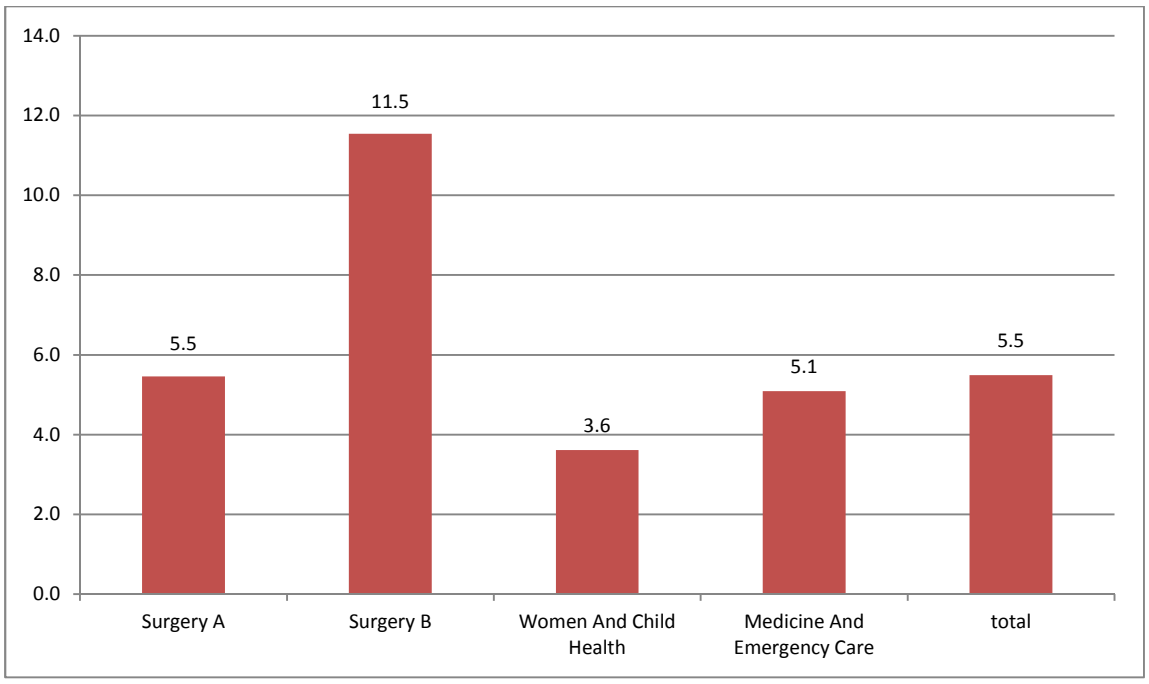
Complaints received per 1000 FCE (Finished Consultant Episodes) Q3 2015/16



Although the majority of complaints received are still made about Medicine, it is again Surgery B that has the highest number of complaints per 1000 FCE. Surgery B has been working closely with the Elective Access Team to improve the way that appointments are managed and utilised across the Group and this work started in Q4 2015/16. The plan is to speed up and streamline the triaging process, re-align clinic appointment schedules to maximise capacity, and review (looking forward) all clinics regularly at 1 week hence and 6 weeks hence. Meridian have been contracted to assist the Group with this work which commences with earnest week commencing Monday 18th January 2016.

Reference is also made to the theme of complaints in section 2.2 and **Appendix 7** in order to better understand the types of complaints made against Surgery B. **Appendix 2a and 2b** show the breakdown of complaints rates for both 1000 Bed days and 1000 FCEs by group.

Complaint rate per 1000 FCE for Q3 2015/16



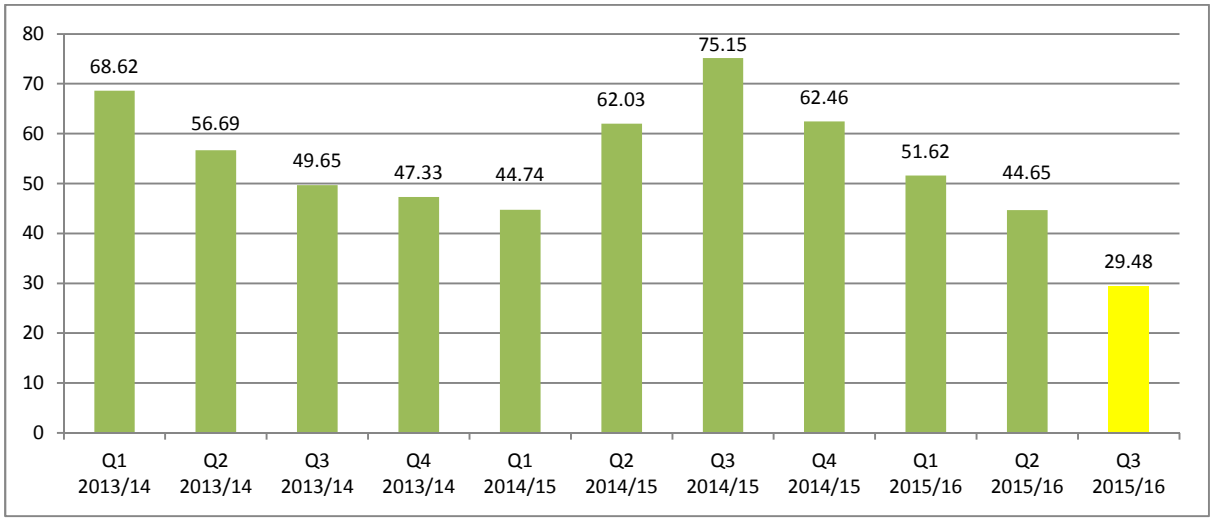
1.5 Timeliness of Responses

As previously reported, Q2 and Q3 2014/15 showed a spike in the average days taken to respond to complaints, and this was largely due to the volume of older cases that had been finalised. Q4 2014/15 saw a predicted decrease, and this has continued through the first three quarters of 2015/16 as cases continue to be managed within agreed timeframes and the number of cases being closed (that had exceeded their response dates) becomes fewer still. The rate has gone down from 44.65 to 29.48, a reduction of 15.17 days.

Of the complaints made since April 2015 there has been 41 (out of 567) cases sent after their agreed target dates. This means that 93% have gone out on or before the agreed date.

Of note is the fact that the breached cases remain in the minority, but have increased. Reasons for this include the administration of complaints within the Governance team, and the need to prioritise quality over target dates, in a few cases.

Average days to respond by quarter in Q3 2015/16



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

1.6 Complaints managed by resolution meeting

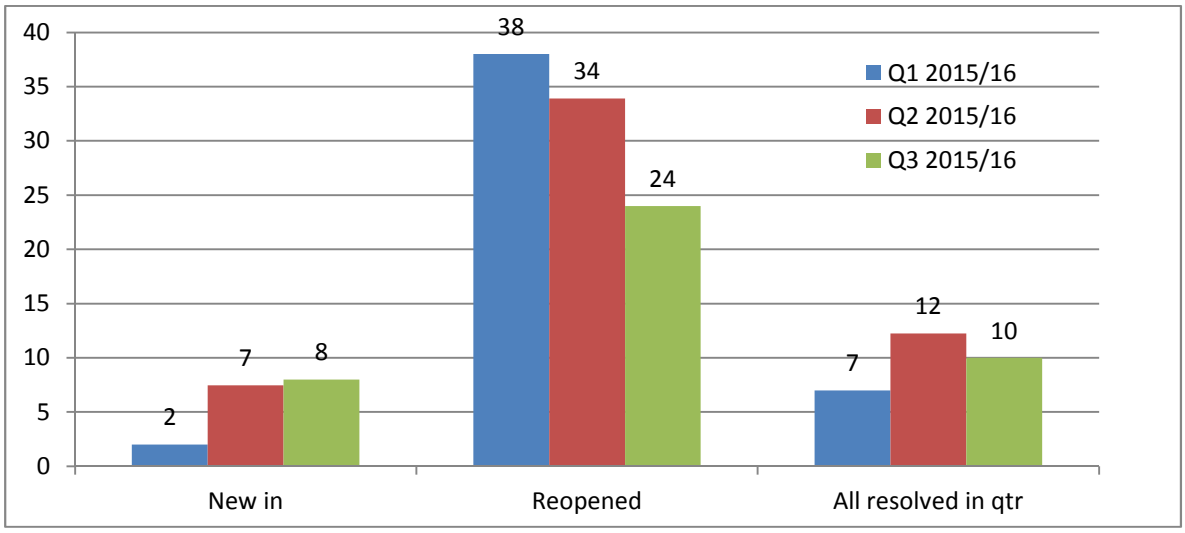
It is recognised that for some complaints, a resolution meeting, as opposed to a written response can be more effective in addressing concerns. Complainants whose concerns relate to a patient who has died will always be offered a meeting. Some complainants will express a preference to meet with the Trust as opposed to receiving a written response, and other complainants may present cases or stories that would suggest a meeting is the more appropriate way to resolve it. The take up rate of complaints resolution meetings is monitored and for Q3 2015/16 this was 10% for both complaints being made for the first time, and those that are reopened. This compares to 12% in Q2 2015/16 and 7% for Q1 2015/16.

Given that this rate is still relatively low feedback from the complaints team on why include the following reasons:

- Complainants being too emotional soon after the death of their family/ friend to meet with the Trust in the first instance.
- Complainants wanting 'something in writing' first so that they can consider next steps.
- Availability to meet with us at the latter end of the year was an issue in some cases.

Work is now being undertaken to monitor all complaints that are flagged as being best managed by a meeting (every mortality complaint and those identified at triage) in order to ensure that the complaints process stays focused on the needs of complainants. This work is also being undertaken as a reaction to the survey result that suggests that complainants were not given this option when planning their complaint with them.

% of complaints that were managed by a resolution meeting as opposed to a written response. Q3 2015/16 compared to Q2 2015/16 and Q1 2015/16

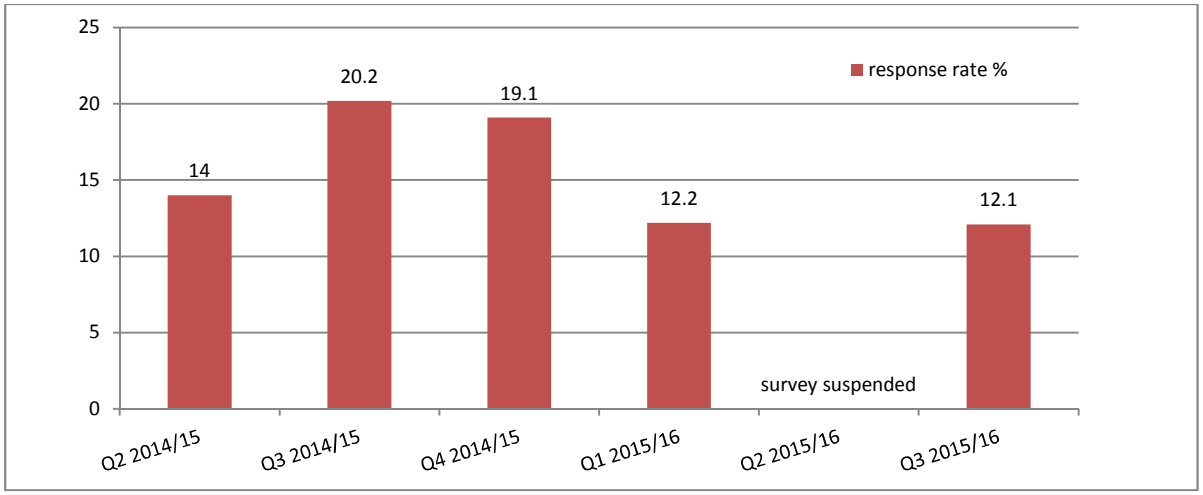


1.7 Complaint satisfaction survey

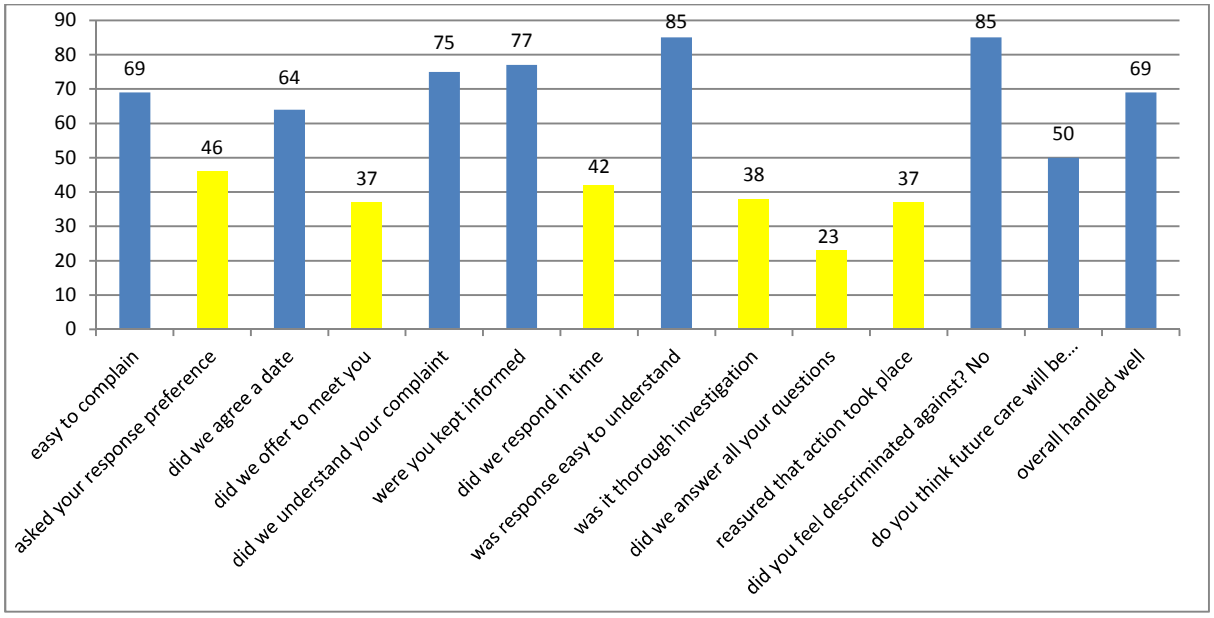
All complaints closed from 1 October 2015 onwards are now receiving a revised satisfaction survey, sent 4 weeks after they have received their final response. The return rate was 12.1%, slightly lower than previous quarters (19.1% in Q4 2014/15 and 12.2% in Q1 2015/16.) No surveys were sent in Q2 whilst it was under revision.

Work has started on investigating how we can continue to encourage a higher response rate, including consideration as to whether the timing of when questionnaires are sent is appropriate. It is important to acknowledge that paper survey methods are out dated, and new methods of data collection should be trialled. In Q4 2015/16 we will however continue using the current method to ensure that this survey has been implemented for a sufficient enough period of time to judge whether the method is still appropriate.

Response rate for Complaint Satisfaction Survey for Q3 2015/16 compared to Q1 2015/16, Q4 2014/15, Q3 2014/15 and Q2 2014/15



Complaint Survey results by % Q3 2015/16



KEY POINTS

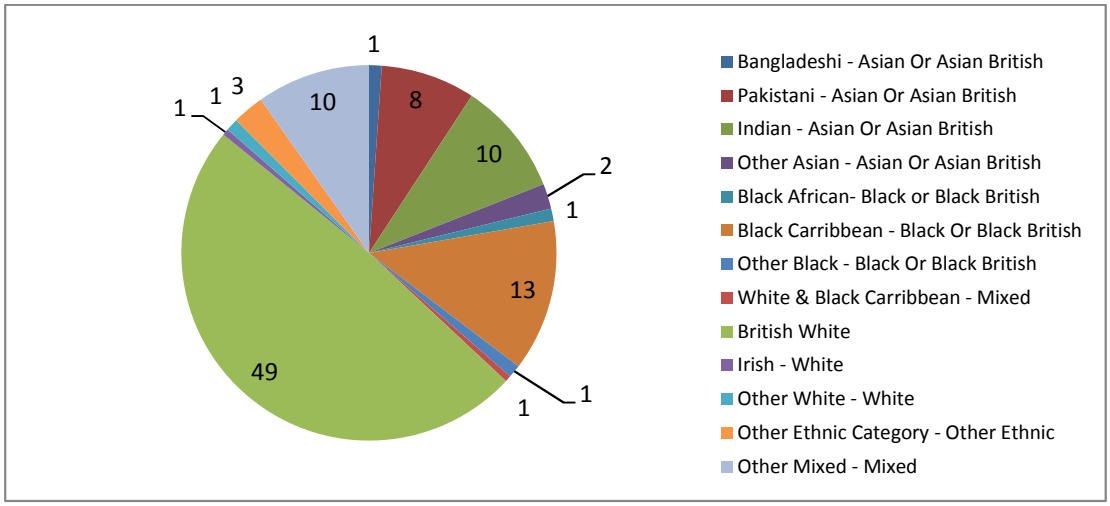
- Surgery B still have the highest complaint rate, a high number relating to appointment management, with work continuing to improve the management of Surgery B appointments.
- 93% of complaints resolved in this quarter were sent within their target date. This has increased slightly from the previous quarter, but remedial action is in place to ensure breaches remain rare, this is the first time for many years that the Trust has been able to report such compliance.
- The new Complaints Satisfaction Survey was started with good results in terms of feedback, but a poor response rate.

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 5a**.

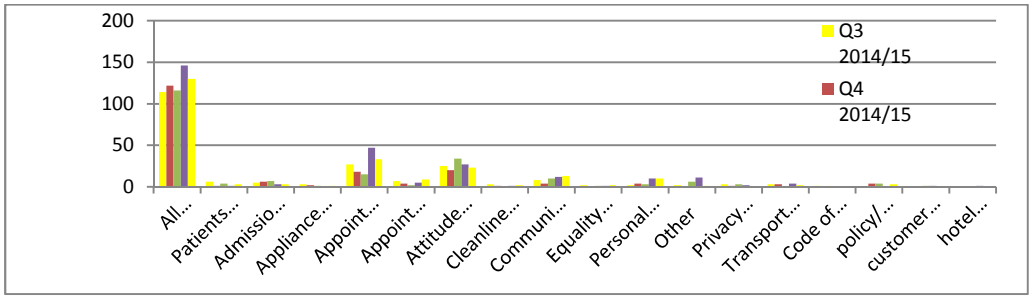
Subject of complaint by % Ethnicity Q3 2015/16



In the last 3 quarters of 2014/15 there was disproportionality in the ethnic mix of complainant's versus our patient population. This trend continued to a degree into Q1 2015/16 with a lower rate of complaints from the Asian community. In Q2 2015/16 the rate has steadied and complaints rate for this quarter is proportionate at a 10% complaints rate, with the Pakistani community making up 10% of our local population. The same has been reported for Black Caribbean complainants although this was proportionate in Q1 2015/16 and remains so this quarter at 5% complaints rate and 6% of our local population. However once again in this quarter, Black Caribbean complainants made a disproportionately high number of complaints verses the rest of the complainant population. Appendix 5b breaks down the type and grade of complaint, and the Clinical Group it is about.

2.2 Formal complaints by theme

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



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

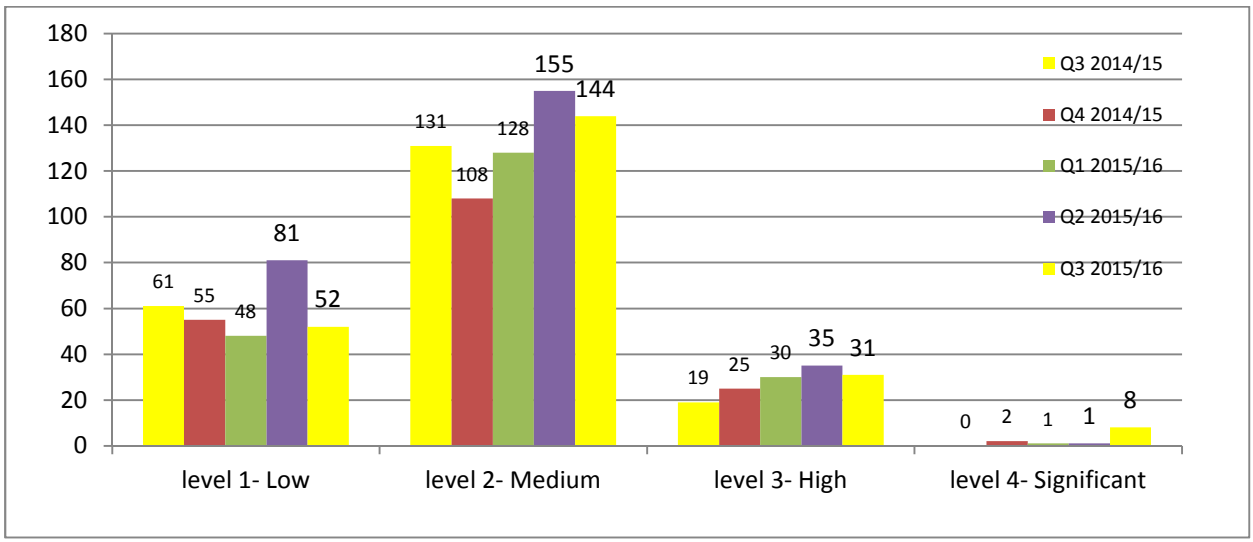
In Q2 and Q3 2014/15 it was reported that Surgery B had a disproportionately higher rate of complaints about their management of appointments but this decreased in Q4 2014/15 and again in Q1 2015/16. In Q2 2015/16 there was a slight increase, and this has continued into Q3 2015/16. 33% of complaints about appointments relate to Surgery B, but it should also be noted that 30% were attributed to Medicine, the highest rate this Clinical Group has seen this year. The rate at which complaints are received about appointments has remained steady over the last 3 quarters, at around 18%.

Appendix 7 specifies the staff groups that feature in the complaints about 'attitude of staff.' In most of the previous quarters, when comparing doctors and nurses, it is more likely that it is the attitude of the doctor that causes concern, not nurses. However, in Q3 2015/16 this is reversed, with nurses having a higher proportion of these complaints.

2.3 Formal complaints by severity

The following is a breakdown of the 235 actively managed complaints by severity and shows that once again complaints considered high or significant (Levels 3 and 4) remain in the minority. However, it is noted that there has been a significant rise in the amount of grade 4 complaints, and they all relate to the death of a patient. This quarter, Level 1 and 2 complaints made up 83% (196) of those received which was 3% lower than the last quarter (86% in Q2 2015/16), and 2% lower than the quarter before. (85% in Q1 2015/16). There were 8 Level 4 complaints, all involving the death of a patient. Appendix 8 details each of these complaints including outcomes.

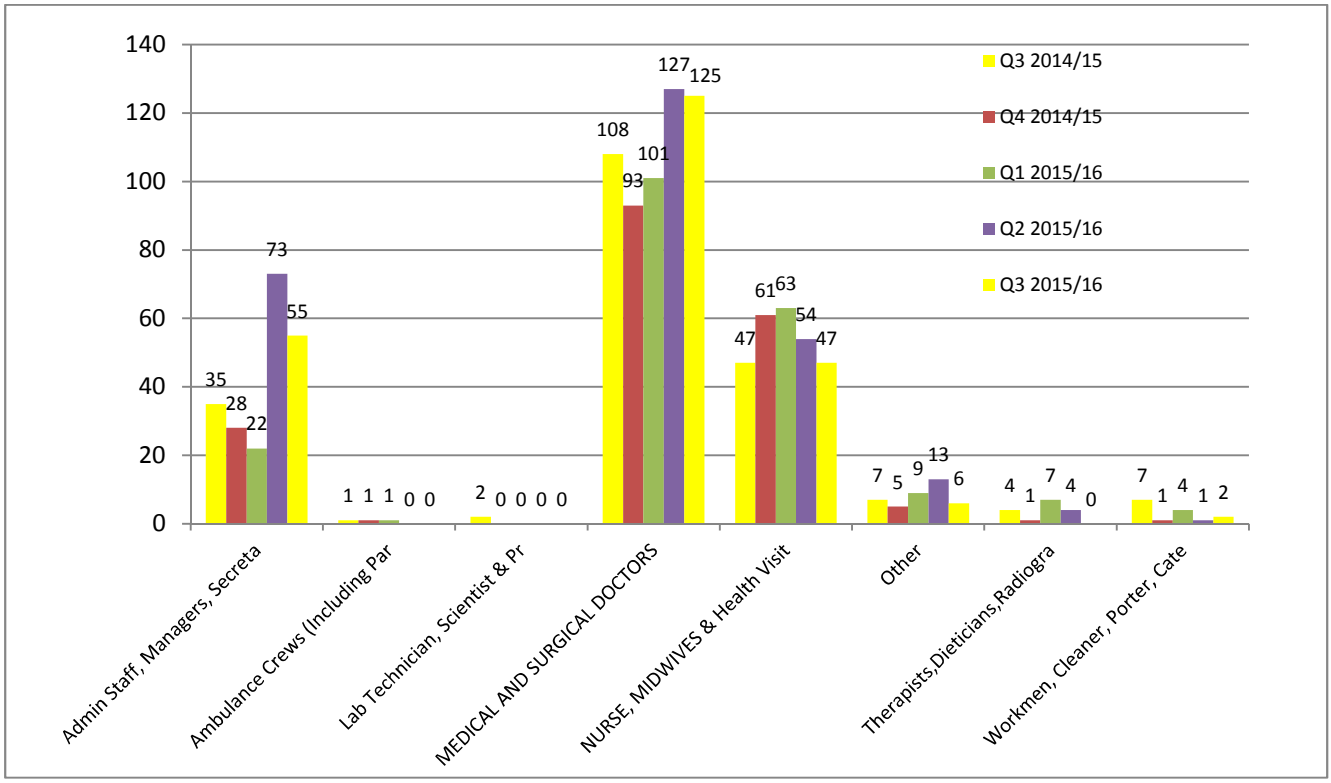
A breakdown the severity grade of complaint for Q3 2015/16



2.4 Formal complaints by profession

It has previously reported that there were no significant changes in the number of complaints received across the seven professional groups. In Q2 2015/16 there was a notable increase in the number of complaints about administrative and managerial staff. This has come down slightly but is still higher than in Q1 2015/16, Q4 2014/15 and Q3 2014/15.

Complaints by staffing group Q3 2015/16 compared to previous 4 quarters



KEY POINTS

- When broken down by ethnicity, complaints regarding Black Caribbean patients have again increased, with complaints about staff attitude notably higher for this ethnic group.
- Elective access are working to improve the way that appointments are managed across many clinical areas and whilst this work continues, this has not yet resulted in a decrease in complaints about appointments.
- Legal Services have completed the implementation of system improvements resulting a reduction of complaints within the Strategy and Governance Corporate Directorate for this quarter.

3. Formal complaints outcomes

3.1 Resolved complaints

250 responses were sent out this quarter compared to 257 in Q2 2015/16, 225 in Q1 2014/15 and 202 in Q3 2014/15.

3.2 Formal complaints upheld.

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

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

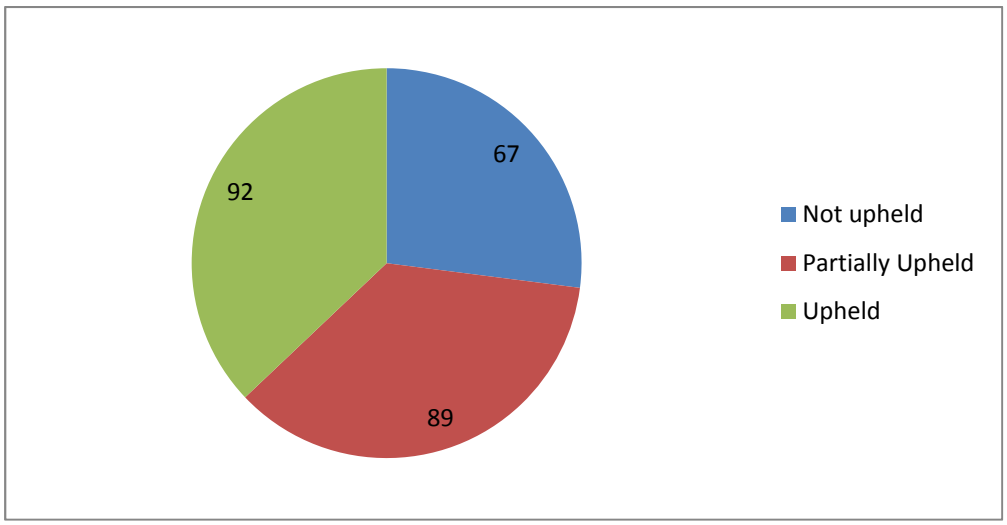
Partially upheld- elements of the complaint were found to be the case, but not all.

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

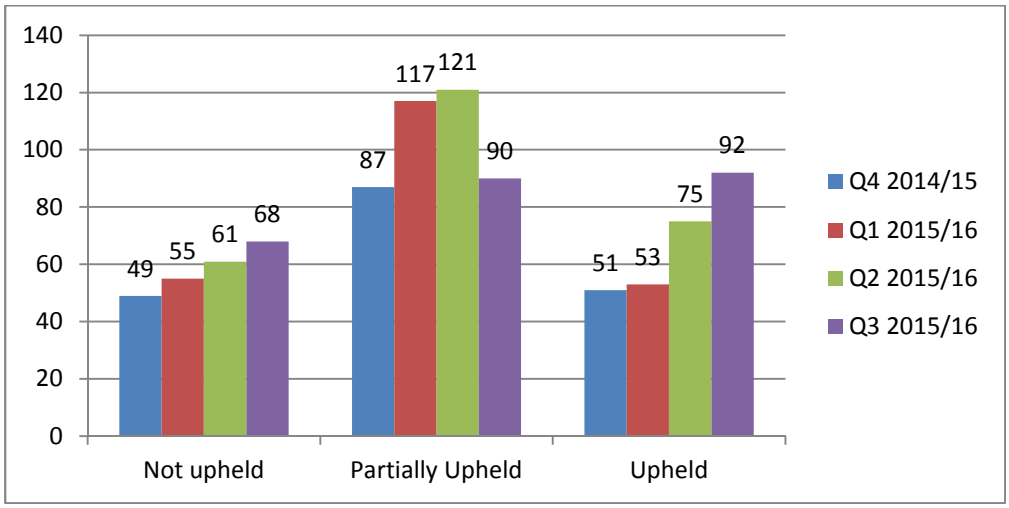
The outcome of complaint responses remain mostly either upheld or partially upheld, and whilst there was a slight increase in the instances of partially upheld in the last quarter, Q2 2015/16 results have reverted back to outcomes that are more consistent with previous quarters.

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

Q3 2015/16 no. of complaint by outcomes



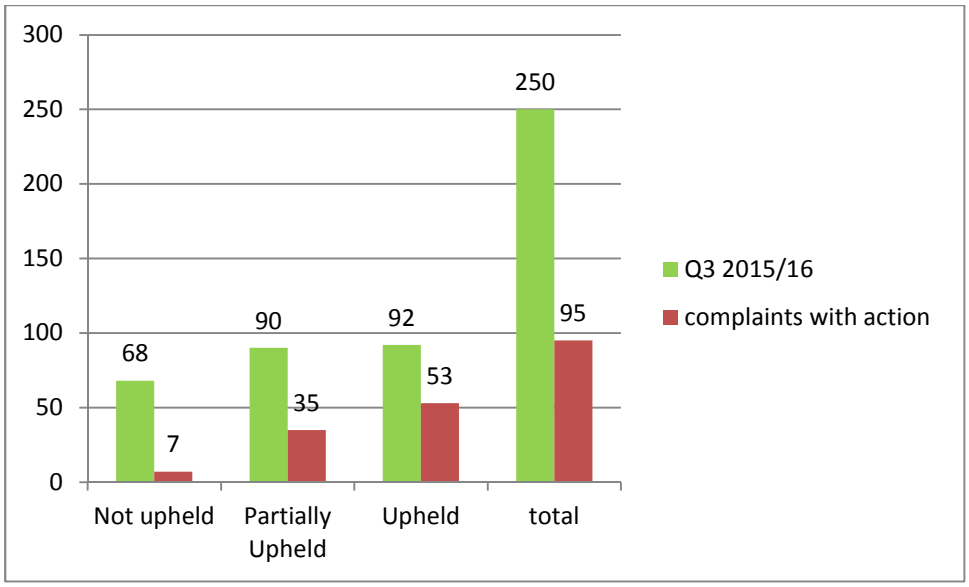
Complaints outcome Q3 2015/16 compared to Q2 2015/16, Q12015/16, Q4 2014/15



Learning from complaints

Complaints provide an important opportunity to improve service, learn from mistakes and identify systemic flaws in order to improve patient experience, and in some cases patient safety. The database used in the complaints process has an action tracker, and records any recommendations that are made for individual complaints.

Reported is a breakdown of all complaints by outcome, where recommendations for action were made. Appendix 6 is a snapshot of the tracker which monitors all complaints where there was an action, post complaint.

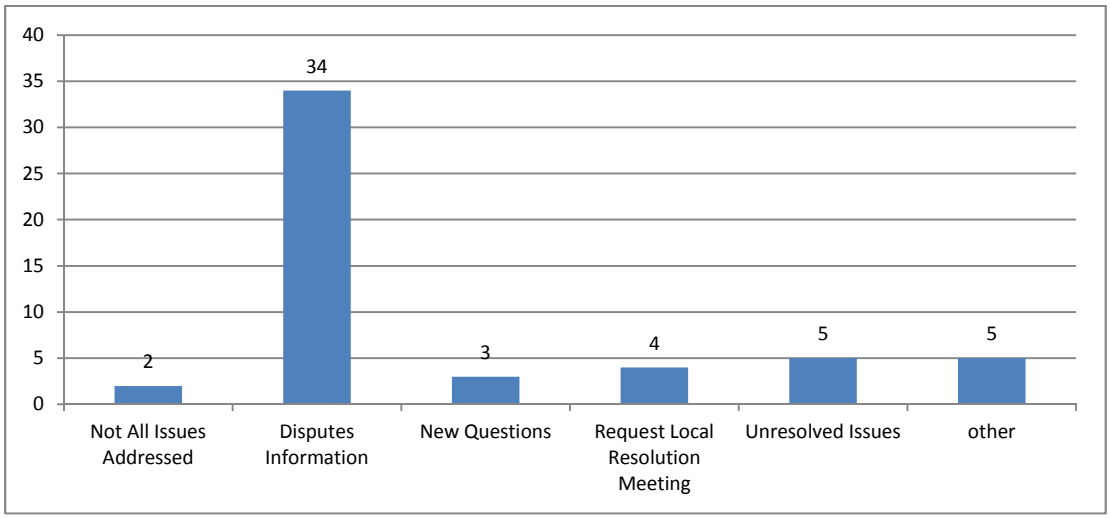


3.3 Reopened cases

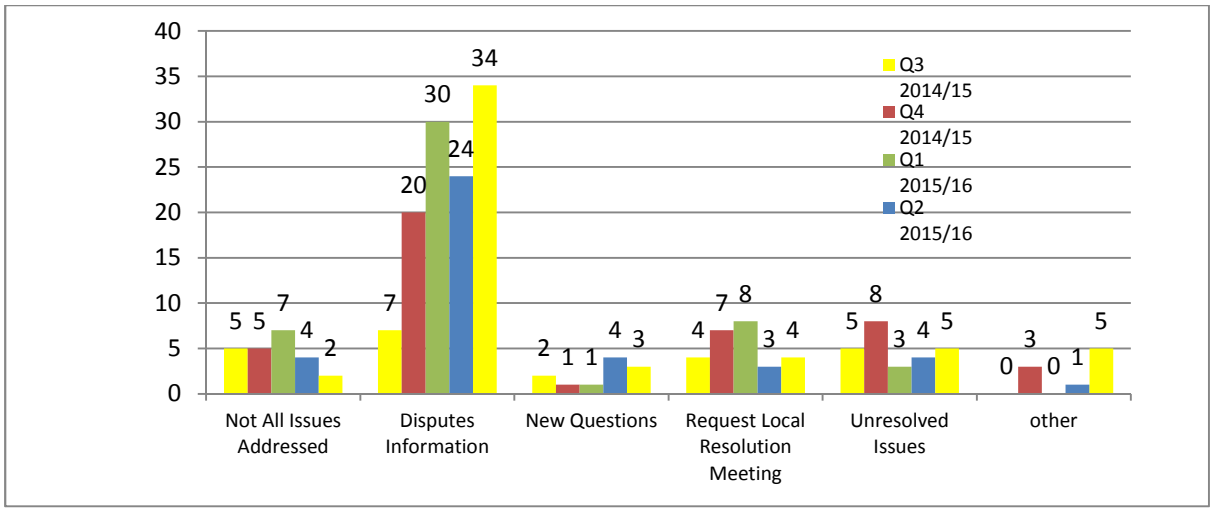
Reopened cases totalled 53 in Q3 2015/16 with 2 (4%) cases reopened because not all issues were addressed first time round. This compares to 40 in Q2 2015/16 and with 4 (10%) cases reopened

because not all issues were addressed first time round. Reopened cases have increased this quarter, but the % reopened because not all issues were covered has more than halved. Most complainants, 64%, reopened because they didn't agree with our response.

Total number of cases reopened and why Q3 2015/16



Total number of cases reopened and why Q3 2015/16 compared to previous 4 quarters



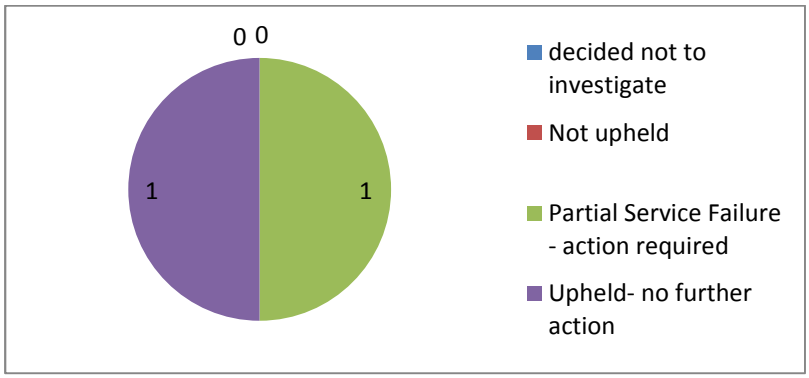
Of those complaints that were reopened because we had not addressed issues the first time, both were for Surgery B. Over the past 3 quarters, there has been no particular Group that has contributed to this type of dissatisfaction as a pattern, and this is the first time Surgery B has featured in this type of reopened case for 6 months. **Appendix 9** shows all reopened complaints by Group and Grade, and continues to show that it is the medium grade (Level 2) complaints that are most likely to be reopened. Also shown in **Appendix 9** is a breakdown of the Medicine and Emergency care Group as this remains the group that received the most reopened cases. This breakdown is shown by both reason and grade.

3.4 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).

15 new PHSO complaints were logged in the three months of this quarter, and 2 enquiries were concluded during this same period. These are shown below.

The outcome of the 2 cases closed in Q3 2015/16



It is unusual to receive so many new complaints from the PHSO in one quarter, and a number of factors should be considered when assessing whether this is a concern for the Trust.

- We have sent far more complaints out in the last 9 months, than in the previous 9 months, and so the number of complainants who have had complaints concluded (and are therefore eligible to go to the PHSO) has increased.
- The PHSO have openly reported that one of the aims for this year and moving forward is to investigate more cases brought to them.
- With that in mind, a larger number of complaints have been accepted by PHSO that haven't been through Stage 2 of the local resolution process, (where a complainant can reopen a complaint giving the Trust an opportunity to review its investigation and final position.)
- The Trust have received an albeit small number of complaints where a mutually agreeable position had not been reached, where the PHSO were actively promoted to give the complainant the independent, escalated review that the complaint warranted.

There is still no pattern in regards to Clinical Group, grade or type of complaint that these 15 PHSO cases.

3.5 SWBH complaints featuring in external publications-

Parliamentary and Health Services Ombudsman (PHSO) in the news

In December 2015, the government announced that there will be a single Public Service Ombudsman (PSO) that will incorporate the work of the Local Government Ombudsman (LGO) and the Parliamentary and Health Services Ombudsman (PHSO). There was no timeframe quoted for the launch of this new body, but the essence of the move to create this new organisation was to make it

easier for the public to complain about public services without having to first work out which Ombudsman to approach.

Q2 2015/16

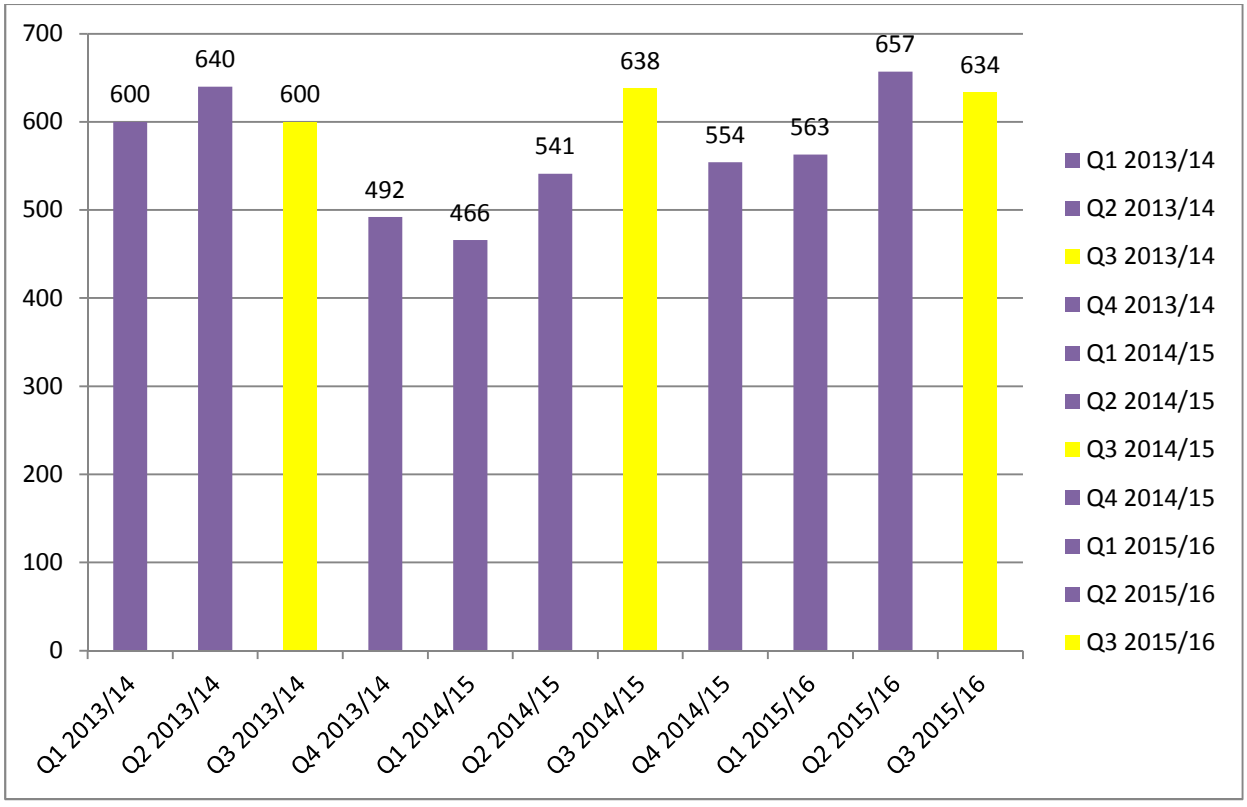
The PHSO reported that they received 2658 (compared to 2393 enquiries in Q1 2015/16) with 331 (compared to 659 in Q1 2015/16) being investigated. Of those, 45% were upheld by the PHSO. The PHSO received 26 enquiries relating to Sandwell and West Birmingham (compared to 67 in Q1 2015/16) with 3 (compared to 13 accepted for investigation for Q1 2015/16) being investigated by them. This was a relatively low rate for this quarter and of course a quarter behind this report. We do know already because of activity from the last three months that this rate will be reported as higher in Q4 2015/16.

4. PALS

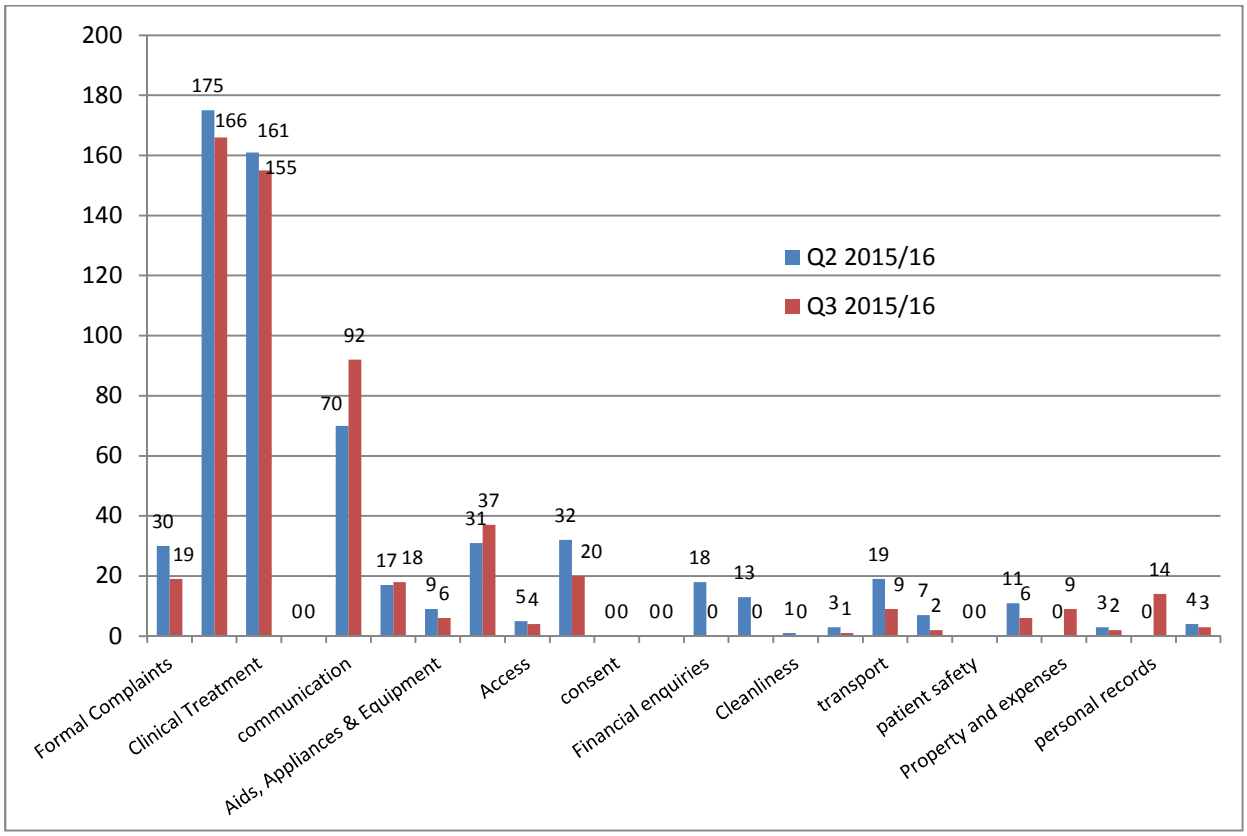
The Patient Advice and Liaison Service (PALS) continue to play a vital role in providing patients with a local advocate who can investigate concerns. As well as reporting the standard enquiries, work has continued in the collection of compliments for this quarter, of which there were 220.

The total number of PALS enquiries made for Q3 2015/16 was 634, compared to 657 in Q2 2015/16, 564 in Q1 2015/16 at 564 and 554 in Q4 2014/15. The number of enquiries for Q3 2015/16 is only 4 less than for the same period this time last year in Q3 2014/15 at 638.

Graph shows the number of enquiries of PALS by quarter over the past since Q3 2013/14.



The following are the enquiries taken by PALS in Q3 2015/16 compared to Q2 2015/16



Appendix 10 reports all PALS enquiries compared to the last 4 quarters, and also broken down by Clinical Group and in future reports, will also compare this Clinical Group with previous quarters.

Appendix 11 shows the compliments collected this quarter.

5. Development work from previous quarters now implemented

5.1 Legal Services had systemic issues with the way that Subject Access Requests were being managed, resulting in there being a back log of requests which were not being managed within the 40 day time limit legislated for this type of request. Much work was done on improving monitoring systems, and refocusing staff in order to improve the efficiency of this work. In October 2015, approximately 45% of requests were over the 40 day limit and by the end of the quarter, this had improved to 7%.

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

6.1 **Integrated reporting across Governance** in order to better understand the link between an incident that results in a complaint and in turn may result in a legal claim. This involves using the Safeguard database system to ensure that episodes that are reported as incidents, logged as complaints and claimed for as medical negligence, are linked together. This reduces duplicated work and ensures cohesive responses to all stakeholders. This work still continues into Q4 2015/16.

6.2 Some consideration needs to be given to the collection of the **compliment data**. The current method of collection relies too heavily on a manual tick sheet that is not consistent, making the analysis of trends difficult. Safeguard (complaints database) can be used to record compliments, but it does rely on commitment from staff to record compliments on this database. This work is being discussed with the Patient and Staff Engagement Committee in order to implement this across the Trust. A trial was planned in Paediatrics for the beginning of 2016, but this had been put on hold in order to focus on patient care on the ward. This is tabled to be discussed again at the Patient and Staff Engagement Committee meeting in January 2016.

6.3 Work started to understand from **Black Caribbean and Pakistani** communities their complainant behaviour on the basis of the disproportionality of the rate vs population percentage. This trend however started to even out in Q1 2015/16. In Q2 2015/16 it is reported that there is no disproportionality and so this work has been suspended. Given that this imbalance reappeared in the data for Q3 2015/16 but specifically for just Black Caribbean and mainly around attitude of staff, there will a piece of work done with Equality and Diversity to develop a strategy in relation to staff training.

6.4 In order to test a different method of **Complaint Satisfaction Survey** complainants who supply an email address will receive an emailed with their attached to it (that can be filled in electronically) and the return rate will be monitored separately and reported upon in Q4 2015/16.

7. Conclusion

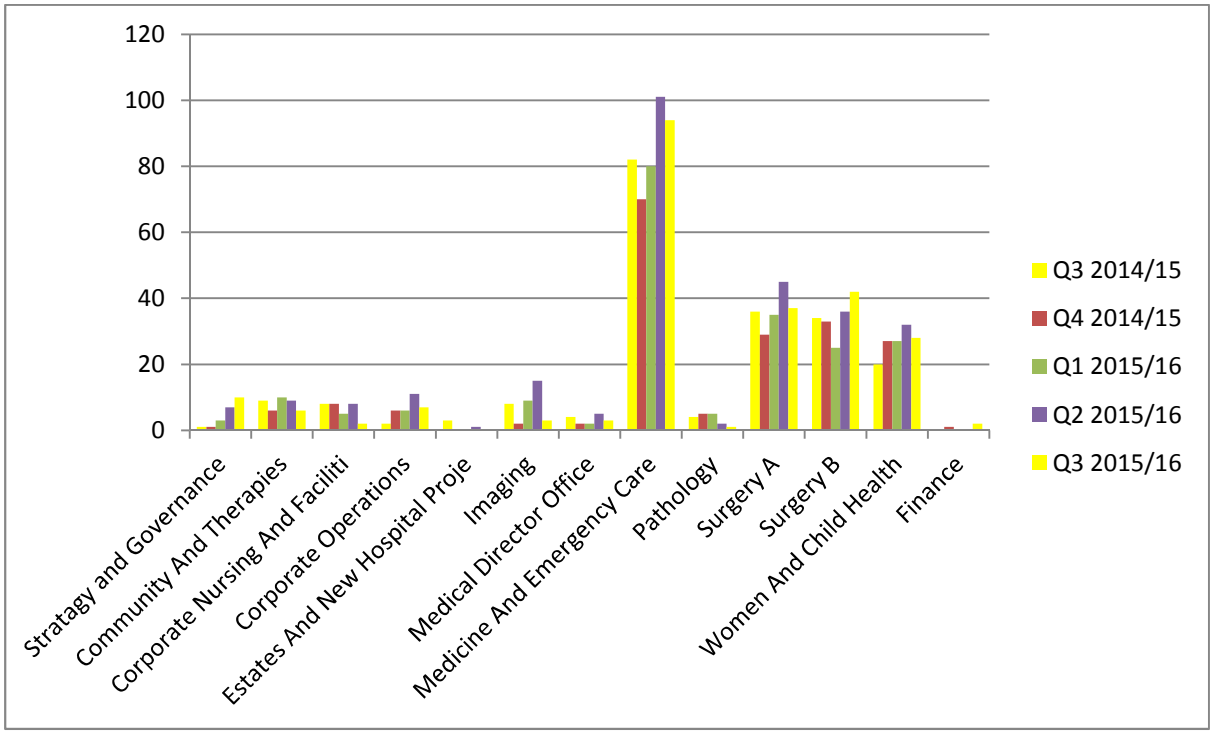
7.1 The total number of complaints has decreased this quarter and there has been return of higher rates of complaints about appointments about Surgery B and plans have been implemented to address this although this work is expected to take some time before eradicating the appointment concerns all together. There was also a return of the disproportionate complaint rate about Black Caribbean patients. There has also been a steed decrease about Legal Services and they have corrected systemic issues that were resulting in poor service to SARS (Subject Access Request) customers.

7.2 Complaints continue to be sent out largely on time, although there was a slight increase in those cases that did get sent out after the agreed target date.

7.3 PALS enquiries have decreased and they will continue to work towards improvement the rate that compliments are captured. A new method of capture will trial in Women and Child Health through part of Q4 2015/16 to investigate whether this would work if implemented across the whole Trust.

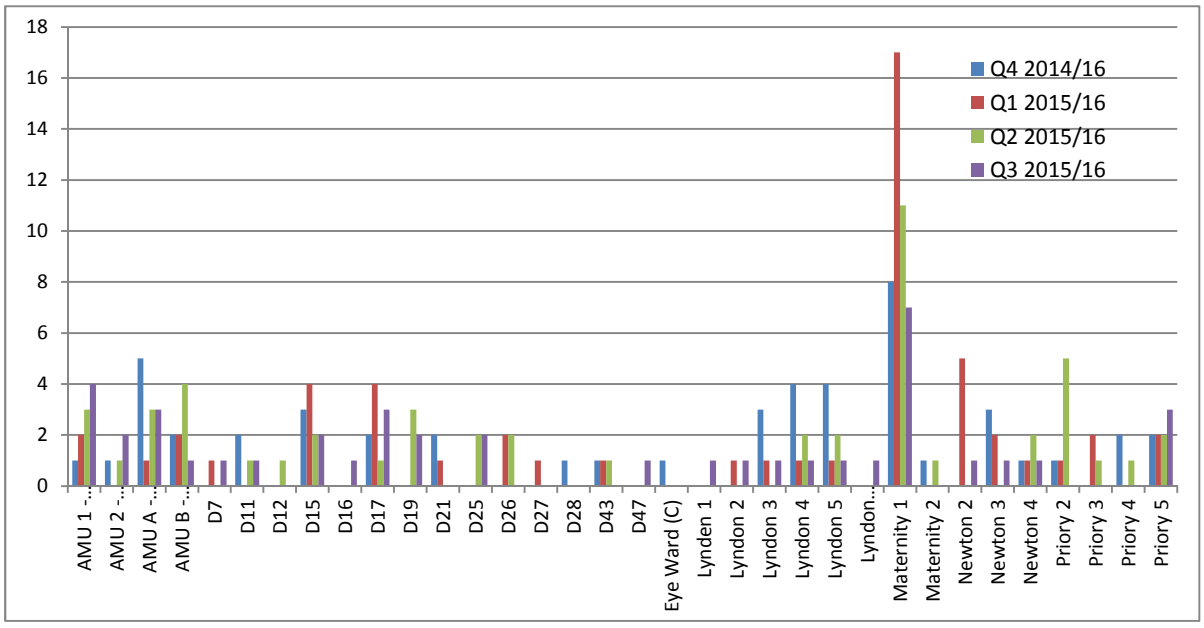
Appendix 1a

Complaints received by Clinical Group and Corporate Directorate for Q3 2015/16 compared to Q2 2015/16, Q1 2015/16, Q4 2014/15 and Q3 2014/15 (same time last year.)



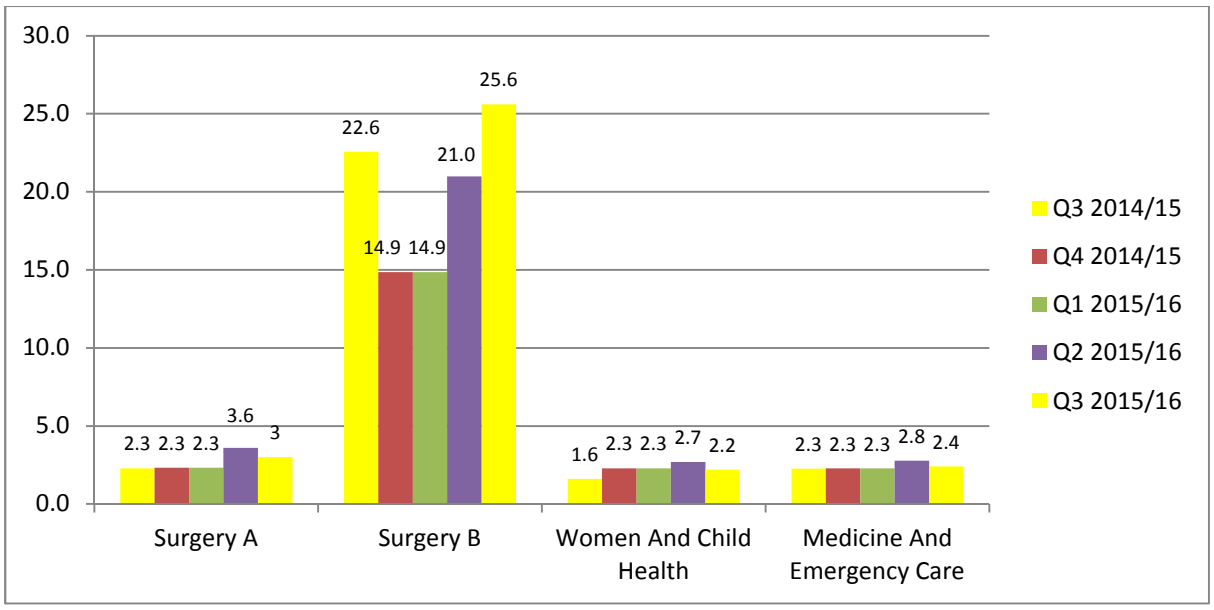
Appendix 1b

Complaints received by Ward (where applicable) for Q3 2015/16 compared to Q2 2015/16, Q1 2015/16, and Q4 2014/15



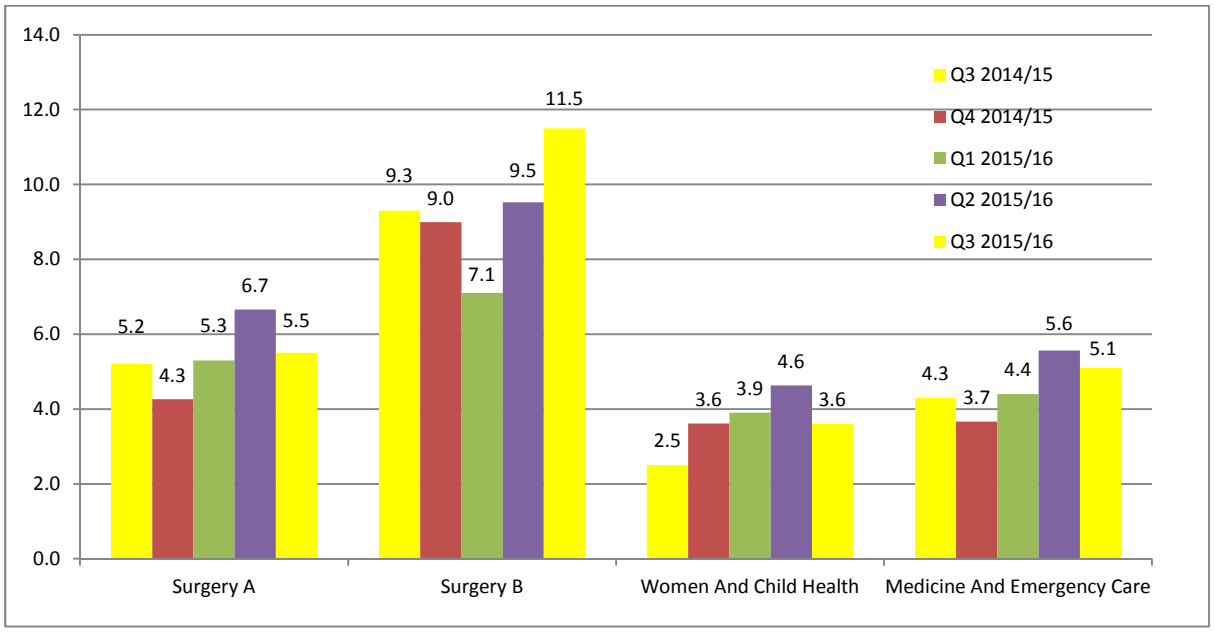
Appendix 2a

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



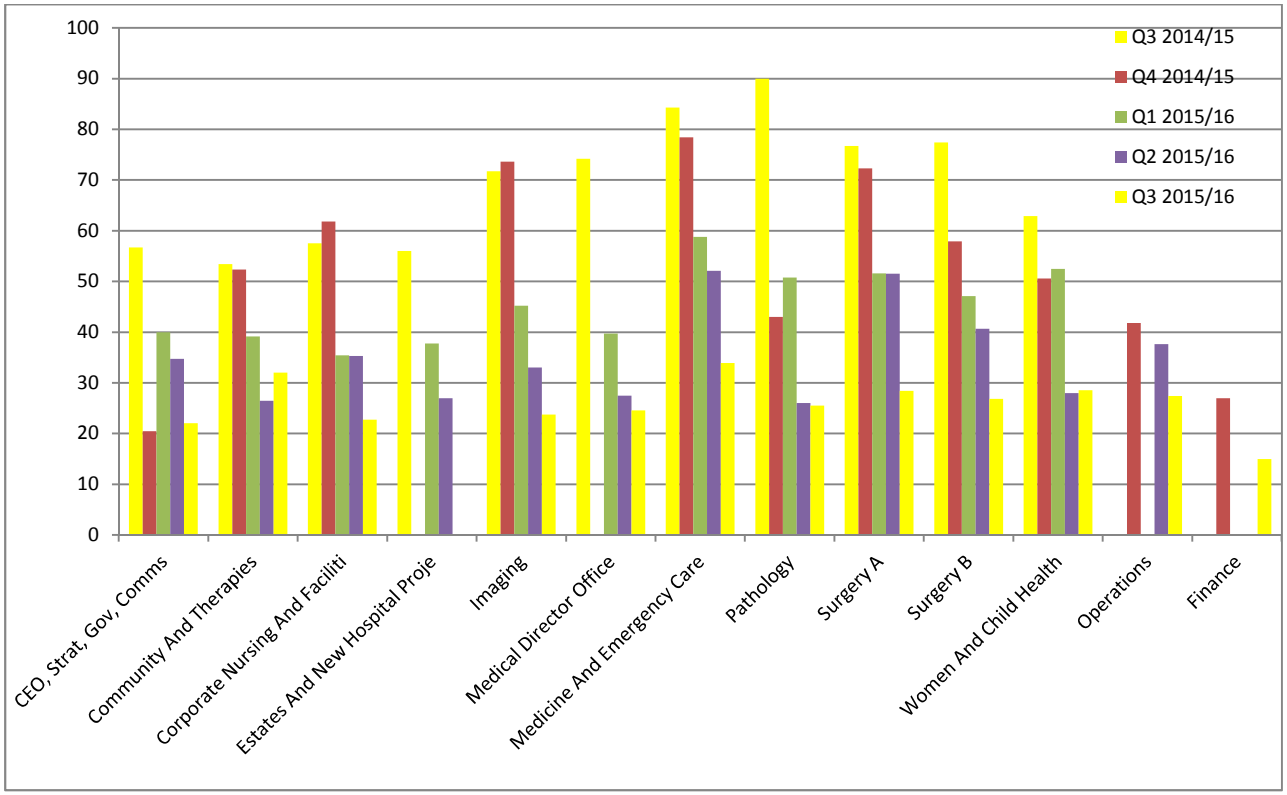
Appendix 2b

Complaints rates by 1000 FCE for Q3 2015/16, Q2 2015/16, Q1 2014/15, Q4 2014/15 and Q3 2014/15 (this time last year)- by the top four Clinical Groups



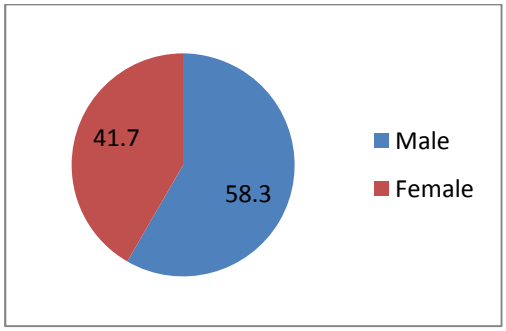
Appendix 3

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

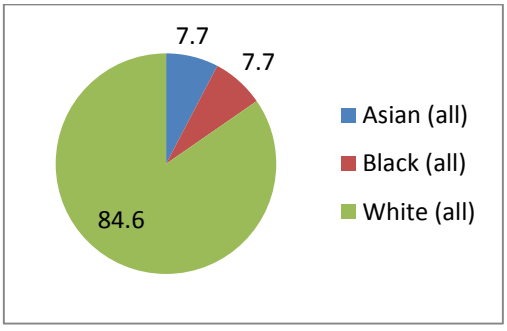


Appendix 4

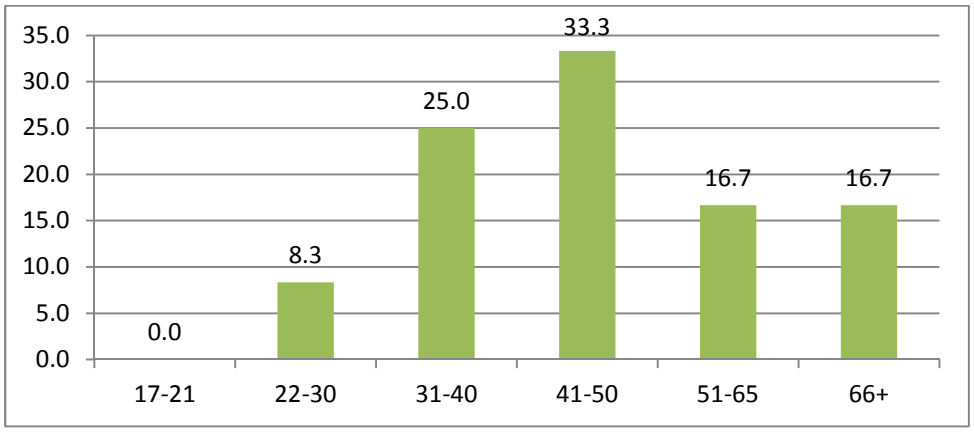
Break down of survey respondents by gender in Q3 2015/16



Break down of survey respondents by broad ethnic groups in Q3 2015/16



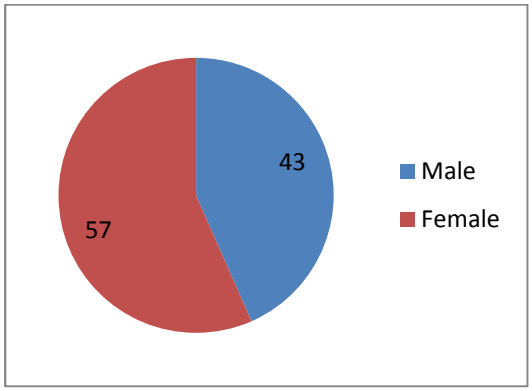
Break down of survey respondents by age



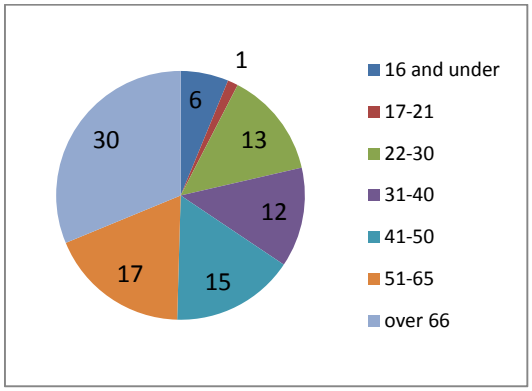
Appendix 5a

A breakdown of all complainants by % by age and gender where specified for Q3 2015/16

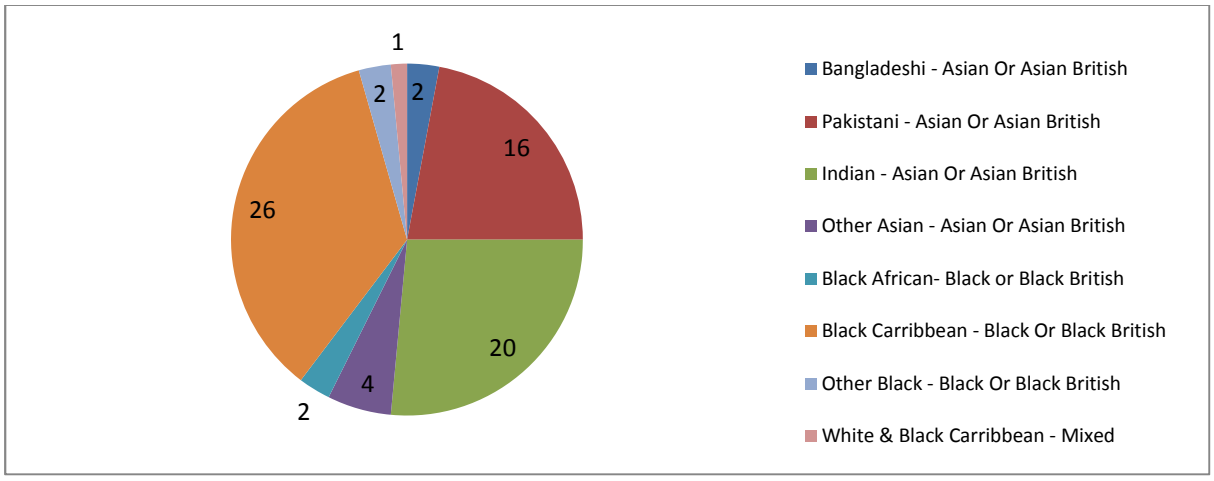
Gender (%)



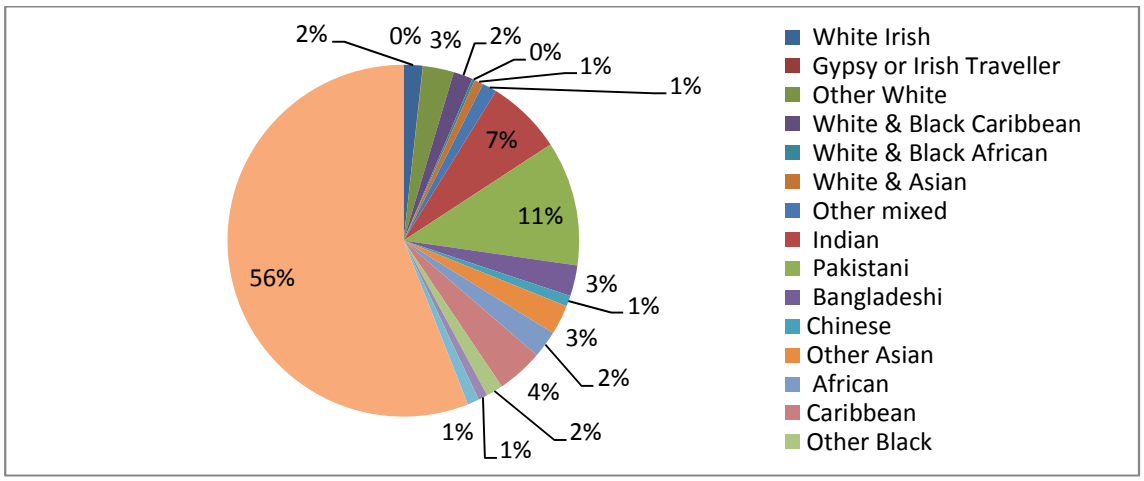
Age (%)



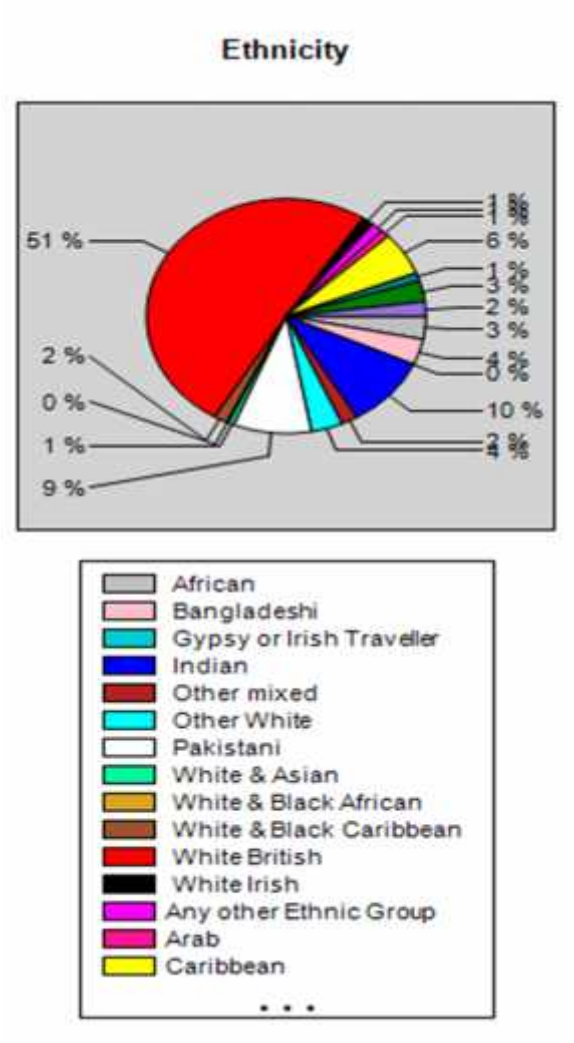
A breakdown of all complainants by %, by ethnicity (where recorded) for Q3 2015/16 without White British



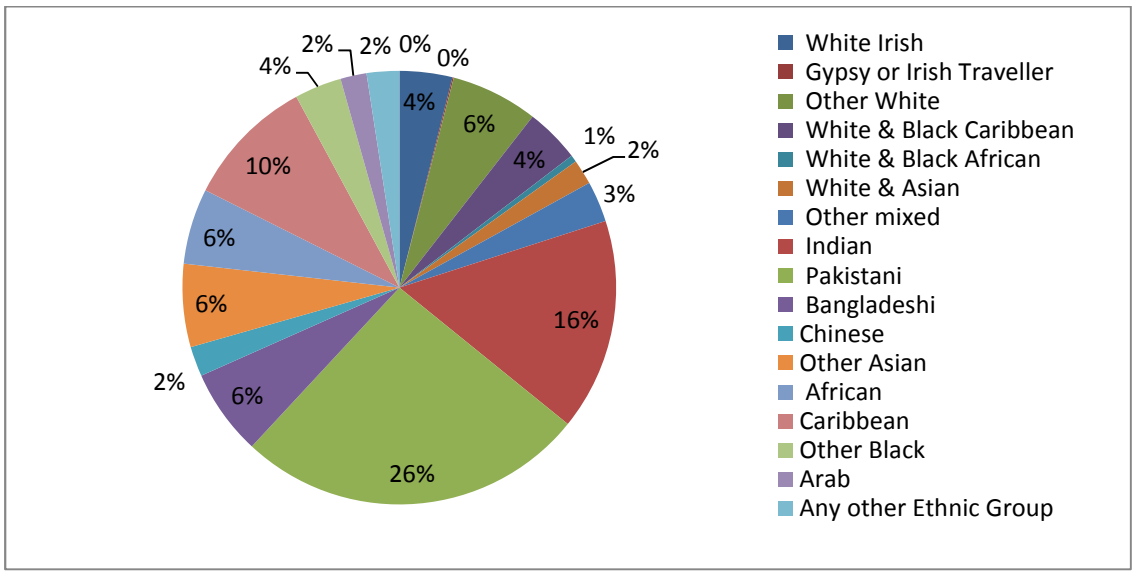
Ethnicity split by Sandwell and West Birmingham Population as taken from the 2011 census and quoted out to the Local Demography report prepared by the Trusts Equality and Diversity team in 2013.



Ethnicity split of patient population

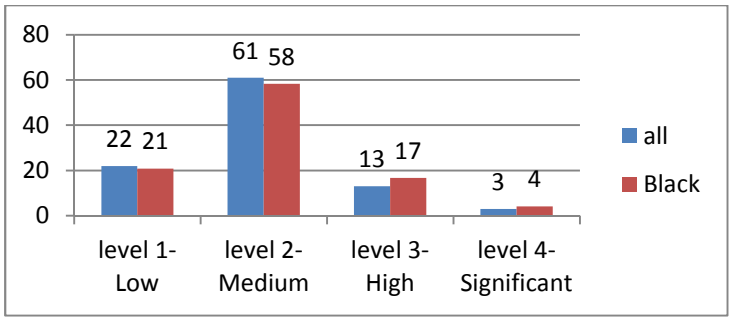


Ethnicity split by Sandwell and West Birmingham Population as taken from the 2011 census and quoted out to the Local Demography report prepared by Equality and Diversity in 2013, without White British.

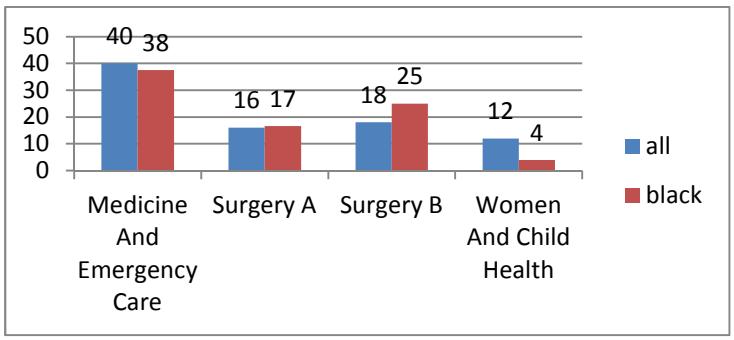


Appendix 5b

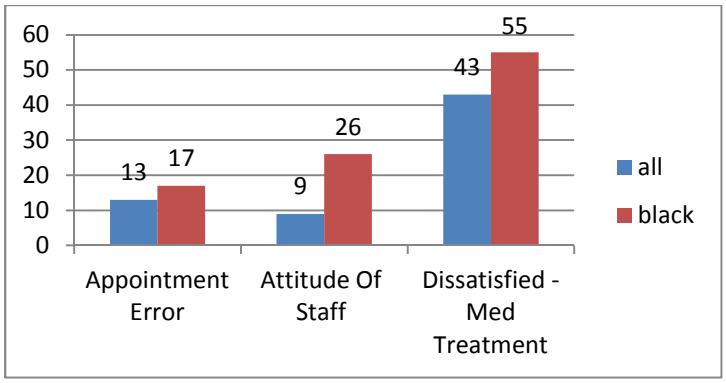
% of complaints made by or on behalf of Black Caribbean patients by grade for Q3 2015/16



% of complaints made by or on behalf of Black Caribbean patients by the 4 largest Clinical Group for Q3 2015/16



% of complaints made by or on behalf of Black Caribbean patients by complaint theme for Q3 2015/16



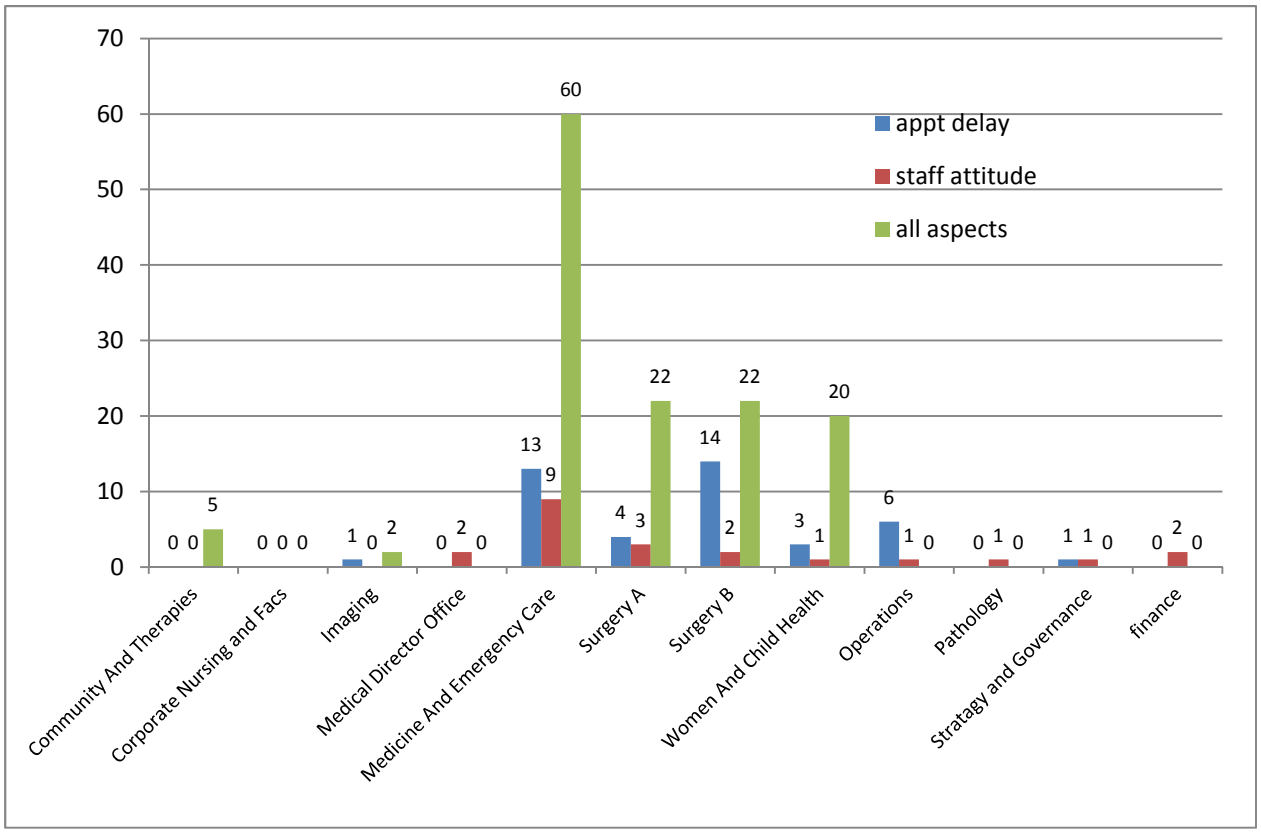
Appendix 6

Action tracker of complaints with post complaint action (for Q3 2015/16)

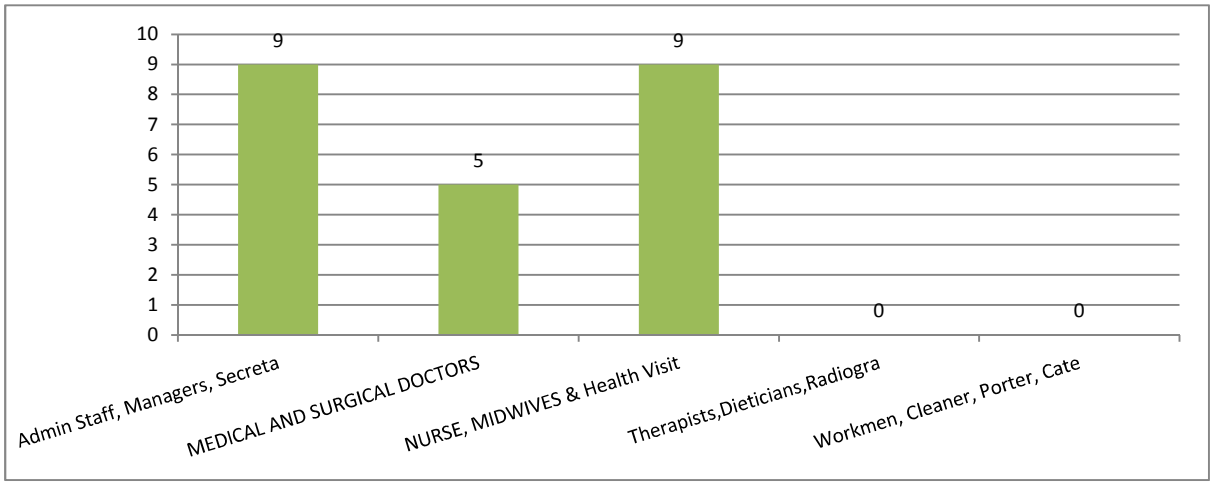
Response Date	Action Type	Action Details	Target Date	Completion Date	Complainant advised?
22/09/2015		DIRECT FROM TRUST RESPONSE - In light of your comments, we will review the pathway where repeat ABR tests show no or little change and look to offer parents the option of being sent a written summary of the results after appropriate peer review and analysis.	30/11/2015	03/11/2015	Improvement advised at the time of the complaint in the complaint response, implementation not advised since.
14/10/2015	Monitor Situation	Feedback to be given to doctor about how the patient felt at the time of the test. Complaint response apologised for this but assurance was given that the doctor would specifically receive this feedback.	20/11/2015	05/11/2015	Called patient to confirm that the doctor had now received this feedback.
23/11/2015	Raise Awareness	Departmental management have made contact with all staff within ophthalmology to remind them of the Trust Promises, including 'going the extra mile', and 'being polite, courteous and respectful'. It was also made clear that staff must introduce themselves when speaking with patients and relatives.	15/12/2015	23/11/2015	Improvement advised at the time of the complaint in the complaint response, implementation not advised since.
6/12/2015	Review Care Given	An action was agreed at the conclusion of the complaint resolution meeting that the patient should have their next appointment brought forward, rather than having to wait until February 2016 and this has been done.	31/12/2015	16/12/2015	Letter sent to patient confirming that new appointment had been made for 18 January 2016.
29/12/2015	Change Procedures	In response to feedback from the complaint, and with consultation from staff also, all bins on the unit have been replaced by bins with soft close lids.	22/12/2015	22/12/2015	Called complainant to advise that this has been done.

Appendix 7

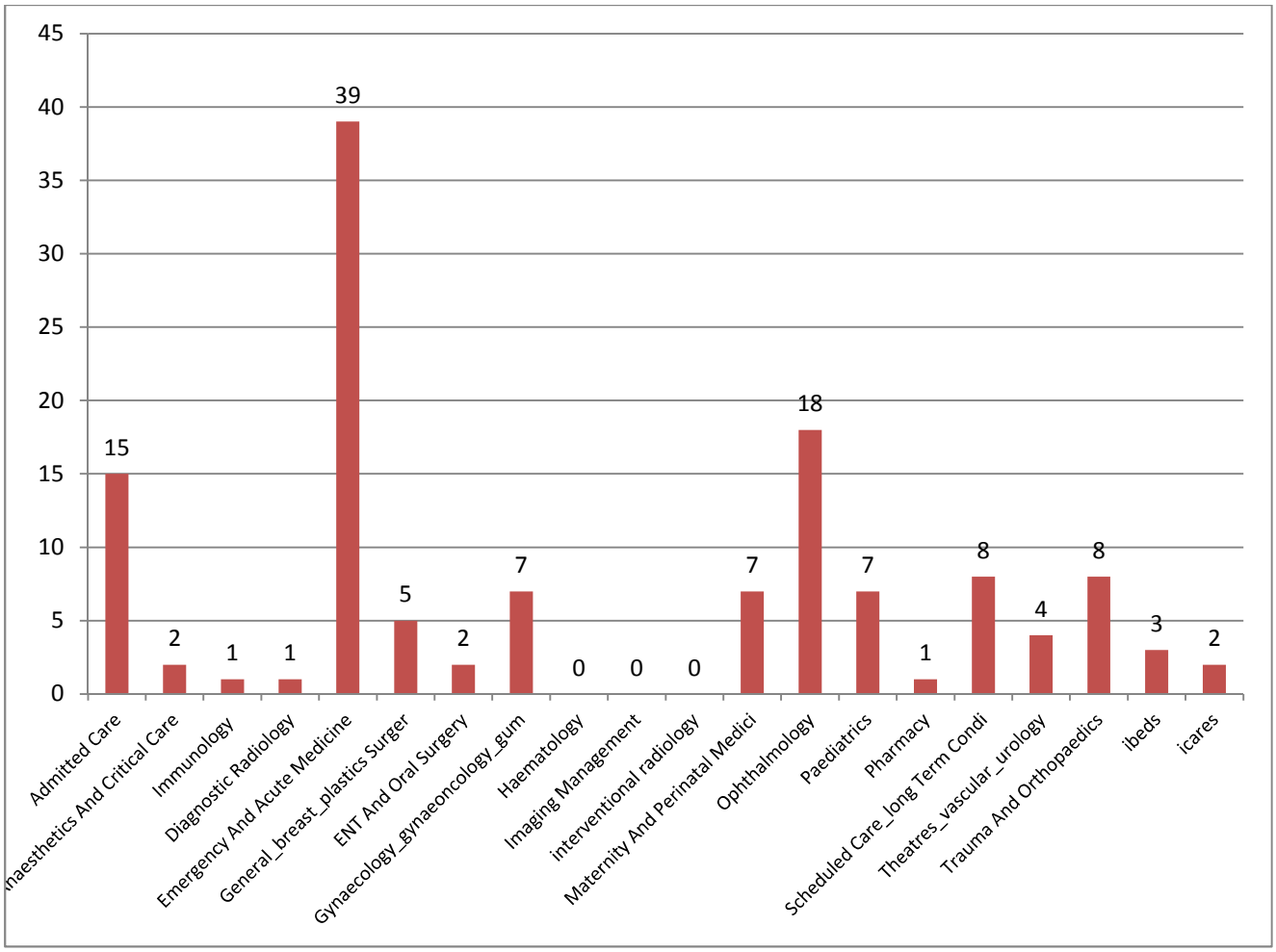
A breakdown of the top three themes complained about, broken down by Clinical Group or Corporate Directorate for Q3 2015/16. Where there were no complaints for this theme for a Clinical Group or Corporate Directorate, then they are not featured in this breakdown.



A breakdown of the 'attitude of staff' theme by staff groups for Q3 2015/16



A breakdown of the 'all aspects of clinical treatment' theme by Trust wide clinical directorate Q3 2015/16



Appendix 8

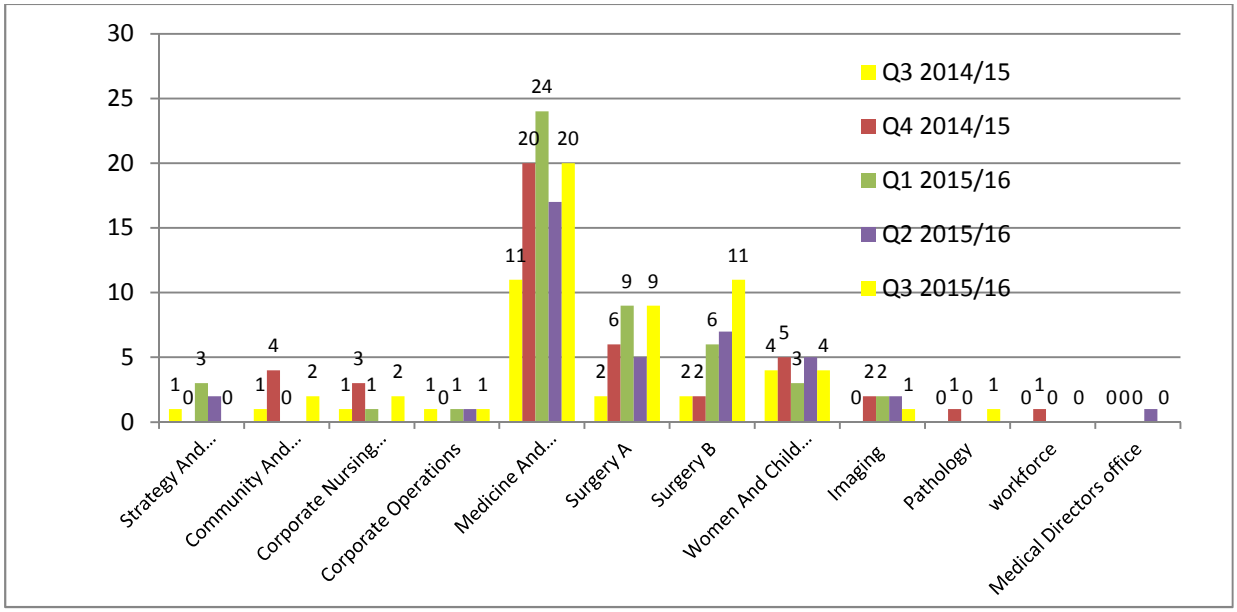
BREAKDOWN OF ALL 8 GRADE 4 COMPLAINTS INVOLVING DEATH OF PT IN Q3 2015/6

Details of complaint	Who involved	Outcome/ investigation to date
Patient fell down stairs and suffered pains in his chest. When the family telephone WMAS they were told to monitor him at home. The family took the patient to the A&E at City where they were kept waiting for over 2 hours whilst the patient visibly deteriorated. Patient was admitted to CCS and died 5 days later.	Sandwell and West Birmingham Hospitals NHS Trust, Medicine and Emergency Care West Midlands Ambulance Service	**Errors found from both organisations but ultimately it was felt that given the significance of the patient's injuries, along with his age, the outcome was likely to remain unchanged.**
Parents feel that the poor care given to their son was a contributory factor to his death.	Sandwell and West Birmingham Hospitals NHS Trust, Women and Child Health	**Protocols were followed by all staff involved in this child's care, and advice sought from a paediatric specialist from Birmingham Children's Hospital (BCH). The outcome would not have been avoided if the child would have been transferred to BCH.**

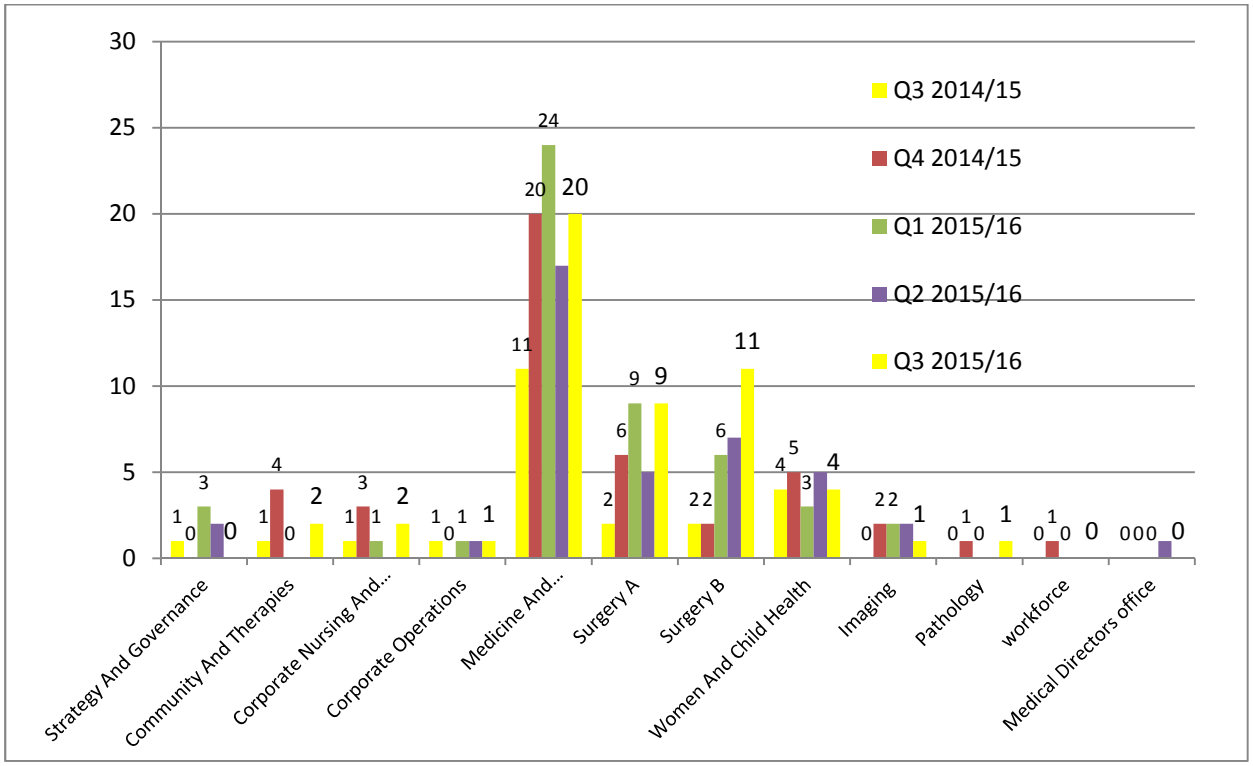
Details of complaint	Who involved	Outcome/ investigation to date
The patient's death certificate states that the cause of death was 'hospital acquired pneumonia' (HAP)- the family feel that this is down the poor care and treatment she received whilst in Sandwell.	Sandwell and West Birmingham Hospitals NHS Trust, Medicine and Emergency Care	**The complainant's concerns that her mother contracted HAP due to the use of endoscopy equipment being unclean have been investigated and nothing was found to suggest that the cleaning regime on the day the patient attended for her endoscopy was not followed.**
The family had raised questions with regard to the withdrawal of the warfarin several times and no-one has ever got back to them, the patient went onto have a massive stroke and died.	Sandwell and West Birmingham Hospitals NHS Trust, Medicine and Emergency Care	**Reintroduction of warfarin might have prevented the stroke, and thus the patient's death**
The patient underwent an endoscopic retrograde cholangio pancreatogram (ERCP) which resulted in her death. Her daughter was not informed that she was to undergo this procedure. She thinks it important that changes are made to policies regarding the next of kin being notified and is claiming compensation for this and her mother's death.	Sandwell and West Birmingham Hospitals NHS Trust, Medicine and Emergency Care	**This complaint is ongoing and the investigation is not yet concluded**
Patient was rushed in to theatre for a C Section and the baby was born without signs of life, but was resuscitated and is now brain damaged.	Sandwell and West Birmingham Hospitals NHS Trust, Women and Child Health	**It has not been concluded as to whether the brain damage was caused through lack of oxygen or whether this occurred prior to birth, but all emergency protocols were followed and the Trust has since met with the family to explain our findings.**
Patient attended A&E where it was found that she had an infection in the stent in her left kidney. She was nil by mouth for 7 hours before the operation but during the operation she vomited and aspirated (some food went into her lungs). She was taken back to CCS but died.	Sandwell and West Birmingham Hospitals NHS Trust, Medicine and Emergency Care and Sandwell and West Birmingham Hospitals NHS Trust, Surgery A	**This complaint is ongoing and the investigation is not yet concluded**
Baby was being treated for GBS Meningitis and transferred from Stoke PICU to Sandwell. The doctors and nurses did not appear to realise how ill the baby was and didn't not listen to the parents. Is the baby still alive?	Sandwell and West Birmingham Hospitals NHS Trust, Women and Child Health	**This complaint is ongoing and the investigation is not yet concluded**

Appendix 9

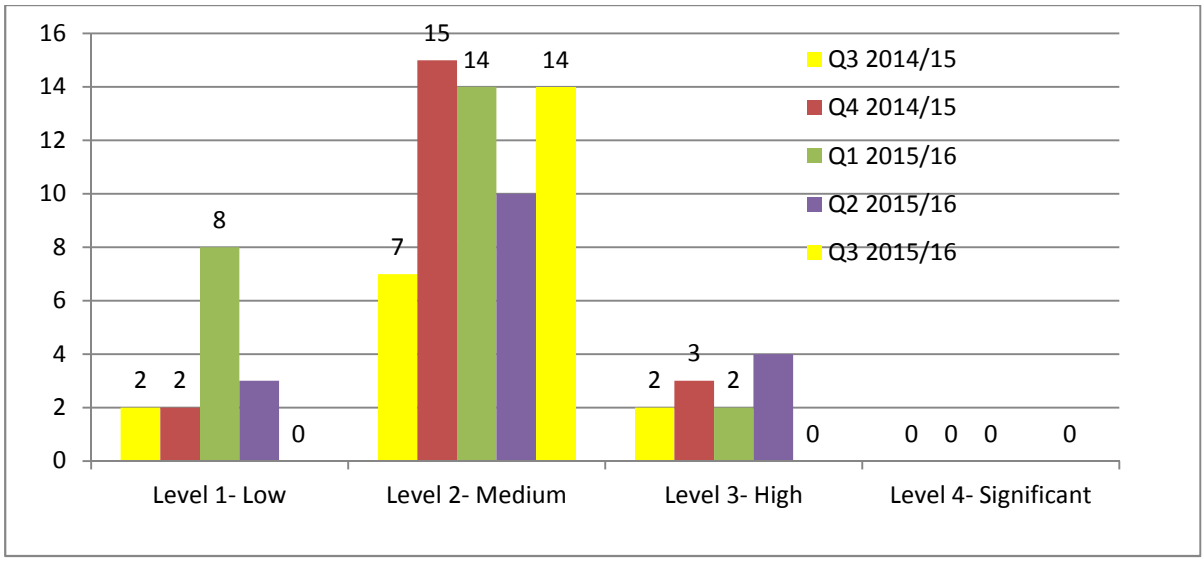
Complaints that have been reopened in Q3 2015/16 by Clinical Group and Corporate Directorate compared to Q2 2015/16, Q1 2015/16 and Q4 2014/15



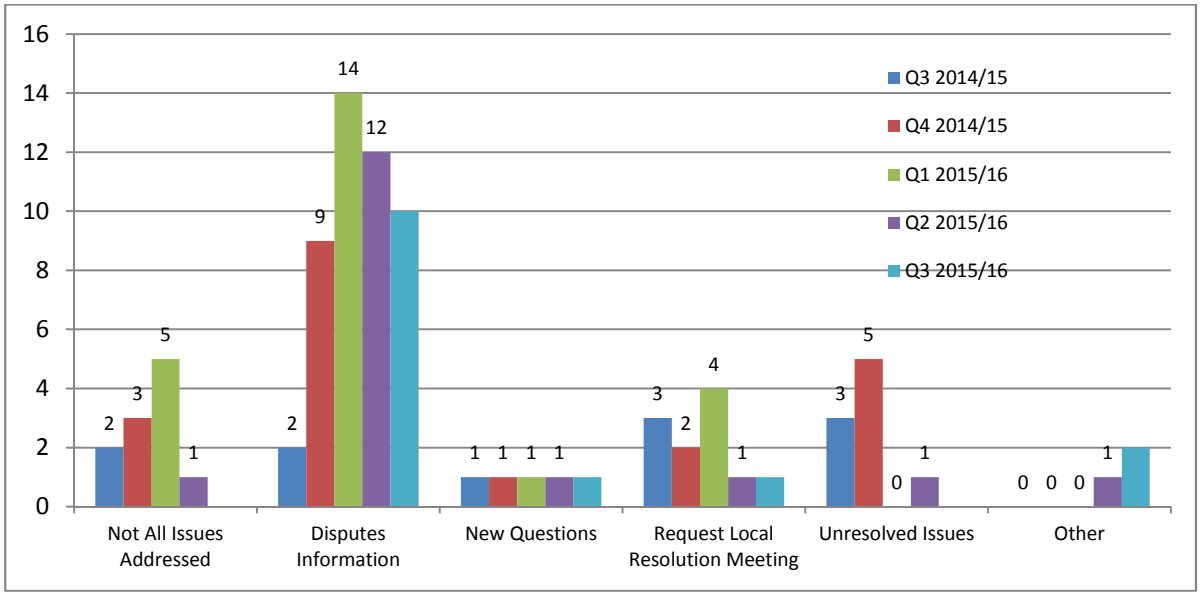
Complaints that have been reopened in in Q3 2015/15 compared to Q2 2015/16, Q1 2015/16 and Q4 2014/15 by Grade.



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

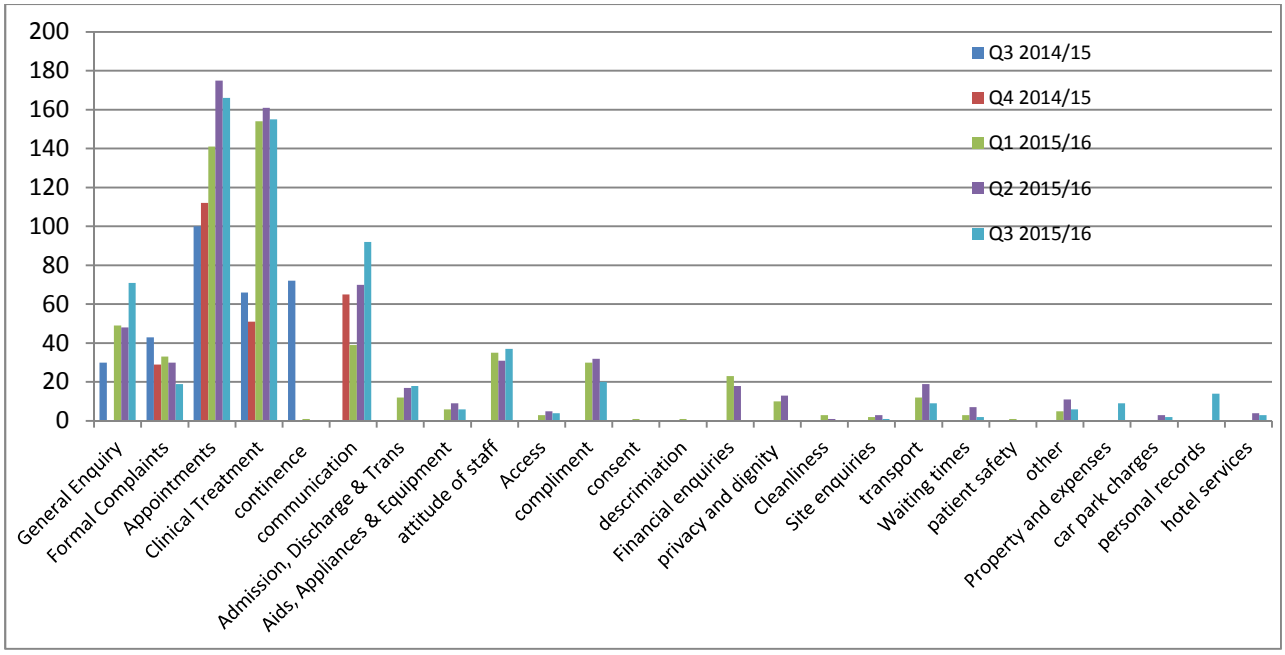


Reopened complaints for Medicine and Emergency Care by reason Q3 2015/16 compared to Q2 2015/16, Q1 2014//15 and Q4 2014/15

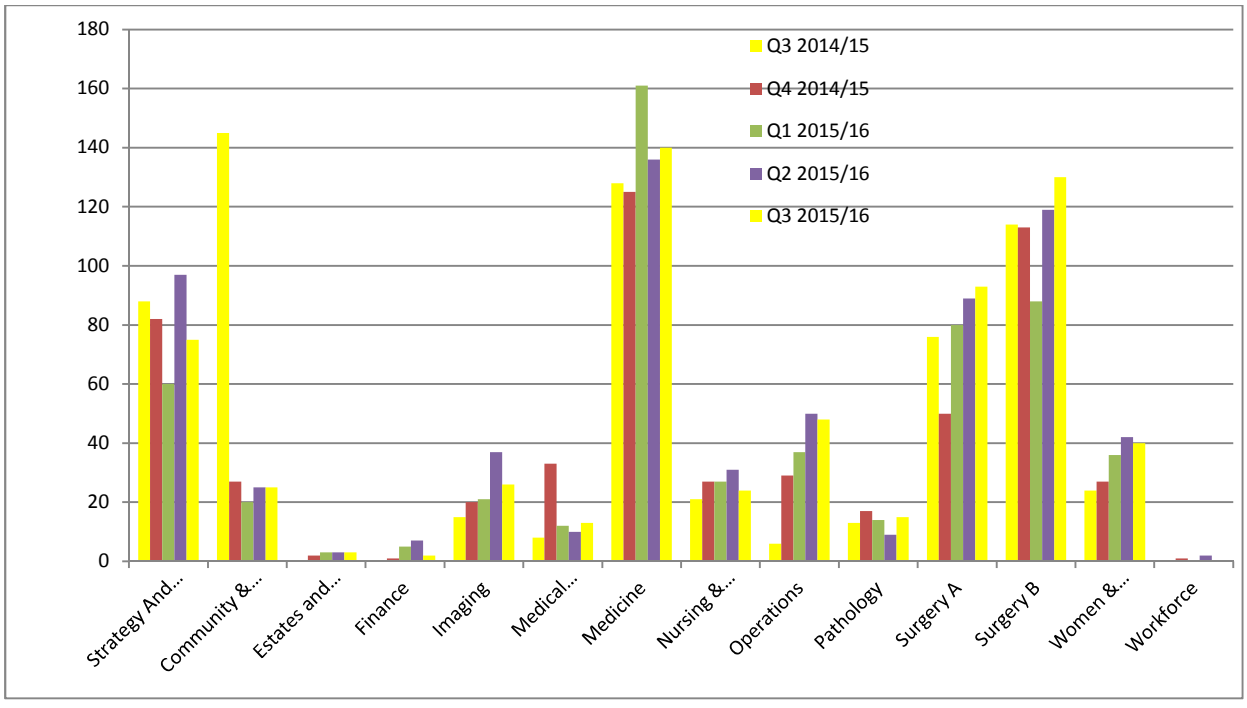


Appendix 10

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

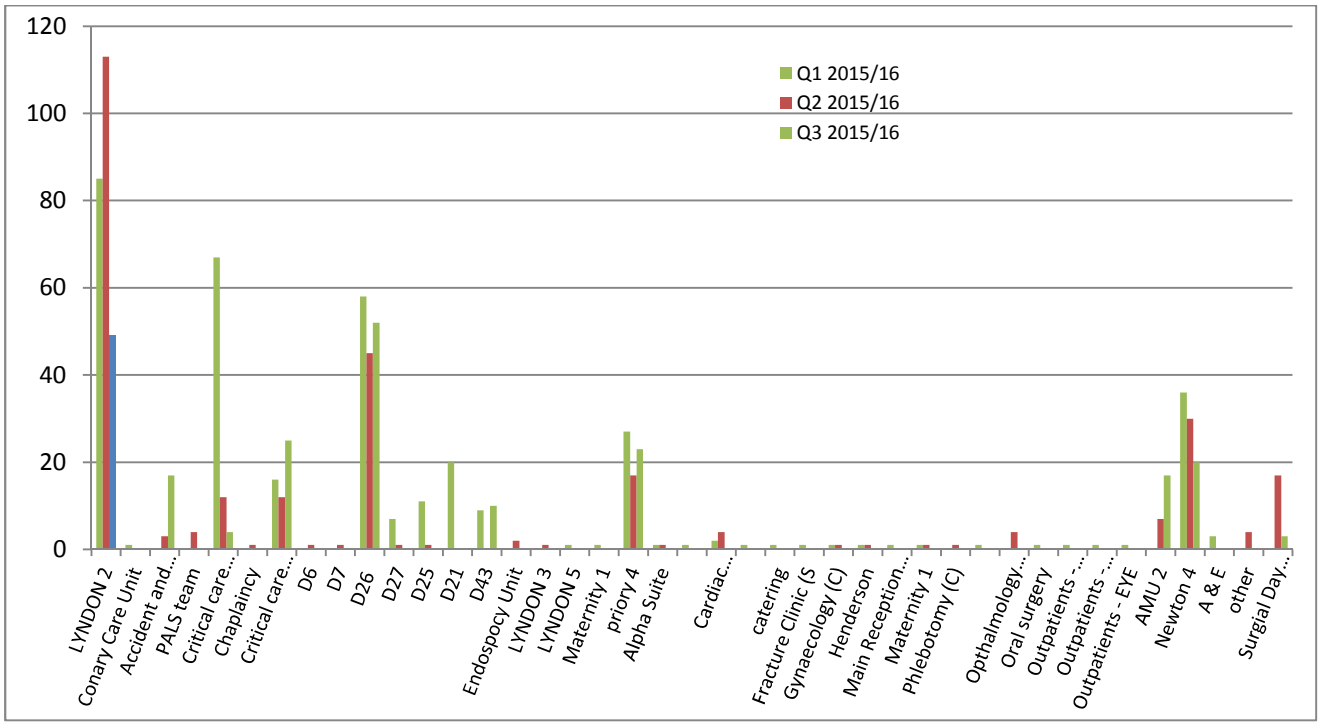


PALS enquiries broken down by group for Q3 2015/16, compared to Q2 2015/16, Q1 2015/16 and Q4 2014/15



Appendix 11

Compliments Q2 2015/16



This shows the breakdown of compliments collated by the wards that responded for Q2 2015/16, totalling 220. A more comprehensive reporting tool (as opposed to the manual tick sheet currently in use) using the Safeguard data base will hopefully be trialled in Q1 2016/17 so encourage an increase in the number of compliments we record and report.