Health Scrutiny Committee

Monday 15th February, 2016, at 6.00pm
In Committee Room 2 at the Council House, Priory Road, Dudley

Agenda - Public Session

(Meeting open to the public and press)

1. Apologies for absence.

2. To report the appointment of any substitute Members for this meeting of the Committee.

3. To receive any declarations of interest under the Members' Code of Conduct.

4. To confirm and sign the minutes of the meeting held on 21st January, 2016 as a correct record.

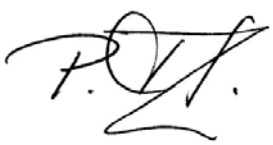
5. Public Forum – To receive questions from members of the public:-

   The Public are reminded that it is inappropriate to raise personal cases, individual details or circumstances at this meeting, and that an alternative mechanism for dealing with such issues is available.

   Please note that a time limit of 30 minutes will apply to the asking of questions by members of the public. Each speaker will be limited to a maximum of 5 minutes within the 30 minutes.

6. NHS Quality Accounts Provider Reports 2015/16 Pages (1 – 11)

7. To consider any questions from Members to the Chair where two clear days notice has been given to the Strategic Director Resources and Transformation (Council Procedure Rule 11.8).



Strategic Director Resources and Transformation
Dated: 5th February, 2016

Distribution:

Members of the Health Scrutiny Committee:
Councillor Hale (Chair)
Councillor A Goddard (Vice-Chair)
Councillors M Attwood, K Casey, K Finch, S Henley, Z Islam, S Phipps, N Richards, D Russell and E Taylor.

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Minutes of the Health Scrutiny Committee

Thursday 21st January , 2016 at 6.00 p.m.
in Committee Room 2 at the Council House, Dudley

Present:-

Councillor C Hale (Chair)
Councillor A Goddard (Vice-Chair)
Councillors M Attwood, K Casey, K Finch, S Henley, Z Islam, N Richards, D Russell, E Taylor and D Vickers

Officers

M Farooq (Head of Law and Governance) (Lead Officer to the Committee), I Newman (Chief Officer Finance and Legal Services), K Jackson (Acting Chief Officer of Health and Wellbeing) and K Buckle (Democratic Services Officer – Resources and Transformation Directorate).

Also in Attendance

P Clarke – Chief Executive of the Dudley Group NHS Foundation Trust
L Broster – Dudley Clinical Commissioning Group
N Bucktin – Dudley Clinical Commissioning Group
S Wellings – Dudley Clinical Commissioning Group

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32. **Apologies for Absence**

Apologies for absence from the meeting were submitted on behalf of P Bradbury and Councillor S Phipps.

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33. **Appointment of Substitute Members**

It was reported that Councillor D Vickers had been appointed to serve in place of Councillor S Phipps for this meeting of the Committee only.

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34. **Declarations of Interest**

Councillor S Henley declared a non-pecuniary interest in Agenda Item No 7 – Joint Strategic Needs Assessment (Next Steps) in so far as it related to West Midlands Fire Service, as an employee of the Service and Councillor D Vickers declared a non-pecuniary interest in Agenda Item No 9 – Dudley New Model of Care (Vanguard) Programme Update in so far as it referred to the Black Country Foundation Trust as a Stakeholder Governor in that Trust

35. **Minutes**

Resolved

That the minutes of the meeting of the Health Scrutiny Committee held on 19th November, 2015 be approved as a correct record and signed.

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36. **Public Forum**

No issues were raised under this agenda item.

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37. **Medium Term Financial Strategy**

A joint report of the Chief Executive, Chief Officer Finance and Legal Services and Strategic Director People was submitted on the Medium Term Financial Strategy (MTFS) for 2018/19 approved by Cabinet on 18th January, 2016 as a basis for further consultation, with emphasis on proposals relating to the Committee's terms of reference. Items directly specific to this Committee were those relating to the proposed Public Health budget for 2016/17 as contained in paragraphs 37 and 38 of the report submitted.

In presenting the report submitted, the Chief Officer Finance and Legal Services made particular reference to details in relation to the Public Health Grant Allocation which was expected in late January and although the budgetary position had improved there remained significant deficits.

In responding to a question of a Member in relation to the non-delivery of the Better Care Fund performance element, it was noted that this related to the level of non elective admissions to hospital and those targets not being met.

N Bucktin advised that the new draft guidance with regard to the Better Care Fund removed the pay for performance element of the fund and would remove any further pressures in that regard and the Clinical Commissioning Group had agreed to underwrite the £1.6m deficit for 2016/17, in place of the pay for performance element of the fund and there was a requirement to produce an action plan designed to reduce delayed transfer of care and the Clinical Commissioning Group expected that to be implemented.

The Chair advised that details relating to the Better Care Fund and delayed transfers of care would be presented to a future meeting of the Committee and commented that it was re-assuring that in the future the new fund was unfettered and would be received directly by the Council.

Resolved

That the Committee note the proposals of the Cabinet for the Medium Term Financial Strategy to 2018/19, taking into account the considerations set out in paragraph 47 of the report submitted.

38 **Joint Strategic Needs Assessment (JSNA) – The Next Steps.**

A report of the Chief Officer Health and Wellbeing was submitted on the proposed Join Strategic Needs Assessment (JSNA) process and implementation plan.

In presenting the report submitted, K Jackson, Acting Chief Officer of Health and Wellbeing made particular reference to the review process and the ten areas for development contained in the Implementation Plan, as set out in the report submitted.

It was noted that there was the requirement to widen the range of Joint Strategic Assessment products which were to be defined in order to ensure that those became more accessible

Members were referred to Appendix 1 to the report submitted, that provided additional detail on how the programme may work illustrating the process and outlining that the framework blended both the needs assessment and community assets together in order to provide a partnership led, evidence based Health and Wellbeing Strategy that delivered community outcomes.

Arising from the presentation of the report submitted, Members asked questions and made comments and suggestions and K Jackson, Acting Chief Officer of Health and Wellbeing responded as follows:-

- The graphs contained in the report submitted illustrated how the data would be synthesised to identify the key priorities in relation to health and wellbeing for the Borough.
- That in addition to the intelligence work in the St James's Ward in order to develop intelligence regarding community assets in Dudley, further mapping work would take place throughout the Borough in order to gather intelligence in relation to all community assets.
- In relation to the suggestion that there was the requirement to consider the equality impact of joint strategic needs upon a more indepth basis including age inequality, it was noted that needs and assets across the Borough would reflect health equality and investigate how changes could be implemented to address health and age inequality.
- The data gathered was based around issues that impacted on health and wellbeing in the broadest sense and a full range of data would be considered in order to investigate priorities in the Dudley Borough, which would include consideration of health and demographic data and data based upon social, economic and educational conditions which would be obtained from all stakeholders throughout the Borough.
- Data would be obtained with a view to make it much more accessible to enable healthcare providers to make more informed decisions.
- The Joint Strategic Assessment process would be embedded in the commissioning of community hubs that fall within the People Directorate and in addition could be utilised across all healthcare providers.

N Bucktin, Dudley Clinical Commissioning Group (CCG) advised that the Group utilised the information contained in the current Joint Strategic Needs for commissioning purposes and each year the Dudley Health and Wellbeing Board required the CCG to demonstrate how their plans had taken into account detail contained in the Joint Strategic Needs Assessment.

N Bucktin also referred to work that was taking place surrounding hyper tension and improving the diagnosis rate of those with expected high prevalence and the re-design and re-commissioning of diabetes services, with the redesign specification responding directly to the information contained in the Joint Strategic Assessment of Needs and Assets.

It was noted that there was a Multi Disciplinary Team that had been established in order to identify specific issues surrounding the particular practice team populations, in order to respond in different ways to that practice population. Investigations in relation to developing a new model of care by utilising a re-stratification tool which identified those patients most at risk of hospital admission and that Multi Disciplinary Teams utilising that tool to identify patients in order to reduce the level of risk and manage their conditions more effectively, producing better outcomes was referred to.

N Bucktin also referred to professionals being conscious of resources however they had a professional responsibility to deliver the best possible care for their patients and it was noted that Clinical Commissioning Group would investigate the most cost effective method of delivering services when commissioning those services

In relation to the development of a Joint Health and Wellbeing Strategy and the review of intelligence in the Joint Strategic Assessment of Needs and Assets in order to establish a list of possible priorities the Public Health Consultant advised that the target for the work to be completed should be met in March, 2016.

The Chair referred to the data influencing Community outcomes.

A Member suggested that due to the Joint Strategic Assessment of Needs and Assets document being fundamental to health care, the possibility of providing Members at the beginning of each new municipal year with a one page document detailing the stakeholders involved with the assessment.

Resolved

That the information contained in the report and Appendix to the Report submitted on Joint Strategic Needs Assessment (JSNA) – The Next Steps together with Members comments and suggestions, be noted.

39. **General Practice Closures and Mergers.**

A report of the Chief Officer, Dudley Clinical Commissioning Group was submitted providing assurances that the Dudley Clinical Commissioning Group was complying with NHS regulations and policy governing the closure and merger of general practices.

In presenting the report submitted, S Wellings the Vice Chair and non Executive Director of the Dudley Clinical Commissioning Group, referred to the need to restructure primary care throughout the Dudley Borough together with the regulations and policies of NHS England, which had to be considered when dealing with an application for closure or merger including the financial viability, condition and accessibility of the Practice.

It was noted that there was a detailed process that providers had to follow and conduct a 12 week consultation process.

S Wellings provided details and circumstances in relation to the St Thomas Medical Centre and Bean Medical Practice Merger, the application to close the Market Street branch surgery in Kingswinford and the application to close Masefield Road branch surgery of the Lower Gornal Medical Practice.

Arising from the presentation of the report submitted, a Member asked a question in relation to the reduction in Government funding for practices in deprived areas and commented on the consultation process together with the financial viability of the Masefield Road Branch Surgery remaining open.

S Wellings responded stating that the Government wished to ensure that contracts were more consistent across the Country, no longer providing personal medical contracts that had previously been utilised in deprived areas. It was noted that there was a requirement to design a new medical contract for Dudley residents with modelling taking place in order to investigate the impact on different areas and the intention over a period of time to improve the standard of general practice.

S Wellings advised that the Care Quality Commission report had concluded that General Practitioner Services within the Dudley Borough were generally good and he also emphasised the requirement to consult the public in relation to closures and mergers.

In responding to a query regarding the possibility of preventing closure of the Masefield Road branch surgery, S Wellings referred to the lack of prescription facility services nearby and the lack of nearby parking. It was noted that there had been a change in Government Policy relating to funding and the Lower Gornal Medical Practice wished to protect and retain the additional services that they had invested in. The Consultation which would take place at the Himley Road Methodist Church in February was referred to.

It was noted that the Clinical Commissioning Group were committed to integrate services to ensure that care was wrapped around patients with the importance of providing the widest level of service in the best possible way being emphasised.

Resolved

(1) That the information contained in the report submitted on the assurance that Dudley CCG was complying with NHS Regulations and policy governing the closure and merger of general practices, be accepted.

(2) That the Dudley Clinical Commissioning Group be requested to consult the Committee on future changes to contractual arrangements regarding mergers and closures, as part of the formal consultation process.

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40 **Dudley New Model of Care (Vanguard) Programme Update.**

A report of the Chief Officer, Dudley Clinical Commissioning Group was submitted on the Dudley New Model of Care (Vanguard) Programme Update.

In presenting the report submitted N Bucktin, Dudley Clinical Commissioning Group made particular reference to the Group being amongst the first vanguards chosen to deliver a multispecialty community provider model of care, commissioning best practice pathways in both planned and urgent care.

It was noted that as part of a listening exercise in relation to shaping successful integrated care, the Council's ten Community Forums would receive health and social care presentations during their next cycle providing participants with the opportunity to share their views and opinions in order to help shape the formation of better integrated health and social care.

The method by which the activity to deliver the model was being managed was referred to and it was noted that a multi-agency Partnership Board met monthly to oversee the delivery of the programme, with the West Midlands Fire Service recently being invited to join the Board.

N Bucktin reported on an application to NHS England for further funding in order to support the new model of care, including the development of new services.

N Bucktin also referred to the comprehensive spending review in relation to health and social care and the possibility of accelerating plans with the Council to integrate health and social care by 2017.

Arising from the presentation of the report submitted a Member congratulated the Dudley Clinical Commissioning on being amongst the first vanguards chosen in the Country.

In responding to a query of the Chair regarding the graph regarding the Vanguard aggregate scores by domain, N Bucktin advised that the current performance deficit related to the new model of care based around the three new aspects of General Practitioner Contracts which were access, continuity of care and co-ordination, with co-ordination referring to services for patients with a number of conditions, including those who were elderly. It was noted that although co-ordination required further work due to continuing issues, the new model of care performance indicators in relation to access and continuity of care were fairing well.

N Bucktin referred to the requirement for further work in relation to co-ordination being due to under reporting of cases, for example in relation to hyper tension as that condition existed in more patients than the data suggested and that could be due to either patients failing to present or patients remaining undetected.

K Jackson referred to the need to raise awareness to encourage patients to access their General Practitioner at an earlier stage and the mechanism for raising awareness was through campaigns organised by public health, with continuing work required in relation to raising awareness.

A Member commented that the role of Public Health was crucial in relation to raising awareness especially in relation to diabetes. It was noted that approximately 17% of the population who had varying medical conditions remained undetected as they were failing to consult with their General Practitioners, with the main cause remaining a failure to recognise the symptoms of conditions such as diabetes

In responding to a question from the Chair, N Bucktin referred to risks and issues and managing those risks and it was noted that the three substantial risks referred to in the report submitted would be considered by the Partnership Board at their meetings.

It was also noted that in terms of disagreeing there remained the possibility that partners would disagree, however it was hoped that the Board would get to a position where an agreement was reached for example on any new organisational form required to deliver the new model of care.

It was noted that in relation to the risk identified regarding the management capacity in terms of the submission to NHS England and the requirement to provide a value proposition, a further value proposition was to be submitted which would identify a more efficient mechanism for workforce planning in order to deliver the programme within the defined timescales.

It was further noted that the budget in relation to health and adult social care would continue to change due to setting and would continue to affect the nature of the risks identified and ongoing risks would continue to be monitored throughout the course of the programme at each meeting of the Partnership Board.

Resolved

That the information contained in the report submitted on the Dudley New Model of Care (Vanguard) Programme Update together with the requirement for it to be commissioned jointly by the Clinical Commissioning Group and the Council, be noted.

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41 **Sport Participation and Physical Activity.**

It was noted that the Chair would liaise with Officers regarding the final recommendations to be submitted to Cabinet relating to Sport Participation and Physical Activity.

The meeting ended at 7.50 p.m.

Chair

The Dudley Group NHS
NHS Foundation Trust

Agenda Item No. 6(a)

Health Scrutiny Committee – 15th February 2016

THE DUDLEY GROUP NHS FOUNDATION TRUST

QUALITY ACCOUNT/REPORT SUMMARY FOR 2015/16

1. Introduction

This paper confirms what quality priority topics and associated targets the Trust set at the beginning of the year in April 2015 and which were initially published in the Quality Account for 2014/15. It also gives an indication of the Trust's present position (at the end of December 2015) with the twelve targets but it has to be appreciated that a final complete analysis and conclusion can only be undertaken after the end of the financial year which falls on 31st March 2016. The paper also indicates how the Trust is deciding on the quality priorities for 2016/17. At the time of writing, the full details of those priorities have yet to be agreed as these will be dependent on the final results against the 2015/16 targets and what goals are set both nationally and by our local commissioners, the Dudley Clinical Commissioning Group.

As has happened in previous years, a draft of the quality account/report will be circulated when available to the committee for formal comment. The final version will be provided too, which will include full end of year data, the statutory statements from the organisation on quality and a quality overview to include the Trust's position with a selection of local and national quality indicators.

2. Quality Priorities/Targets for 2015/16 and present position at quarter 3 – December 2015)

1. PATIENT EXPERIENCE	
Hospital	**Community**
a) Achieve monthly scores in the inpatients Friends and Family Test (FFT) that are equal to or better than the national average. b) Achieve monthly scores in the outpatients Friends and Family Test that are equal to or better than the national average.	a) Achieve monthly scores in the community Friends and Family Test that are equal to or better than the national average.

Present position

The FFT is used in all NHS organisations across the country and gives an indication from patients about whether they would recommend the service they have had to their friends and family. The table below shows the percentage of people from the Trust each month who would recommend the service compared to the national percentage across all organisations.

Quality Priority	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Trust inpatient FFT %	96	97	98	97	99	97	97	97	99
National %	95	96	96	97	96	96	96	96	*n/a*
Trust outpatient FFT %	84	82	82	88	90	89	88	84	88
National %	92	92	92	92	92	92	92	92	*n/a*
Trust community FFT	97	98	96	96	94	93	97	95	99
National %	96	95	95	95	96	95	95	95	*n/a*

n/a = national figure not yet available

The results show that up to December the inpatient area is achieving the target with the Trust results each month being equal to or above the national average. For community, the Trust FFT score has been equal to or above the national average for 6 of the 8 months for which comparable scores are available. Unfortunately, for outpatients the Trust score has been consistently below the national average. As a result of the latter, efforts are being made to:

a) improve the response rate. To support response rate growth, several initiatives that have been rolled out or are scheduled to be implemented in the quarter including:

- Friends and Family App launched early September 2015

- Refreshed the Trust FFT test webpage September 2015

b) Analysis of comments received is fed back to the lead staff in each of the outpatient areas so that improvements can be made to the patient experience. As part of this process we have introduced a 'You said, we have' initiative which includes having posters displayed in the appropriate areas. Leads for each area are also required to report on the actions they have taken in their area which is recorded on a central log.

2. PRESSURE ULCERS	
Hospital	**Community**
a) Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year. b) Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2015/16 reduces from the number in 2014/15.	a) Ensure that there are no avoidable stage 4 pressure ulcers acquired on the district nurse caseload throughout the year. b) Ensure that the number of avoidable stage 3 pressure ulcers acquired on the district nurse caseload in 2015/16 reduces from the number in 2014/15.

Present Position

Hospital

Period	2014/15	2015/16
No. of stage 3	41	21
No. of Stage 4	1	0
Total	42	21

Community

Period	2014/15	2015/16
No. of stage 3	11	2
No. of Stage 4	0	0
Total	11	2

The above tables indicate the comparison of the figures for 2014/15 and the present position at the end of December 2015. It can be seen that all of the targets look like they will be met at the end of the year. There have been no avoidable stage 4 ulcers in either the hospital or community. With regards to avoidable stage 3 ulcers in the hospital with three quarters of the year completed there are only about half of the ulcers of last year. The picture of the avoidable stage 3 ulcers in the community is even better at the end of December compared to last year.

(Please note than the present 2015/16 figures up to December are likely to change dependent on the outcomes of Root Cause Analysis) investigations as to whether reported pressure ulcers are avoidable or unavoidable the results of which may only be available up to three months after the incident is reported).

3. INFECTION CONTROL	
Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley Clinical Commissioning Group to agree on any avoidability/lapses in care.	
Clostridium difficile	**MRSA**
Have no more than 29 post 48 hour cases of Clostridium difficile with lapses in care	Have 0 post 48 hour cases of MRSA bacteraemia (blood stream infections).

Present Position

These infection control targets are set for the Trust by NHS England based on our performance in previous years. With regards to Clostridium Difficile, the target this year is to have no more than 29 cases caused by a lapse in care. The decision on whether there has been a lapse of care is made in conjunction with Dudley Clinical Commissioning Group and experts from Dudley Public Health. While there are a number cases up to the end of December for which a decision still has to be made the number of definite cases so far is 11 so the Trust is on track to achieve the target.

With regards to MRSA bacteraemia there have been two cases so far this year which means that that target has not been met.

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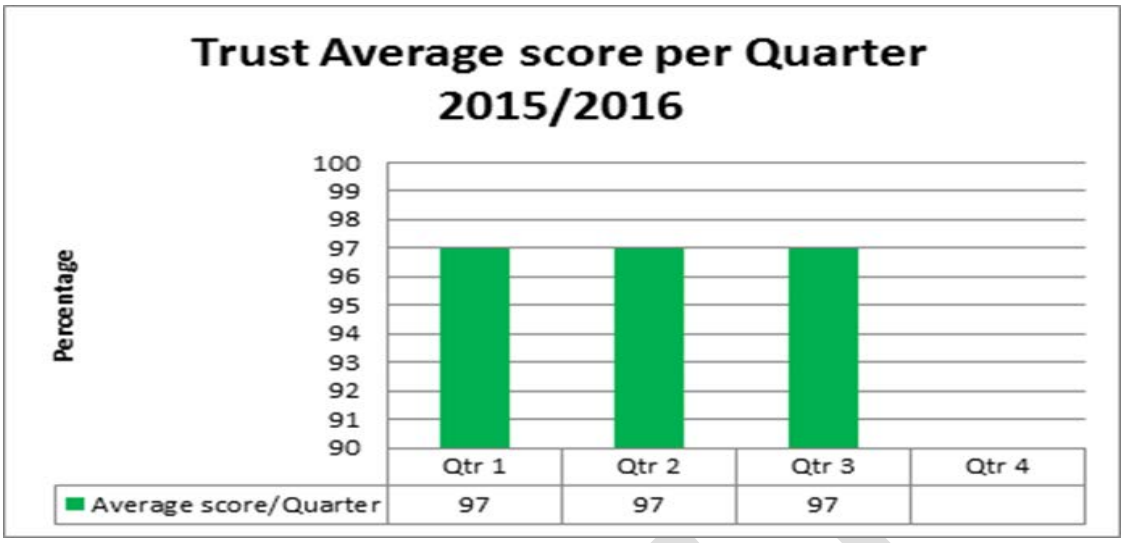
4. NUTRITION AND HYDRATION
Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items): a) is 90 per cent or above in each of the first three quarters for the Trust as a whole b) has a 'Green' rating (93 per cent or above) in the final quarter for every ward in the hospital

Every month on every ward an audit on nutrition and hydration occurs with ten patients. This consists of checking the nursing documentation, asking the patients about their care and assessing environmental factors. For each quarter of the year up until December 2015, as the graph below shows the overall average score has been 97% which means the target is presently being met. Looking ahead to when all individual wards have to be 93% or above, there are some areas that aren't consistent with this target and so additional targeted training is being taken with these wards to ensure the final quarter target will also be achieved.



5. MORTALITY

Ensure that 90 per cent of in-hospital deaths undergo specialist multidisciplinary review within 12 weeks by March 2016.

Our Mortality Tracking Process includes clinical coding, validation, multidisciplinary specialist audit and where necessary senior medical and nursing review led by our Deputy Medical Director. This process takes up to 12 weeks in total to ensure that each and every death occurring in hospital is understood and that we are responsive to the information we gather from the process. At present, we are on schedule to achieve this target.

Overall – With the data available for 11 of the 12 targets, it can be seen that the majority (eight) are on track to be met with three targets missed so far. However, as previously stated things may change by the end of the financial year.

4. Prioritisation of quality priorities for 2016/17 and involvement of patients and the public in our decisions

The Trust Board of Directors are of the view that the majority of the existing topics are still key care issues of importance to patients and the public and so should remain priorities next year. This view was endorsed at a recent meeting of the Council of Governors. It was agreed to retain all of the priority topics except for mortality, the review of which is now a well-established and robust system which has been seen as a good example of practice with the underlying computer system being shortlisted and placed in the finals of a top national award for the use of Information Technology to improve patient safety. This topic is to be replaced by the use of medications and pain control.

The Trust has consulted in a number of ways with the public and various interested bodies on these proposals. A questionnaire was designed for this purpose. It was distributed at the Annual Members meetings and was available for completion on the Trust website.

5. Proposed Quality Priorities/Targets for 2016/17

PRIORITY 1: PATIENT EXPERIENCE
This priority to be retained. Although the detailed targets of this have not been decided one definite element will cover the issue of ensuring effective patient Pain Control.
PRIORITY 2: PRESSURE ULCERS
This topic to be retained. Discussions are occurring with the commissioners to agree the exact target; this is likely to involve a requirement to reduce further the incidence of Stage 3 avoidable pressure ulcers in the hospital and a zero tolerance to Stage 4 avoidable ulcers in both hospital and community.
PRIORITY 3: INFECTION CONTROL
This topic to be retained and the Trust will be set targets by the Department of Health. For MRSA Bacteraemia a zero tolerance is likely to continue.
PRIORITY 4: NUTRITION AND HYDRATION
This topic to be retained and the target set will depend on the outturn figures for 2015/16.
PRIORITY 6: MEDICATION
This is a new topic for 2016/17 with the specific target yet to be decided.

6. Equality Impact

The Dudley Group NHS Foundation Trust is committed to ensuring that as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

7. Recommendation

7.1 That the committee receives this report for information and provides its view on the quality priorities for 2016/17.

Dawn Wardell, Chief Nurse
Derek Eaves, Professional Lead for Quality
The Dudley Group NHS Foundation Trust
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Contact Officer: Liz Abbiss
Telephone: 01384 244404 Email: Liz.Abbiss@dgh.nhs.uk

Quality Account 2015-16 Update for Dudley HOSC

Performance

There are nationally set standards for ambulance services to achieve as a service

Red 1: Respond to 75% of calls within 8 mins
These are for life threatening conditions, the most time critical patients

Red 2: Respond to 75% of calls within 8 mins
These calls may be life threatening but less time-critical and should receive an emergency response within 8 minutes irrespective of location in 75% of cases.

Red 19 Mins: Respond to 95% of calls within 19 mins

Green 2: Respond to 90% of calls within 30 mins

Green 4: Triage 90% of calls in 60 mins

Referral Target: Target 90% achieved

Category	Dudley CCG YTD (April 2015 – Jan 2016)	Trust YTD (April 2015 – Jan 2016)
Red 1(75%)	82.7	79.1
Red 2 (75%)	76.1	76.0
Red 19(95%)	99.0	97.3
Green 2 (90%)	90.8	90.8
Green 4 (90%)	99.8	99.8

The nationally agreed target of 30 minutes turn around to free ambulances back from delivery of patient in Emergency Department to fully operational. It is agreed that for the high percentage of cases, it is reasonable to take 15 minutes to carry out clinical hand over of patient into the care of the hospital, leaving a further 15 minutes for the ambulance crew to complete their patient documentation and tidy the vehicle in preparation for the next call/patient.

WMAS recognises the great improvement in turnaround at RHH and continues to work with RHH colleagues to improve further.

Hospital	Average Turnaround Time YTD (mins)	Hours lost over 30 mins YTD (hours)	Longest Turnaround YTD	Over hour delays YTD
Russells Hall	28:09	925	3:22:40	57
Feb 2015	31:25	1996	2.22.27	466

Incident Disposition for 999 calls

This is a breakdown in percentage of how calls are managed by

- telephone triage (hear and treat)
- attendance and discharged at scene(see and treat)
- attended and conveyed to an appropriate treatment centre (see and convey)

(Apr 15 - Jan 16)	Dudley CCG YTD	Trust YTD
Hear & Treat	4.8	4.7
See & Treat	32.0	35.3
See & Convey	63.1	59.8

Staffing, skill mix in ambulances in Dudley CCG Area

Number of staff	224
Paramedic skill mix	47%
Training completed/planned	100%
Staff Appraisals completed/planned	100%

Patient Experience

	Complaints	PALS	Compliments
Total	31	101	213
Highest reason for contact	Aspects of Clinical care (17)	Lost property (42)	

Ambulance Quality Indicators

April –November 2015	Black Country	WMAS
ROSC At Hospital (Overall Group)	30.68%	30.90%
ROSC At Hospital (Comparator Group)	56.96%	51.35%
PPCI Treatment within 150 minutes	*	85.53%
STEMI Care Bundle	82.33%	77.76%
Stroke Care Bundle	97.69%	96.09%
Stroke Stroke FAST + patients transported to Hyper Acute Centre within 60 minutes	*	56.18%
Cardiac Arrest Survival to Discharge (Overall Group)	8.11%	9.41%
Cardiac Arrest Survival to Discharge (Comparator Group)	29.11%	25.23%

*Data not possible by area

Quality Account Priorities 2015/16

Patient Experience

Priority 1: Improved engagement with Learning Disabled Service Users

Trust Web Page

The Trust has taken steps to engage with learning disabled service users by attending the National Autism & LD event in Birmingham 2015.Leaflets where distributed to all organisations that attended. The Easy Read material has been placed on the Trust web page within its own site and incorporates the following:

- Calling 111 advice
- What happens when you call an ambulance
- What to do if you are badly hurt or very unwell
- Going to hospital for an appointment
- What to do if you are unhappy or concerned
- Safeguarding adults patient information
- Five year forward view
- Trust membership Form

Training for call centre staff

Training for call centre staff has been provided both for 111 staff and our own EOC's through Enav package which is interactive and requires a pass mark to achieve the certificate and comprises of the following:

- Autism Spectrum Disorder
- Learning Disabilities training information
- Learning Disabilities Awareness
- National Ambulance Communicating with People with Learning Disabilities
- NHS Learning Disabilities prompt card
- MENCAP How to guide to health
- WMAS Safeguarding
- Carers Rights guide
- Equality Act 2010 carers rights
- The MIND Guide to communicating with people with a learning Disability

Community Engagement

Various community events have been attended across the region with the added advantage of the Trust Engagement Ambulance being available for all to view and learn more about the Trust.

List of events in the Black Country area to be confirmed at March WMAS Engagement Events

Patient Experience

Priority 2: Working with Public Health England to reduce Health Inequalities

The Trust has set up a joint working group with key representatives from West Midlands Public Health England (PHE) team.

Three joint meetings have taken place, with a further two task and finish groups on:

*Data sharing

*Drug and Alcohol abuse.

A joint plan has been developed to look at key areas

*Prevention related to cardiovascular disease amongst vulnerable communities.
*Drug and Alcohol Abuse
*Mental Health
*Making every contact count
*Data sharing
*Healthy workforce

The Trust will agree the key measures for success under each of the above priority areas with PHE colleagues, for measurement during 2016/17 (year 3 of the work)

Patient Safety

Priority 3: Reduce the risk of avoidable harm from delays in ambulance attendance.

The Trust has improved its operational response times which have proven to reduce reported incidents or complaints relating to harm due to delays in ambulance attendance.

Final report to be published April 2016

Priority 4: Publicise lessons learnt and good practice from incidents, claims and complaints.

The Trust Learning from incidents claims and complaints is published in the form of the Learning Review Group Report (attached document).

The Trust website is in the process of being updated to include a Patient Safety zone which we expect to go live in March 2016. The zone will include more details of how the Learning Review Group works and more detailed reports relating to our more serious incidents.

Clinical Effectiveness

Priority 5: Ensuring the care delivered on scene is timely and effective

Safe on Scene Project

The Trust has introduced a project team to

1. To describe the change in job cycle time, time on scene and multiple vehicle utilisation ratios over the last 5 years
2. To identify the reasons why there have been changes
3. To understand how job cycle time, and time on scene impact on patient care and clinical outcomes
4. To map current ways of working and how these impact on job cycle time, time on scene
5. To make recommendations on changes to the current ways of working that maximise resource utilisation by optimising the impact of job cycle time and time on scene
6. To ensure that the time on scene is not putting patient care at risk

The group is working with colleagues and Commissioners in order to achieve these objectives. A position statement on the project progress will be available for the Trust HOSC/ Healthwatch engagement events planned for early March.

Priority 6: Continue to improve all clinical outcomes

Ambulance Quality Indicators / Clinical Performance Indicators	14-15	15-16 (Apr-Nov 15)	
ROSC at time of arrival at hospital (Overall)	28.71%	30.90%	✓
ROSC at time of arrival at hospital (Utstein Comparator group)	45.57%	51.35%	✓
PPCI < 150 minutes	88.14%	85.53%	✗
STEMI Care Bundle	72.49%	77.76%	✓
Percentage of FAST Positive Stroke Patients potentially eligible for stroke thrombolysis who arrive at a Hyper Acute Stroke Unit within 60 minutes of call	46.93%	56.18%	✓
Percentage of suspected stroke patients who receive an appropriate care bundle	94.00%	96.09%	✓
Cardiac Arrest Survival to discharge (Overall survival rate)	8.29%	9.41%	✓
Cardiac Arrest Survival to discharge (Utstein Comparator group survival rate)	20.62%	25.23%	✓
Asthma Clinical Performance Indicator Care Bundle	86.00%	99.78%	✓
Single Limb Clinical Performance Indicator Care Bundle	26.92%	40.65%	✓
Febrile Convulsion Clinical Performance Indicator Care Bundle	83.40%	76.47%	✗
Elderly Falls Clinical Performance Indicator Care Bundle	6.08%	2.33%	✗