Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue: West Bromwich African Caribbean Resource Centre, West Bromwich, B70 6LY

Date: 7 July 2016; 0930h – 1230h

Members attending:

Mr R Samuda	(RSM)	Chairman
Ms O Dutton	(OD)	Vice Chair
Mr M Hoare	(MH)	Non-Executive Director
Mr H Kang	(HK)	Non-Executive Director
Mr R Russell	(RR)	Non-Executive Director
Dr P Gill	(PG)	Non-Executive Director
Cllr W Zaffar	(WZ)	Non-Executive Director
Mr T Lewis	(TL)	Chief Executive
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
Mr T Reardon	(TR)	Deputy Chief Finance Officer

Board Support

Mr D Whitehouse	(DW)	Head of Corporate Governance

Time	Item	Title	Reference Number	Lead
09:30h	1.	**Apologies – Ms Olwen Dutton and Mr Tony Waite**	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
09:35h	3.	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 2 June 2016 as a true and accurate records of discussions*	SWBTB (07/16) 058	Chair
	4.	**Update on actions arising from previous meetings**	SWBTB (07/16) 058(a)	DW
09:40h	4.1	**Ten out of Ten: VTE and MRSA screening on pilot wards**	SWBTB (07/16) 059	CO
09:50h	4.2	**Mortality data – rebasing update**	SWBTB (07/16) 060	RST
10:00h	5.	**Questions from members of the public**	Verbal	Chair
10:15h	6.	**Chair's opening comments**	Verbal	Chair
		UPDATES FROM THE BOARD COMMITTEES		
10:20h	7.	To consider the update from the **Quality & Safety Committee** meeting held on 24 June 2016 and to note the minutes of the meeting held on the 27 May 2016	SWBTB (07/16) 061 SWBTB (07/16) 061(a)	OD/ CO

Time	Item	Title	Reference Number	Lead
	8.	To note the minutes of the **Audit and Risk Committee** meeting held on the 1 June 2016	SWBTB (07/16) 062	**RR/ KD**
	9.	To consider the update from the **MPA Committee** meeting held on the 24 June 2016 and the revised minutes of the meeting held on the 30 March 2016	SWBTB (07/16) 063	**RS/ TL**
	10.	To consider the update from the **Workforce and OD Committee** meeting held on the 27 June 2016	SWBTB (07/16) 064	**HK/ RG**
	MATTERS FOR APPROVAL OR DISCUSSION			
10:30h	**11.**	**Chief Executive's report** *(including safe nurse staffing on wards D19/ McCarthy)*	SWBTB (07/16) 065	**TL**
10:45h	**12.**	**Never Event in Obstetrics**	SWBTB (07/16) 066	**RST**
11:00h	**13.**	**Maternity Review**	SWBTB (07/16) 067	**CO**
11:15h	**14.**	**Trust Risk Register**	SWBTB (07/16) 068	**KD**
11:40h	**15.**	**Board Assurance Framework**	SWBTB (07/16) 069	**KD**
11:50h	**16.**	**Cancer services: 10 point plan**	SWBTB (07/16) 070	**RB**
12:00h	**17.**	**Learning disability promises**	SWBTB (07/16) 071	**CO**
12:10h	**18.**	**Workforce redesign 2016-18 delivery update**	SWBTB (07/16) 072	**RG**
12:20h	**19.**	**Bed base to Midland Metropolitan Hospital**	Presentation	**TL**
	MATTERS FOR INFORMATION			
12:30h	**20.**	**Integrated Performance Report** • Sickness absence • RTT	SWBTB (07/16) 073	**TW**
	21.	**Financial performance – P02 May 2016**	SWBTB (07/16) 074	**TW**
	22.	**Medical Appraisals Annual Report**	SWBTB (07/16) 075	**RST**
	23.	**Any other business**	Verbal	**All**
	24.	**Details of next meeting** The next public Trust Board will be held on 4 August starting at 09:30am in the Committee Room, Rowley Regis Hospital.		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC

Venue Boardroom, Sandwell General Hospital **Date** 2 June 2016 09:30h – 13:00h

Members Present

Mr Richard Samuda	Chair
Ms Olwen Dutton	Vice Chair
Mr Robin Russell	Non-Executive Director
Dr Paramjit Gill	Non-Executive Director
Mr Mike Hoare	Non-Executive Director
Mr Harjinder Kang	Non-Executive Director
Cllr Waseem Zaffar MBE	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:

Ms R Wilkin	Director of Communications
Mrs C Rickards	Trust Convenor

Board support:

Mr Duncan Whitehouse	Head of Corporate Governance

Minutes	**Paper Reference**
1 Apologies	
There were no apologies as all Board members were in attendance.	
2 Declarations of interest	SWBTB (05/16) 020
Ms Dutton highlighted that she was no longer a partner at Bevan Brittan having now become a partner at Anthony Collins. She was also a Trustee of the Almshouse Trust. Councillor Waseem Zaffar MBE highlighted his position as Cabinet Member for Transparency, Openness and Accountability at Birmingham City Council.	
3 Patient Story	
The Board heard a series of audio comments from patients about their experiences of care at the Trust and the quality of service received, the efficiency of service, waiting times and communication between staff and patients.	

Ms Dutton highlighted the issues raised around lack of communication and being informed where appointments were overrunning. Mr Lewis highlighted that survey data was consistently positive. Work was underway to re-profile all clinics with Ms Barlow stating that intervention work was in place to address the issues highlighted.	
4 Minutes of previous meeting – 5 May 2016	SWBTB (05/16) 022
Resolved: that subject to the correction of minute 14 to read £5m, the minutes of the previous meeting were agreed as an accurate record.	
5 Update on actions arising from previous meetings	SWBTB (05/16) 022a
The following actions were agreed from the action tracker: • **The Learning Disability paper to be brought to the July meeting of the Board** • **A report on cancer services to be brought to the July Board** • **Volunteering scorecard to be included on the action tracker with a report back to a future meeting.** Ms Dutton volunteered to be the link Non-Executive Director in respect of the Cancer Board.	
5.1 Local food suppliers (Halal)	SWBTB (05/16) 023
Mr Ovington introduced the report which set out the work being undertaken to source locally supplied food for patients including Halal. 3 options were currently being explored. Cllr Zaffar MBE welcomed the the update reiterating the need for locally sourced food that met the varying requirements of the local communities served by the Trust. It was imperative to adhere to food safety standards and also to be open and transparent about the supply chain. He pointed to HEFT as a local example which could be explored in terms of the use of local suppliers. Mr Ovington stated that discussions were taking place with HEFT exploring their supply chain. Ms Dutton highlighted the positive feedback that had arisen from the in house inspections in respect of the quality of the food served in the Trust. Mr Lewis stated that changes would follow the appropriate procurement processes with the likelihood of a plausible route forward before the end of the calendar year.	
5.2 Cancelled Operations – update on the pre assessment process	SWBTB (05/16) 024
Ms Barlow introduced the report which provided an interim position setting out the work around the process mapping of the assessment process and areas of improvement. There was as yet not a standardised new way of working. It was intended to utilise the Board day walkabouts in a few months as a means for the Board to test progress. Ms Dutton queried whether the theatre utilisation review would link to this work. Ms Barlow stated that it would. In response to a question from Mr Lewis about resolving pre assessment dates and theatre scheduling dates Ms Barlow stated that patients	

would receive a pre-assessment appointment on leaving outpatients. She highlighted that there was good clinical engagement to move this forward.	
5.3 Paediatric community caseloads	SWBTB (05/16) 025
Ms Barlow introduced the paper which provided an update on the tackling of community caseloads in the Women's and Children Group. The progress to date has included a single point of contact for all services, a triage process for all services except community midwifery, multi practitioner delivery of care, centralised delivery of care, electronic patient records and the use of community clinics. Work was ongoing to secure an appropriate IT platform to optimise the use of technology and there was an ongoing review of the caseloads/ case mix of staff according to grade. Mr Lewis stated that there was a lot of positive messages in the report but with the need for a detailed plan going forward and a recognition of the need for urgency in driving these changes forward. **Action: that a report be brought back to the August Board and the Director of Midwifery invited to an upcoming meeting of the Quality and Safety Committee**.	
5.4 Junior doctor placements 2016-17	
Mrs Goodby introduced the report which highlighted 23 gaps in junior doctor allocations across FY1/ ST higher and lower posts. Each of the unfilled placements were listed in the report. Work will have been concluded by the end of June with positions being advertised in July. Mr Lewis challenged why earlier progress could not be made. In response to a question from Mr Hoare as to any knock on implications he stated that that there was not a likelihood of achieving the agency cap rate given the data included in the report. The Trust needed a credible approach to engaging with key labour markets such as India. The Trust had one of the highest application rates from the University of Birmingham and was working closely with Aston Medical School. The latter would continue to develop with assurances provided to the Finance and Investment Committee. **Action: that a report be brought back to the September/ October Board providing evidence of progress**.	
5.5 Primary Care Interface Prescribing	
Dr Stedman introduced the report which outlined the governance process in place in respect of prescriptions issued by the Trust, the impact on GPs and the types of generic drugs that could be provided. The Trust had a 'generic first' approach to prescriptions unless there was a specific indication otherwise. Where patients were discharged then they would invariably leave with the generic equivalent. This was more complicated in outpatients where a patient may take a prescription to a local pharmacy where the decision would rest with the local pharmacist. The Drugs and Therapeutic Committee was a means of working through any ongoing issues with strong representation including local CCGs.	

6 Questions from members of the public	
Mr Cash congratulated the Trust on its financial performance for the previous year in terms of ending the year in surplus, the positive internal inspection process and Kelly Stackhouse having won the RCNi patient choice award.	
7 Chair's opening comments	
Mr Samuda thanked those that had contributed to the internal inspection process. The outcomes would provide valuable feedback to the Trust and evidenced the commitment of the Trust to undertake open and honest self-assessment of its performance. He also drew attention to the successful Leadership Conference which brought together the Trust's top leaders to discuss the delivery of key priorities and accompanying values and behaviours.	
8 Update from the Finance and Investment meeting held on the 27 May 2016	SWBTB (05/16) 027
The minutes were noted. Mr Samuda highlighted the ongoing need for traction in terms of delivery against the financial savings required and income generation. The work of the PMO was encouraging with the need for clear sight through to the Board of the impact of the various transformations schemes.	
9 Consider the update from the Quality and Safety Committee meeting held on the 27 May 2016 and to note the minutes of the meeting held on the 22 April 2016	SWBTB (05/16) 028
The minutes were noted. Ms Dutton highlighted the focus the committee had given to focussed care and the work that had been put into driving improvement in this area. The committee had also welcomed the refocusing of the Clinical Audit Plan against the Trust's key priorities and CQC Improvement Plan. She also highlighted the conversations that took place in respect of pressure ulcers. Mr Lewis agreed that there was a recent increased trend but that overall the data was not higher than the previous year.	
10 To note the Charitable Funds Committee meeting held on the 189 May 2016	SWBTB (05/16) 029
Cllr Zaffar MBE highlighted that the 2016-17 grant programme was progressing well as was the Midland Metropolitan Hospital appeal. The staff team restructure had been completed and all but one of the posts had been recruited to. Mr Lewis stated that there were issues being raised in terms of the restructuring of the Charitable Fund but that these were being addressed on an individual basis. If any of these were being raised with Board members then they should contact Ruth Wilkin who would pick up the issues individually.	
11 To consider the update from the Audit and Risk Committee meeting held on the 1 June 2016	SWBTB (05/16) 030
Mr Russell highlighted that the Audit and Risk Committee had met the previous day to review the draft accounts. The auditors had provided an unqualified audit opinion with all areas of judgement correctly exercised. The committee commended the draft accounts to the Board. He asked that the Board offer their thanks to the Finance Team	

and Communications Team in pulling the Annual Report and Accounts together in an accessible and timely manner.	
12 Chief Executive's report	SWBTB (05/16) 031
Mr Lewis introduced his report stating that the Trust would welcome 3 new chaplains in the coming week. He also congratulated Kelly Stackhouse for having won the RCNi Patient Choice Award. There was also positive news in terms of the ongoing fall in sickness absence rates across the Trust. The in month figure had fallen to 4.03% with an ongoing relentless focus on long term sickness cases. Mr Lewis stated that he was leading a review of the bed base through to the opening of the Midland Metropolitan Hospital. The emergency bed base was still not where it needed to be but work was ongoing to address this and Mr Lewis would provide further updates as appropriate. There remained the need to reduce the pay bill whilst retaining recruitment of appropriately skilled staff to deliver the Trust's vision in terms of excellence in integrated care. Ms Dutton queried the impact on recruitment of the outcome of the EU referendum. Mr Lewis stated that there would be work taking place at a national level to work through the implications of this. Dr Gill highlighted the positive Research and Development away day that had been held with 50-60 people attending. There was clear ambition around the direction of travel. Mr Lewis stated that a review of job planning was underway to ensure research and training was embedded and effective capacity existed. Mr Samuda queried progress in terms of GP collaborations and the linkages through to the Your Health Partnership. Mr Lewis stated that the Trust was likely to sign memorandums with Modality and certainly Your Health Partnership. It was important to go beyond simply the location of services and look at blended roles between acute care and doctors. Respiratory medicine was one example of where these opportunities were being explored. Cllr Zaffer MBE highlighted the annual audit of training and that access to training was reflective of the workforce and local communities which the Trust should shout about. In regard to safe staffing Ms Dutton queried the statistics presented. D19 was flagged as one of the wards with low night time fill rates. Mr Ovington stated that the ward was often not full but that he would provide specific detail a part of the next update to the Board. Mr Lewis stated that there was still work to be done in terms of the number of rota patterns that existed in the Trust and that these different patterns needed to be reduced to double digit figures. Mrs Goodby stated that as part of the recruitment and retention work they were looking at the types of shift patterns that worked best with older staff often preferring the longer shift patterns whilst younger staff wanted a greater work life balance with shorter shifts. It was imperative that staff had access to rotas well in advance.	

Miss Dhami flagged the Never Event that Mr Lewis had referenced providing an assurance that an action plan was in place and that evidence was being sought that changes had been complied with. Work had been undertaken to look back at Never Events with feedback being provided to the Quality and Safety Committee.	
13 Trust Risk Register	SWBTB (05/16) 033
Miss Dhami introduced the Risk Register stating that no new risks were being escalated to the Board. Mr Lewis stated that the estates risks would be picked up elsewhere including the MPA committee. He challenged progress in respect of risks 135 and 326. In terms of services to patients with a learning disability his understanding was that there were now 2 nurses across the sites as a new member of staff had recently been appointed. His understanding was that in respect of risk 326 there had been progress in sorting the appointment process for a trauma nurse in the Emergency Department. Dr Gill queried progress in terms of radiology staffing. Mr Lewis stated that work was underway to address the reframing of staff time such as in the effective attendance at meetings. Work was underway to drive improvement.	
14 Preparation for the summer consultation	SWBTB (05/16) 034
Mrs Goodby introduced the report which set out the programme for the summer consultation relating to 450 wte roles affected by the 2016-18 workforce changes. The proposals were wide ranging affecting multiple groups at the same time. The detail will be worked through by the Workforce and OD Committee and approved with the timetable appended to the report that set out week by week the actions to be taken as part of the consultation process. Mr Lewis stated that the Quality and Safety Committee would have the opportunity to review and quality and safety impacts of the schemes. There were some specific large schemes most notably in respect of Medical Records and in facilities with changes to ward services officers. Mrs Rickards cautioned against posts being deleted but then then additional bank staff being hired to fill gaps. Any reductions in staffing must follow on from changes to workflows. Ms Dutton challenged whether there was a clear understanding of the impact of these proposals in terms of individual quality impact assessments having been completed. Mr Ovington stated that there was a robust QIA process which he had a role in signing off. **Action:** **That the Workforce Committee review bank staff cover of particular roles**	

14.1 2016-18 Workforce Changes Phase 1 Progress Report	SWBTB (05/16) 035
Mrs Goodby introduced the report which set out progress of the statutory workforce consultation that commenced on the 6 April 2016 (the Easter consultation). There had been weekly PPAC meeting which had engaged trade unions. One scheme was extended into June as the consultation did not commence until the 11 May. This was in respect of the Operations, 24 Hour Site Team proposal. Consultation had now concluded in all but 4 schemes. Mr Lewis stated that an extension had only been granted for one scheme for specific reasons. **Resolved:** **The Board resolved that:** • **The implementation of the schemes where consultation had been concluded be approved.** • **That the outcome of delayed schemes would be reported to a future Board meeting.**	
15 Financial Plan 2016-17	SWBTB (05/16) 036
Mr Waite introduced the report stating that for 2015-16 the Trust had met its key financial duties and targets with a headline surplus of £3.8m. This had been achieved however with a reliance on contingencies. There remained an underlying deficit of £7m at the start of the new financial year. There was a plausible route through to delivery. The Trust had set out an ambitious plan in terms of the scale of recovery. An assessment had been made of the ability to manage downside risks and modest provisions had been made for fines/ restructuring. The intention was to stretch delivery as set out in the paper. For May there was the prospect of delivery to plan. Delivery was embedded into key programmes such as the bed capacity work and the workforce programme. The right capacity and capability was essential. The paper set out the progress that had been made in the development of the plan and a clear remedy back to financial surplus. For this year the focus would be to bring the Trust back towards plan. The objective was to end the year in a financially balanced position with the 2017/ 18 plan requiring the delivery of stretched targets to bring the Trust into alignment with the Long Term Financial Model. The intention was to deliver £45-50m of savings over 2 years with the ability to deliver to scale and ensure effective execution of the plan. Mr Kang clarified that it was a 2 year plan and challenged whether the step change needed month by month has been mapped onto 1 side of paper. It was important the Board was clear as to the profile and continuum of the ask over the full 2 years. Mr Waite stated that it was a 2 year programme to get the Trust back on plan. Mr Samuda questioned whether income for year 2 was set or subject to further discussion. Mr Lewis stated that negotiations were ongoing with local CCGs. He went on to highlight the establishment of the PMO and how the Executive Team would make best use of the resource. Weekly meetings had been established to drive the pace of	

transformation. Mr Russell challenged the realism of the CIP numbers in terms of the £10.4m equating to the proposals set out in the paper. Mr Waite responded stating that the calculations had been made on a part year basis. It was not simply about wte reductions but also agency and additional pay costs. A third of the total would be driven by workforce reductions. Ms Dutton challenged the assurances around delivery of the plan. The plan raised high expectations with a large increase in additional income through increased bookings. She challenged the confidence that could be placed on the pace and traction needed to deliver against the proposals. If the proposals proceeded on the basis of being a week behind per months as indicated in the report then would the target be achieved? Ms Barlow stated that in relation to planned care then there was a shortfall in April but this coincided with the impact of the industrial action that occurred over that period. In May the expectation was delivery against plan with an overbooking rate of 2% and a booking rate of 81% for June. The leadership team had a detailed breakdown by specialty every 24 hours. Progress was beginning to be made. Ms Dutton highlighted the essential importance of having access to effective data to track progress and troubleshoot issues as they arose. Mr Lewis stated that a dataset was being established which would be issued weekly. This would be shared to give assurances around progress. Dr Gill challenged the quality of coding and the capacity to deliver consistency around this. Ms Barlow responded stating that coding systems were rated as good. Mr Waite stated that coding was essential both in terms of the quality of patient care but also in terms of income generation. There remained room for improvement in terms of effectively recording co-morbidities. Mr Lewis stated that the Trust was likely to receive a revised control offer. This would hard wire the proposals discussed previously. There were still issues to work through such as if there were fined imposed around failures against the agency cap and what the risks around this may be.	
Resolved: **1. That the Chief Executive be given delegated authority to finalise any control offer for the Trust.** **Actions:** • **That a non-pay discussion takes place at a future Board meeting.** • **That progress around bed capacity be brought to the next Board meeting.**	SWBTB (05/16) 037
16 Initial feedback from in house inspections	SWBTB (05/16) 038
Miss Dhami introduced the paper stating that there were 35 inspectors that visited 26 wards and departments. Patients spoke highly of the care they received and of staff.	

There remained some inconsistencies around the implementation of 10/ 10. Immediate feedback was provided and the inspections had generated lots of useful intelligence. Mr Lewis stressed the importance of ward teams and ward managers. Direct messaging was needed to drive improvements at a local level.	
17 Integrated Performance Report	SWBTB (05/16) 039
Mr Waite introduced the report highlighting 4 hour wait times, cancer delivery and changes to mortality statistics. Mr Kang sought clarity on the trajectory for sickness absence rates. **Action: that a paper on mortality data rebasing be brought to the next meeting of the Board.**	
18 Security Update	
Mr Ovington introduced the report stating the requirement from NHS Protect to have an agreed safety strategy. Mr Hoare stated that it was a good policy as it reflected industry standards. He asked that further work be done to map out the practical timeframes for the strategy and to better identify the dependencies on other parts of the organisation. It was important for example that this fitted within the context of the technology discussions being led elsewhere. Ms Dutton highlighted the national press coverage in terms of harm caused to patients in other Trusts around the country and asked whether the strategy covered such matters. Mr Ovington stated that it did as far as it was ever possible to mitigate the risks of that nature. The Trust regularly reviewed its approach based on NHS Protect guidance. RG highlighted the support needs of the security team with Mr Lewis highlighting the need to align training requests with the strategy. He also stated the need to review the governance procedures outlined in the report to ensure they were appropriate. **Resolved: that the Security Strategy be approved.**	
19 Draft Annual Report and Quality Account	
Ms Willkin highlighted that the Annual Report had been considered at the last Private Board. Any final comments were requested by Monday. The Annual Report would be presented at the Annual General Meeting. **Resolved: that subject to final amendments by the Chief Executive, the Annual Report and Quality Account be approved.**	
20 Annual Accounts 2015-16	
Mr Waite introduced the report stating that all key financial targets had been met. The Trust had been issued with a clean audit opinion. The draft accounts had been	

endorsed by the Audit and Risk Committee. **Resolved: That the Board:** **i. Accept the Audit Committee's recommendation to adopt the financial statements.** **ii. Authorise the Chief Executive and Director of Finance Director to sign the relevant certificates in regard to these financial statements** **iii. Review the draft Letter of Representation and challenge and confirm that:** **i. The application of a general hospital approach by the Trust's professional valuer in arriving at his MEA valuation was an appropriate representation of the existing service potential of current land and buildings** **ii. There were no significant events occurring between the 31.03.16 and 02.06.16 which were material to the financial statements presented.** **iii. All relevant related parties were disclosed in the financial statements** iv. **The proposed representations were fair and complete**	
21 Financial performance – PO1 April 2016	
Mr Waite introduced the report stating that the monthly deficit was £1,657k which was £178k adverse to plan. There remained a significant in month deficit which reflected the Trust's underlying financial position. There was a need for a minimum £19.6m savings programme combined with income recovery plan. There remained no meaningful route to an in year surplus without an STF contribution.	
22 Any other business There were no other items of business.	

Signed ……..

Print ……..

Date ……..

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

17 July 2016

	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTCACT.510	Smoking Cessation	SBBTB (11/15) 181	05-Nov-15	Updates to be provided to the Board as the policy is progressed	TL	01/09/2016	Updates to be provided as appropriate on progress.	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	07/07/2016	Changing Our Lives are being commissioned to udertake an audit of the Trust. The report on the July agenda provides a progress update to the Board	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	04/08/2016	A report was presented to Quality and Safety Committee on the 22 April 2016. At that meeting it was agreed that further work was needed to build an accurate picture of the implications of wider safe staffing and that this be brought back to the Quality and Safety Committee before being presented to the Board.	Open
SWBTACT.531	Questions from the public		07-Apr-16	A car parking strategy be developed	CO	05/01/2017	Car parking startegy to be developed linked to financial planning for 2017/ 18	Open
SWBTACT.532	Cancer Services	SWBTB (04-16) 012	07-Apr-16	A report to be brought back to the Board in July	RB	07/07/2016	Report to be scheduled for the July meeting.	Closed
SWBTACT.537	Complaints and PALs report	SWBTB (05/16) 032	05-May-16	Report to be brought back to the August meeting outlining actions to address higher number of complaints from some community groups	KD	04/08/2016	Report to be presented at the August meeting	Open
SWBTACT.538	Matters arising	SWBTB (06/16) 025a	02-Jun-16	Volunteering scorecard to be brought back to the Board	CO	01/09/2016	Report to be presented at the September meeting	Open

SWBTACT.539	Paediatric community caselaods	SWBTB (06/16) 026	02-Jun-16	Report to the August Board in respect of paediatric community caseloads	RB	04/08/2016	Report due to the August Board meeting	Open
SWBTACT.540	Junior doctor placements	SWBTB (06/16) 026	02-Jun-16	Report to be brought back in terms of progress of junior doctor placements	RG	06/10/2016	Report to be brought back to a future meeting	Open
SWBTACT.541	Summer consultation preparation	SWBTB (06/16) 027	02-Jun-16	Workforce Committee to review bank staff cover of particular roles	RG	26/09/2016	To be considered at the next meeting of the Workforce and OD Committee	Open
SWBTACT.542	Workforce changes Phase 1 Progress	SWBTB (06/16) 028	02-Jun-16	Outcomes of delayed workforce schemes be reported to the Board	RG		To be reported as appropriate	Open
SWBTACT.543	Financial Plan	SWBTB (06/16) 029	02-Jun-16	Bed capacity be an item on the July Board agenda	TL	07/07/2016	Presentation delierved at the July Board meeting	Closed
SWBTACT.545	Integrated Performance Report	SWBTB (06/16) 029	02-Jun-16	Report on mortality data rebasing to be presented to the July Board	RST	07/07/2016	Report included on the agenda for the July meeting	Closed

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**VTE and MRSA screening update**
SPONSOR (EXECUTIVE DIRECTOR):	**Colin Ovington, Chief Nurse**
AUTHOR:	**Colin Ovington, Chief Nurse**
DATE OF MEETING:	**7th July 2016**

EXECUTIVE SUMMARY:

This paper is an update on progress in achieving VTE and MRSA assessments in the assessment units where we are re-implementing 10/10. Board members have visited the assessment units at the City hospital when they were in the early stages of re-implementing 10/10. It would be a fair assessment to say that the enthusiasm to make achievements against the objectives of the project have continued to grow; leaning events have been held at 30 and 60 days, to share progress, learn from each other on what has worked and to plan for the next way of improvement using a PDSA cycle. The 90 day event is being planned currently.

A measure of success would be the demonstration of key indicators where performance was previously weak. VTE has been the subject most discussed at the improvement events and despite real effort progress is limited. There has been a focus on the AMU's by auditing compliance, having designated 'Progress Chasers' to ensure assessments have been done and supporting the Dr's during ward and board rounds to ensure the assessments are done. A daily report is being sent to all Ward Sister's, Service Manager's and Directorate Manager's informing them of the patients who are still waiting for an assessment.

MRSA screening has seen the most significant improvement overall

VTE performance

Unit	April %	May %	June %
AMU1	93.32	94.37	93.66
AMU 2	88.85	89.38	93.14
AMU A	97.85	99.02	97.96
AMU B	63.64	72.22	60
SAU	98.44	99.36	99.83

MRSA Screening

Unit	Pre implementation %	30 to 60 day achievement %
AMU1	76.34	90.95
AMU 2	76	93.38
AMU A	77.18	89.90
AMU B	85.11	94.74
SAU	82.14	92.70

REPORT RECOMMENDATION:

The board are requested to receive the update.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Key objective - Safe High Quality Care, Safety Plan and 10/10 safety standards

PREVIOUS CONSIDERATION:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Mortality Update
SPONSOR (EXECUTIVE DIRECTOR):	Dr Roger Stedman
AUTHOR:	Dr Roger Stedman / Simon Parker
DATE OF MEETING:	29th June 2016

EXECUTIVE SUMMARY:

This paper sets out an analysis of our current position with respect to mortality statistics as reported by HSMR. The Board is requested to note the following:

1) HSMR has risen to 103 for the cumulative period April 2015 – March 2016
2) This movement is largely due to national 're-basing' of the risk adjustment model
3) The re-submission of Palliative care coded data for the same period has abated the movement
4) Our relative position to peers has moved from lowest quartile to upper middle quartile
5) There is nothing concerning about our current HSMR – we are well within statistical control limits (see the funnel plots)
6) Pneumonia diagnostic code is the single largest driver of the change in HSMR – there were fewer deaths from pneumonia in 2015/16 compared to 14/15 (338 cf. 365), however the 'expected' numbers dropped significantly further (305 for 15/16 cf. 350 for 14/15). This has driven up HSMR.
7) Despite coding methodology change for palliative care – we are still reporting below peers for palliative care activity
8) The commissioning of the new end of life hub has prompted a further change to palliative care coding with the use of System One for recording all specialist palliative care activity going forward.
9) Work is being undertaken to improve the accuracy and completeness of palliative care coding with a current underestimate of activity of approximately 50%
10) SHMI – which includes deaths up to 30 days after discharge and does not exclude palliative care deaths has remained stable
11) Crude (unadjusted) mortality rates remain unchanged and mortality reviews indicate a preventable death rate of <2% for the same period.

REPORT RECOMMENDATION:

That the Board satisfy itself of the reasons for the changes to mortality data.

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

Accept	Approve the recommendation	Discuss
	X	

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

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

Comments:

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

Position statement on Standardised Mortality Ratios for the Trust

Summary

- A rising trend in standardised mortality ratios for the Trust (Risk Adjusted Mortality Indicator (RAMI) & Hospital Standardised Mortality Ratio (HSMR)) have been reported in the Integrated Quality & Performance Report over recent months. This has also resulted in the Trust moving away from the top quartile of best performing Trusts.
- It is considered that the underreporting of when patients have received palliative care and the effects of rebasing have contributed to this change in position.
- The HSMR value for the latest 12 month cumulative period ending in March 2016 is 103.2. This is down from 107.4 for the previous 12 month cumulative period. The Trust is not identified as an outlier as this is within statistical confidence limits.
- The Trusts mortality review process which provides for a qualitative overview of the vast majority of deaths that occur in hospital and this has not seen any significant change in the percentage of deaths initially classified by reviewers as being potentially preventable.
- The SHMI value for the Trust for latest 12 month cumulative period (March 15- February 16) is 98.9 and this is also within statistical confidence intervals.

Introduction

Over recent months the Standardised Mortality Ratio values (HSMR & RAMI) reported for the Trust in the Integrated Quality & Performance Report (IPR) have shown a rising trend. The purpose of this report is to provide some further detail on the background to this increase.

Standardised Mortality Ratios

Standardised mortality ratios provide a method of comparing mortality levels in different years, or for different sub-populations in the same year, while taking account of differences in population structure. The ratio is the number of deaths observed divided the expected number, multiplied conventionally by 100. Thus if mortality levels are higher in the population being studied than would be expected, then the value will be greater than 100.

The main mortality indicators reported in the Integrated Quality & Performance Report (IPR) are identified in Table 1 below together with the source of the data.

Table 1 – Sources of data for mortality ratios reported in the Integrated Quality & Performance Report

Indicator	Provider
Risk Adjusted Mortality Index (RAMI) – 12 month cumulative	CHKS
Summary Hospital – Level Mortality Index (SHMI) -12 month cumulative	HED
Hospital Standardised Mortality Ratio (HSMR) – 12 month cumulative	HED

From May 16 there was a change in the source for reporting the 12 month cumulative Hospital Standardised Mortality Ratio (HSMR) value. The source for this value changed from CHKS to HED. The HSMR value derived from HED is also one of the preferred mortality indicators utilised by the

Regional NHS Improvement Office in their mortality indicators monitoring reports. The advantage of using the value from HED is that this is rebased monthly instead of annually. This change is considered to have contributed to the rise in the HSMR values (see Table 2 below).

Table 2- HSMR (12 month cumulative) values reported in the Integrated Quality & Performance Report.

IPR month	Provider	Month end for 12 month cumulative period	HSMR value reported in the IPR
January 16	CHKS	September 15	97.5
February 16	CHKS	October 15	98.7
March 16	CHKS	November 15	98.1
April 16	CHKS	December 15	96.7
May 16	HED	January 16	106.0
June 16	HED	February 16	107.4
July 16	HED	March 16	103.2

Source data for Standardised Mortality Ratios

The standardised mortality ratios (SMR's) are based on routinely collected administrative data or Hospital Episode Statistics (HES) where diagnoses are typically grouped according to the primary diagnoses in the first episode of care. Patients are allocated to these diagnoses baskets which may not be the same as the actual cause of death.

As SMR's are derived from HES data, they will be influenced by the depth and accuracy of clinical coding.

The 'expected' number of deaths

Although in calculating the expected number of deaths there are slight differences in the methodologies between the ratios and between the providers, in principle they all aim to place a probability of dying on each patient admitted after making adjustments for differences in risk among specific patients. In making these adjustments and in establishing a patient's risk profile, how well comorbidities are captured and also whether the patient was receiving palliative care and therefore be expected to die, will be important information.

Adjustments made for palliative care

Adjustments are made for where patients were receiving Palliative Care, but the extent of this is different across the indicators. For example under RAMI, patients coded as receiving palliative care (Z515) are excluded from the numerator, whilst for the HSMR adjustments are made for this. For SHMI values no adjustments are made for when patients receive palliative care.

The 'observed' number of deaths

The observed deaths, the numerator, will be influenced by the quality of care given, i.e. the better the care, the fewer people will die. It will be influenced by place of death .i.e. if the end of life care is

typically given in hospital, the numerator increases. Other factors such as how well a Trust manages the deteriorating, patient, sepsis and also how well it controls of infections will be significant.

There are also some differences between the SMR's in the cohort of patients included in the numerator. For example, HSMR's are based on 80% of in-hospital deaths, whereas RAMI include all deaths. SHMI values are based on both in-hospital and out of hospital deaths that occur within 30 days of discharge.

Rebasing

Mortality Ratios are rebased periodically. They are rebased due to changes seen over a period of time, including improvements in clinical practice, clinical coding and population demographics. The effect of rebasing is to reset the average 'base' value back at 100. Most commonly after rebasing a Trust's value will rise, but by how much will be influenced by a number of factors.

Mortality ratios may also be rebased at different times by their providers. CHKS rebases their RAMI and HSMR values annually, whereas HED rebase their HSMR and SHMI values monthly.

The effect of rebasing has been seen most markedly with the RAMI. CHKS released RAMI 2015 in the autumn of 2015. From May 16 the reporting was changed from using algorithms based on 2014 data (RAMI 2014) to those based on data for 2015 (RAMI 2015). This has had the effect of significantly increasing the reported RAMI values as shown in the table 3 below.

Table 3- RAMI values reported in the Integrated Quality & Performance Report

IPR month	RAMI algorithm	Month end for 12 month cumulative period	RAMI value reported in the IPR
March 16	2014	November 15	92
April 16	2014	December 15	90
May 16	2015	January 16	103
June 16	2015	February 16	103

HSMR values relative to peers

As a result of increased HSMR values the position of the Trust relative to peers has changed. The Trusts position has moved from being in the top quartile of Acute Trusts to currently showing a value that places it in the middle range.

This change relative to all other acute Trusts is illustrated when the examining data for the last 2 years financial years. Figure 1 shows the Trust's position for the rolling 12 month cumulative period ending in March 15 and Figure 2 for rolling 12 month cumulative period ending in March 16. The Trust is highlighted in green.

Figure 1 - HSMR relative to peers for the 12 month cumulative period ending March15 (source HED)

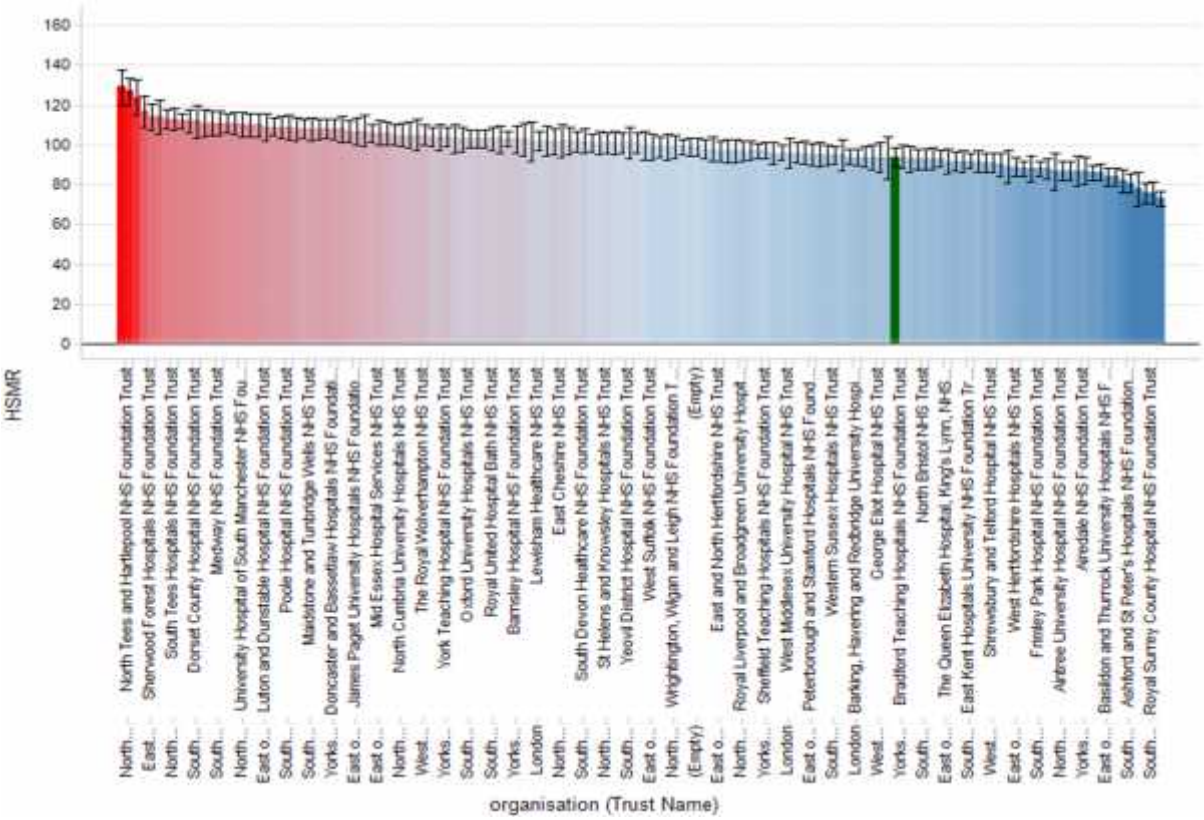
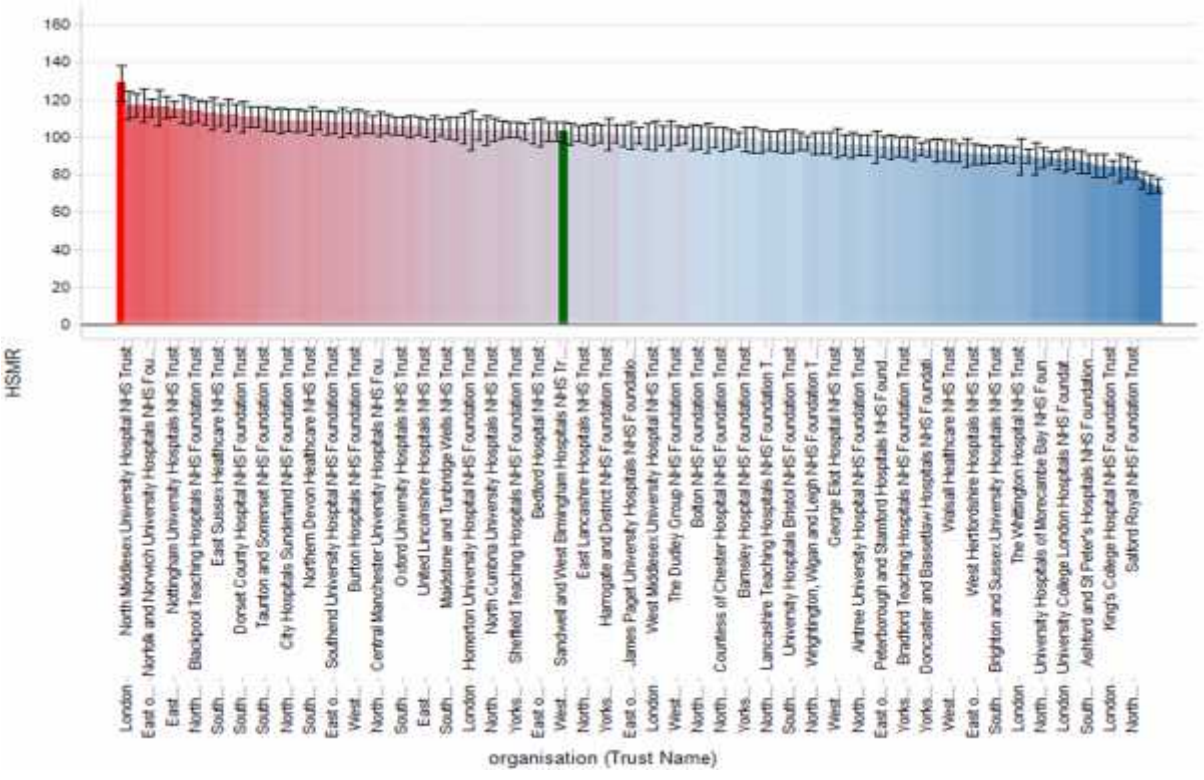
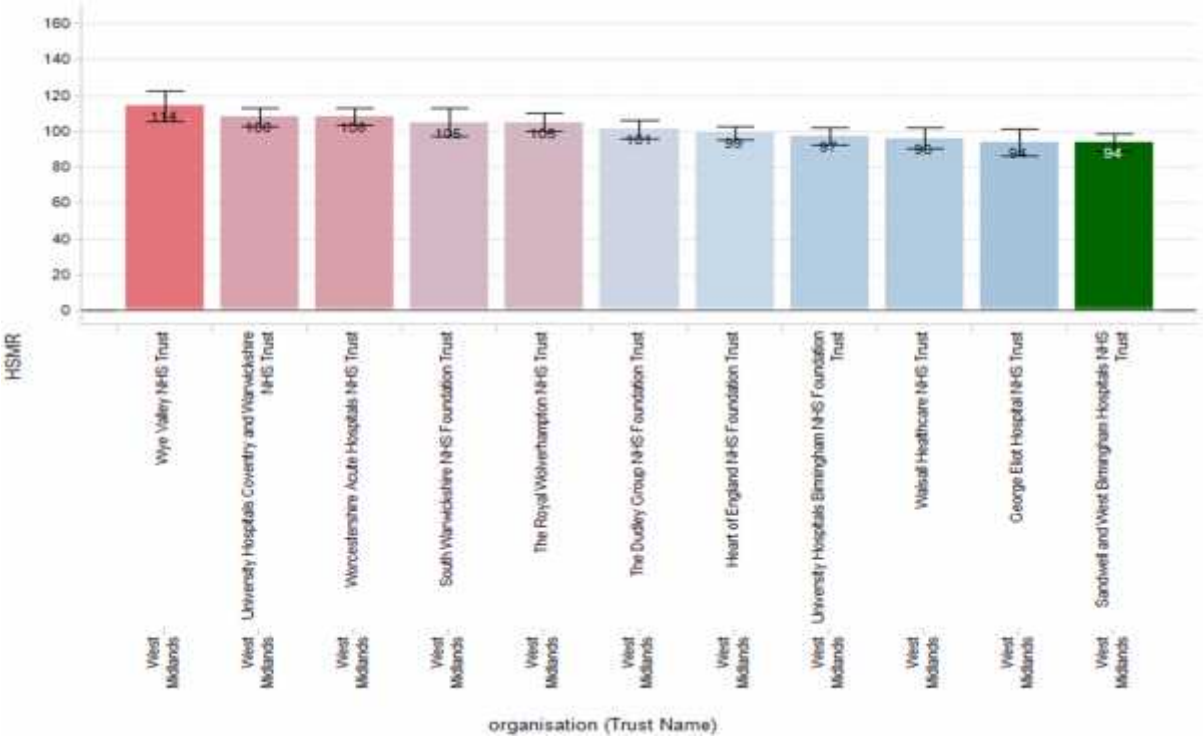


Figure 2 - HSMR relative to peers for the 12 month cumulative period ending in March 16 (source HED)



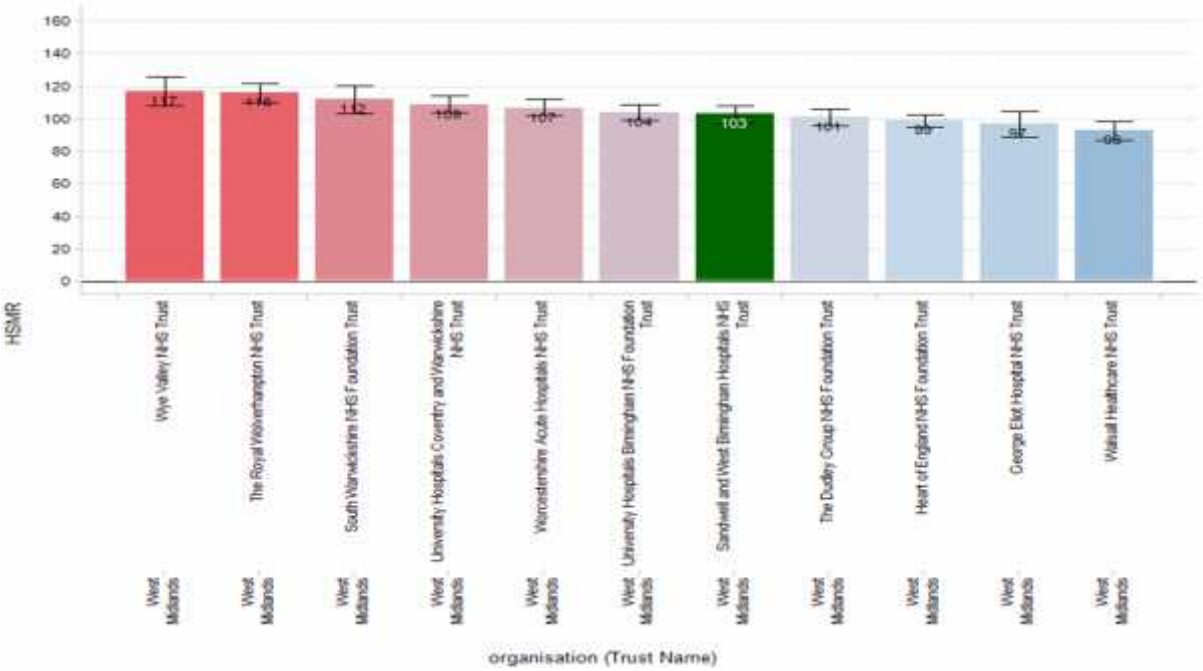
The position of the Trust in relation to peers in the West Midlands for the 12 month cumulative period ending in March 15 is shown in Figure 3 below (source HED).

Figure 3 - HSMRs for West Midland Trusts (12 month cumulative period April 14- March 15)



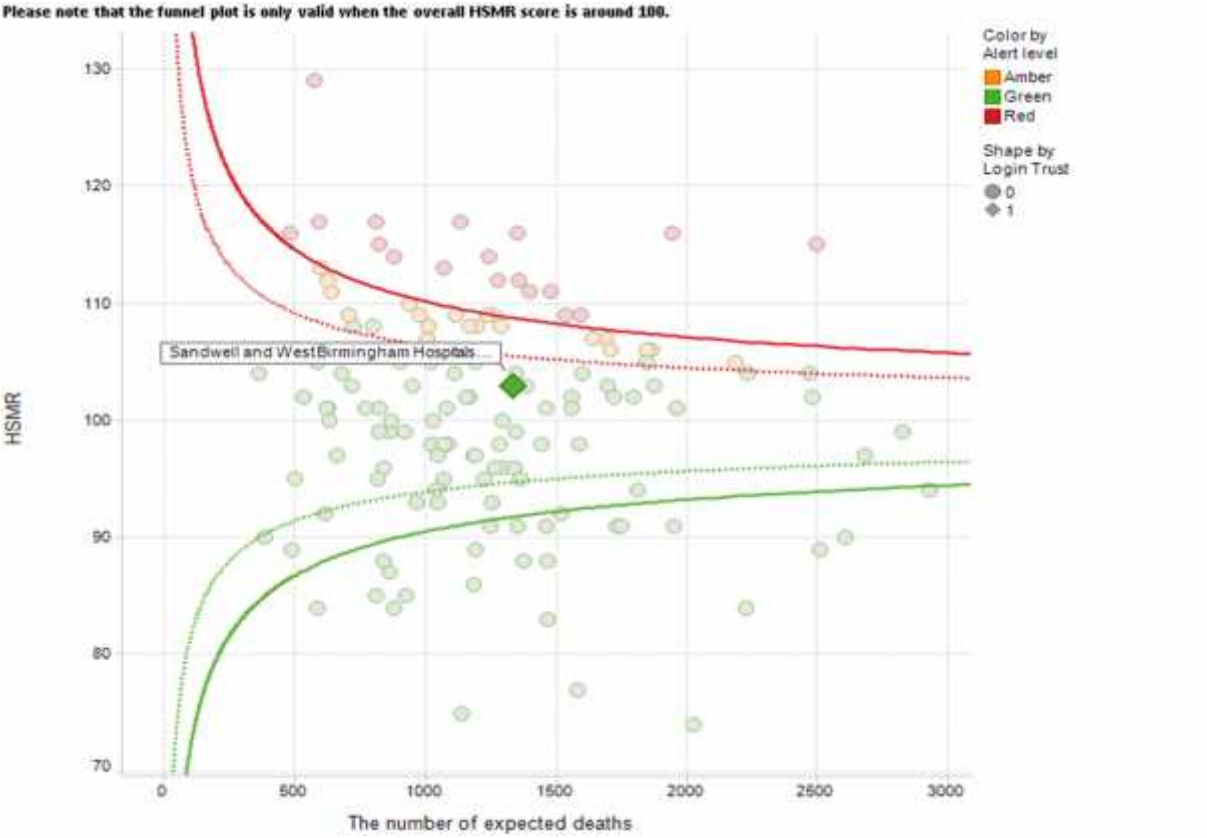
The position of the Trust in relation to peers in the West Midlands for the 12 month cumulative period ending in March 16 is shown in Figure 4 below (source HED).

Figure 4 - HSMRs for West Midland Trusts (12 month cumulative period April 15- March 16)



Although there has been a rise in the HSMR for the Trust to a value of 103 for the latest 12 month cumulative period (April 15-March 16), this value is still within statistical conference limits as shown in Figure 5 below.

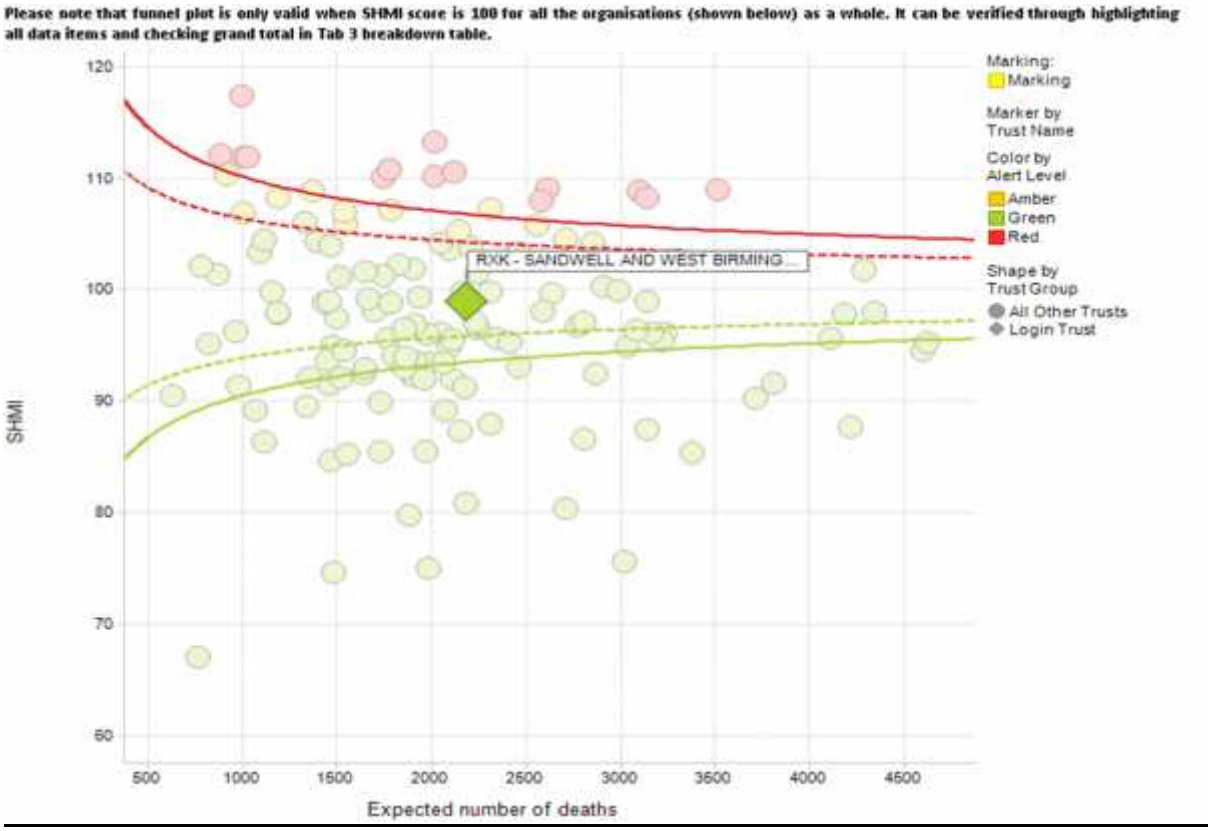
Figure 5 - Funnel plot graph showing for the HSMR values for the 12 month cumulative period ending in March 2016 (source HED).



<u>Summary Hospital Level Mortality Indicator (SHMI) values</u>

The SHMI for the latest 12 month cumulative period ending in March 2016 is shown in Figure 6 below. This shows that the value for the Trust is within statistical confidence limits.

Figure 6- Funnel plot graph for the SHMI values for the 12 month cumulative period ending in March 2016 (source HED).

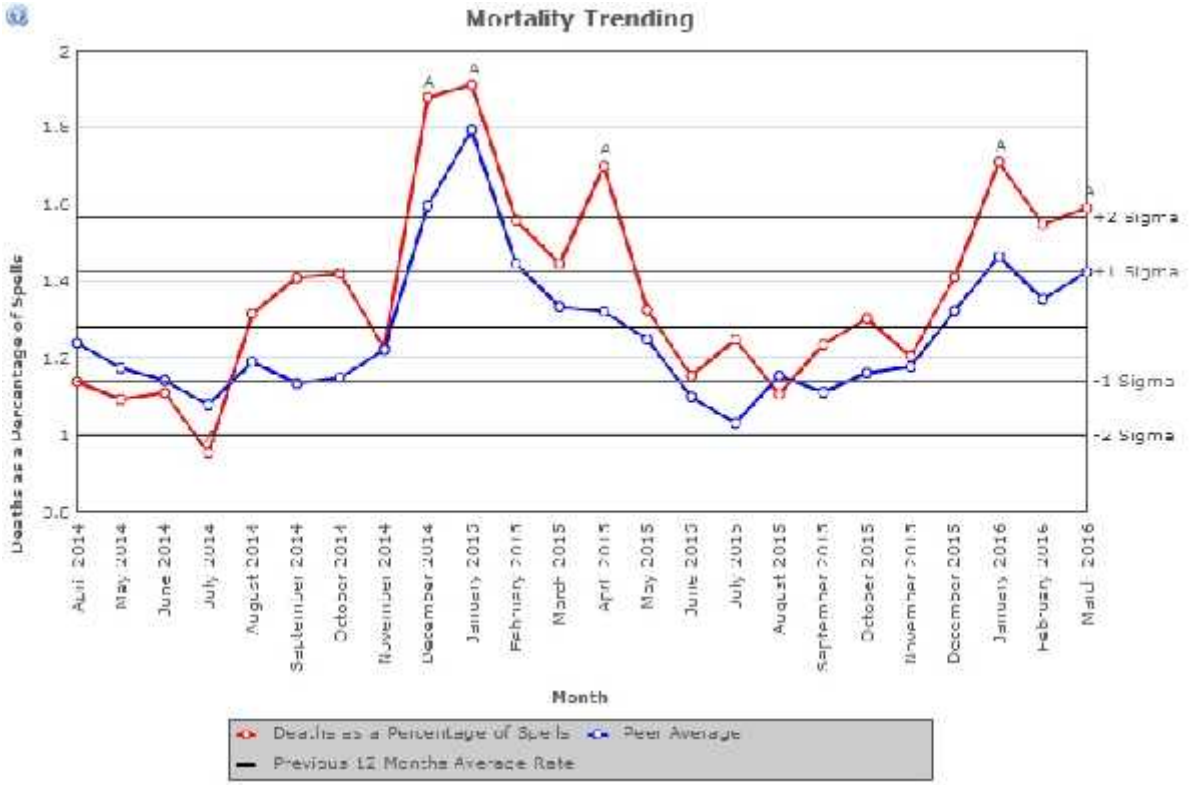


Crude mortality rates

The deaths in hospital as a percentage of hospital spells have increased slightly when data is compared for the last 2 financial years. It has increased from 1.38% in 2014/15 to 1.41% in 2015/16 and remains above the peer average. This trend is shown is shown in Figure 7 below.

For the group of diagnoses which constitute the HSMR basket which include 80% of in hospital deaths, the number of deaths as a percentage of discharges has also increased slightly from 3.58% in 2014/15 to 3.62% in 2015/16.

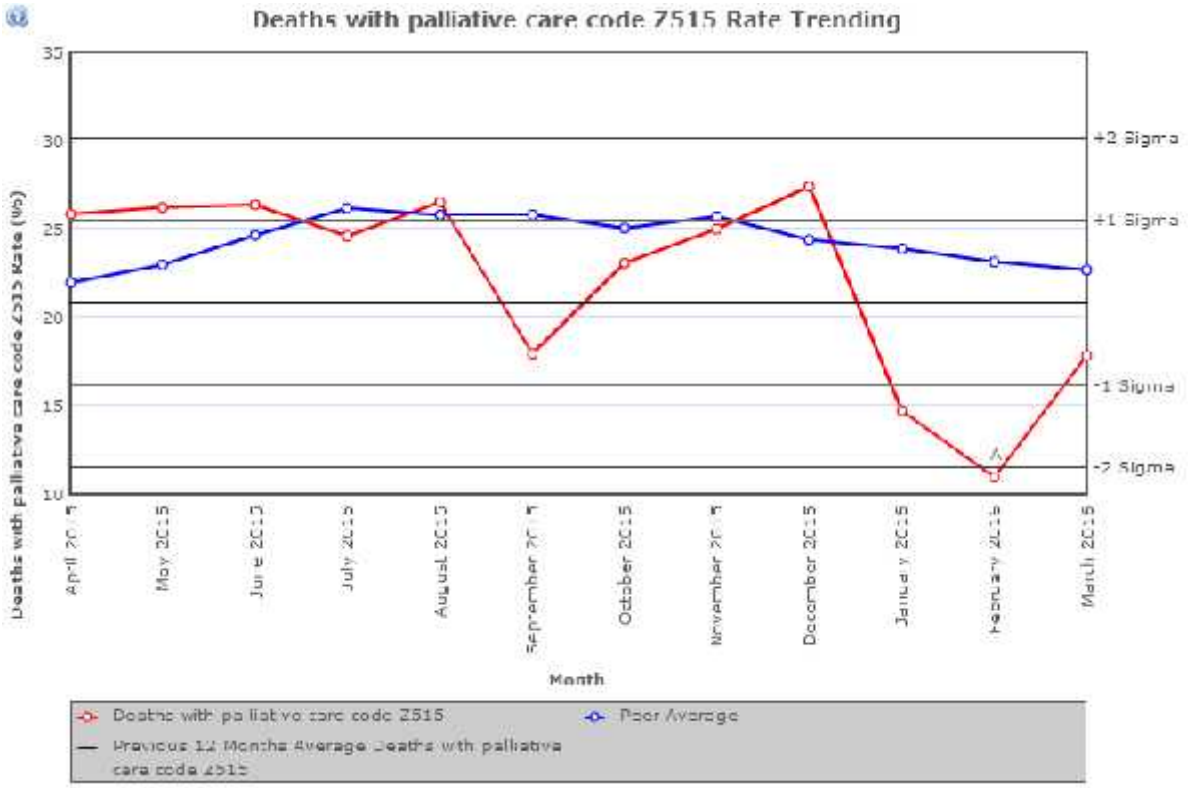
Figure 7 - Crude Mortality Rates for the period April 14 – March 2016 (source CHKS)



Palliative Care Coding

As described above, where a patient is coded as receiving palliative care (code Z515) this is taken into account when calculating the RAMI and HSMR values. A decreasing trend in the use of Z515 codes was detected in October 2015. As a result, the data for the 2015 calendar year was resubmitted in order to address this underreporting. Measures are being taken to improve the capture of palliative care coding going forward, but as Figure 8 demonstrates, so far in this calendar year it currently is below the peer average.

Figure 8 - Palliative Care coding trends (source CHKS)



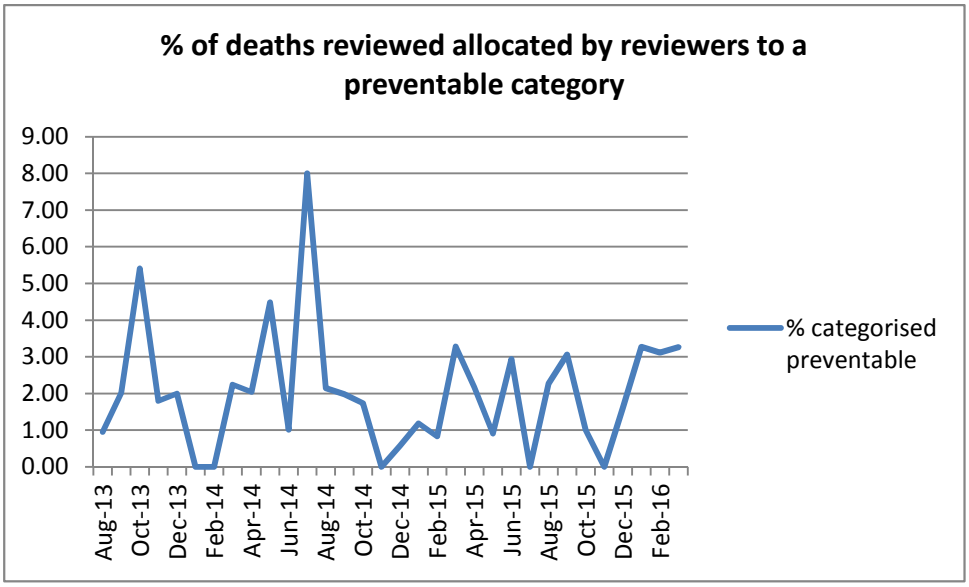
The diagnosis group in the HSMR basket in 2015/16where the observed number of deaths most exceeded those expected was pneumonia (except that caused by tuberculosis). In this period there were 338 deaths where 304 could have been expected. In the previous financial year there were 365 deaths when 350 could have been expected. The rate of death in this diagnosis group has only increased slightly from 16.01% in 2014/15 to 16.87% in 2015/16. In contrast, the percentage of palliative discharges has decreased from 5.2% in 2014/15 to 4.9% in 2015/16.

Quality of care provided in deaths spells

As indicated above, the numerator (observed number of deaths) can be influenced by the quality of care provided. To assist in the detection of any errors or deficiencies in the care processes delivered to deceased patients, the Trust's Mortality Review System (MRS) can provide some assurance**.** The mortality review system involves a qualitative overview of each death by a senior clinician and the death is then categorised as expected or unexpected and also whether the death was considered to be preventable.

Figure 8 below highlights that although there has been a change in mortality ratios and crude mortality, the rate of deaths categorise by reviewers as being preventable has not increased.

Figure 8 – Percentage of deaths reviewed categorised as preventable



Conclusion

- There has recently been a rising trend in the values for mortality indicators for the Trust (HSMR and RAMI) when examining a rolling 12 month cumulative period. For the HSMR, this has resulted in the Trust moving out of the top quartile of Trusts for this indicator.
- Although there has been an increase in the HSMR value for the Trust, this value is still within statistical confidence limits.
- The reason for the increase in the HSMR and RAMI values may be explained in part by inaccurate risk profiling of patients as there has been some underreporting by the Trust of when a patient has received palliative care.
- The rebasing of the algorithms behind the Risk Adjusted Mortality Index (RAMI) has resulted in a large increase in values when compared to the previous period.
- The mortality review process can provide some assurance that the vast majority of deaths in hospital are reviewed and any significant lessons are shared. Analysis of data from this process indicates that the percentage of deaths categorised by reviewers as preventable has not increased.

QUALITY & SAFETY COMMITTEE UPDATE	
Date of meeting	24 June 2016, 10:30-12:00
Attendees	Ms Olwen Dutton, Mr Richard Samuda, Mr Mike Hoare, Ms Rachel Barlow, Mr Colin Ovington, Mr Tony Waite, Mrs Raffaela Goodby, Ms Jacquie Whitaker, Ms Jane Clarke, Dr Trugail and Ms Helen Copeland.
Apologies	Apologies were received from Miss Kam Dhami, Dr Roger Stedman and Ms Claire Parker.
Key points of discussion relevant to the Board	The committee considered progress around children and adult safeguarding. The Domestic Abuse team was fully recruited to and a named nurse vacancy has been filled from the 1 June 2016. Additional video training material was being developed and the Trust was working with Barnardo's to deliver bespoke training. There was a positive working relationship with Sandwell Council. The focussed session concentrated on VTE and Sepsis. The Trust had made improvements in the identification of patients with sepsis and this was due, in part, to the implementation of Vital Pac an electronic observation monitoring system that alerts the user to the possibility of sepsis. There remains however issues in respect of timely recording of data. In regard to VTE there was a lot of focus within multi-disciplinary teams with further work ongoing around screening tools. In respect of quality and safety impacts of the summer consultation the committee explored the QIA process and the challenge and governance process in terms of these being signed off. This would incorporate the impacts on any particular patient group. In terms of performance issues the committee discussed progress in respect of RTT and the improvements in sickness absence rates. Other performance issues included 4 hour wait times, pressure ulcers and falls.
Positive highlights of note	The Board welcomed the positive work being undertaken to address matters of children and adult safeguarding
Matters of concern or key risks to escalate to the Board	Issues were explored in respect of the root causes of some of the serious incidents highlighted in the agenda. The workforce consultation would be a matter of ongoing consideration at a number of the Board committees and the Board itself.
Matters presented for information or noting	There were no additional items presented for information.
Decisions made	As set out above
Actions agreed	As set out above.

Ms Olwen Dutton
CHAIR OF THE QUALITY AND SAFETY COMMITTEE & VICE CHAIR OF THE BOARD
For the meeting of the Trust Board scheduled for 7 July 2016

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee

Venue Anne Gibson Committee Room, City Hospital **Date** 27 May 2016; 1030h – 1230h

Members attending:		**In attendance:**	
Ms O Dutton	Chair	Ms A Binns	Assistant Director of Governance
Mr R Samuda	Non-Exec Director	Mrs D Talbot	Deputy Chief Nurse
Mr M Hoare	Non-Exec Director		
Mr C Ovington	Chief Nurse		
Miss K Dhami	Director of Governance		
Mrs F Shorney	Group Director	**Committee support:**	
Ms J Whitaker	Business Manager	Mr D Whitehouse	Head of Corporate Governance

Minutes	**Paper Reference**
1. Apologies for absence:	**Verbal**
Apologies were received from Ms Barlow with Mrs Shorney attending on her behalf, Dr Stedman with Ms Whitaker attending on her behalf and Ms Parker.	
2. Minutes of the previous meeting	**SWBQS (05/16) 013**
The minutes of the previous meetings were agreed as a true and accurate record subject to amending references to neck of femur and the spelling error.	
3. Matters and actions arising from previous meetings	**SWBQS (05/16) 014**
The Chair welcomed Mr Hoare to his first meeting of the Quality and Safety Committee. The action tracker for the committee was noted.	
3.1 Patient Story to the Board	
Mr Ovington stated that there would be a video to the next Board. Going forward the patient stories would be linked more strongly to the post Board visits. Ms Dutton highlighted the benefits of a mixed approach in respect of patients attending in person and the video's as they facilitated different debate at the meeting.	

4. Executive Director's quality and safety update	
Mr Ovington highlighted that work was underway with AMU B which had seen an increase in falls over recent months. An investigation found fault with some of the seat alarms that were in use. He also highlighted the work that was taking place to reshape the corporate nursing team bolstering the corporate nursing development function. The moving video from the last Board meeting was being used as part of induction to reinforce the importance of Ten out of Ten.	
5. Focussed session - Safety Plan Commitment – Focussed Care	**SWBQS (05/16) 015**
Mrs Talbot introduced the item which provided an update on focussed care. Since 2014 there had been a strong focus on creating a therapeutic environment. At that stage there was not a strong foundation in terms of policies and risk assessments which had since been addressed. The Trust had participated in a national innovation project last year. The original objective was financially driven but this had shifted strongly towards developing a quality patient experience. The project positively engaged corporate functions including HR, Finance and IT. The project was very inspiring including a series of celebration events which had proved excellent in terms of CPD. Changes had been driven by a 90 day review cycle and weekly huddles. A bottom up approach was taken with innovative practice being trialled at a ward level. The policy that had been developed had been rated as a national exemplar being directly aligned to national TDA standards. In terms of outcomes these were not yet showing through significantly in the data but there was clear evidenced improvement in quality despite an increase in the complexity of cases and there had been a big shift in agency and bank expenditure. This was the first time there had been an effective structured implementation plan around the changes which made all the difference. The huddles were proving effective in sharing good practice quickly and facilitating buy in. The approach had enabled the unpicking of cultural issues quickly. Ms Dutton queried whether the approach being taken was sustainable and whether the methodology could then be used for other transformation initiatives. Mrs Talbot stated that the approach had proven effective and that sustainability was being developed through those being involved in stage 1 acting as buddies for the second phase. The intention was for changes to be in place by autumn 2016. A lot of effort had been put into ensuring rapid improvement against Ten out of Ten. Mr Ovington reiterated that that the same methodology was being applied to other key transformation activities within the Trust. The process had generated a huge degree of enthusiasm across the staff team. Ms Dutton queried the integration of John's Campaign within the process. Mrs Talbot responded stating that there was very strong alignment with the principle of partnership between family and staff in providing the best care to the patient. Beds have been purchased to enable family/ carers to stay overnight and money was being sought through the Trust Charity to buy additional therapeutic beds. Mr Ovington stated that the principles of John's Campaign had been integrated into the design of the Midland Metropolitan Hospital. Mr Samuda queried the impact the project had had on discharges. Mrs Talbot stated that as	

most patients were frail they would have an integrated discharge plan. There remained some obstacles in respect of discharge from focussed care but there was a clear plan in place to address these. Mr Ovington stated that it was about ensure effective transfer of care from specialist 1:1 care to being discharged into an environment where a different support package was needed. Mrs Shorney highlighted that it was difficult to robustly assess such patients in A&E and AMU. Proper assessment was bet undertaken in the ambulatory units. Behaviour management of those with dementia could be challenging such as patients choosing to wander about. **Action: that progress is reviewed by the committee in 6 months and through the post Board visits.**	
6 Clinical Audit Plan	**SWBQS (05/16) 016**
Miss Dhami introduced the report highlighting that a positive discussion had taken place at CLE the week previously. The whole focus of the clinical audit plan had changed to one that was very clearly focused on areas where they would make a clear difference and which aligned with the Trust's strategic objectives and CQC Improvement Plan. Further work was ongoing to identify audits with a pediatrics and adults community focus. There would continue to be local audits and there remained long list of national audits that still needed to be undertaken. The Clinical Effectiveness Committee and CLE would receive audit findings especially where these flagged issues in respect of patient safety concerns. The report included clear guidance on how audits would be conducted with the emphasis being around the impact on the patient. The focus was no longer of desktop reviews but in observing clinical practice and speaking directly to patients and staff. Mr Ovington stated that this was a clinical audit plan with teeth that would have a direct impact on improving patient care. In response to a query from Mr Hoare as to whether there was a risk of too many audits which would then risk losing their significance Mr Ovington stated that overall there were fewer audits programmed but with a clearer focus and outcome driven methodology. Ms. Dutton highlighted the value of the new plan linking to the Trust's priorities and that it should form an integral part of the Trust's assurance process around high quality and safe patient care. Ms. Binns highlighted that the plan addressed issues the Board and senior managers were talking about in terms of effective support and challenge to staff on the ground fostering a culture of continuous improvement. **Resolved: that the committee endorse the Clinical Audit Plan and the approach being taken to focus on key priorities and the CQC Improvement Plan.**	
7. Integrated Performance Report	**SWBQS (05/16) 017**
Mr Ovington introduced the IPR highlighting performance in respect of 4 hour wait times where the Trust was still performing strongly against other trusts and performance in terms of harm free care. He drew attention to an increase compared to recent months in the level of pressure ulcers. A root cause analysis was being undertaken of the reasons for the increase. Mr Hoare challenged the monitoring of the appropriate mattresses for patients. Mr Ovington responded by stating that the Trust had a range of specialised mattresses for use and that the appropriate mattress would be used dependent upon the assessment undertaken of the patient. Patients would be turned regularly and seat mattresses were also used. Every	

grade2/3 pressure ulcer was the subject of a root cause analysis. Ms Dutton highlighted the positive fall in readmissions. Mrs Shorney highlighted the intensive work that had been going on around focussed discharge planning including ensuring effective support in the home. Ms Whitaker highlighted the changes that had occurred in mortality data reporting and the rebasing of the denominator which had led to changes in the baseline figures. Ms Dutton welcomed the ongoing fall in sickness absence rates but expressed concern about theatre utilisation. Mr Ovington stated that there was work underway through the Theatre Board to address this and that feedback would be provided to the committee as appropriate. Ms Dutton also challenged progress in respect of bank and agency spend. Mr Ovington responded that overall there was a decrease in the use of agency and bank staff which would flow through the May data presented to the committee and the Board. Ms Dutton asked that a discussion take place at the Board regarding agency and bank spend by profession to understand the impact on certain groups.	
8. Meeting effectiveness	
The committee felt that it was a positive meeting and that specific issues would be picked up through discussion of 8.1 on the agenda.	
8.1. NHS Improvement observations of the Quality and Safety Committee – 22 April 2016	**SWBQS (05/16) 018**
Miss Dhami highlighted that the areas of good practice outweighed the areas for development and that it was always beneficial to receive external feedback to enable the committee to reflect on its practices. Ms Dutton suggested that the feedback was overall positive and that as a committee there it was useful to have flagged up the importance of agreeing clear actions arising from discussions.	
9. Matters to raise to the Board and Audit & Risk Management Committee	
The committee asked that there be a wider discussion about the use of bank and agency staff by professional discipline at the Board as part of the IPR.	
10. Any other business	
Mr Samuda highlighted the idea arising from the Leadership Conference in terms of nurses sharing ideas via a Facebook group and other social media. Mr Ovington stated that any means of sharing ideas and good practice was welcomed whilst retaining the importance of information governance requirements and respecting patient confidentiality.	

AUDIT AND RISK COMMITTEE	
Date of meeting	1 June 2016
Attendees	Mr R Russell, Ms O Dutton, Mr R Samuda, Miss K Dhami, Mr T Waite, Mr T Reardon, Mr C Higgins, Mr A Bostock, Mr R Childow, Mr A Hussain and Mr D Whitehouse.
Key points of discussion relevant to the Board	In reviewing the 2015/ 16 annual accounts the committee were satisfied that all key financial targets had been met with the Trust being given an unqualified audit opinion. The auditors had provided a clean opinion on the use of resources and were overall satisfied with the balanced position the Trust were in. Clarity was sought by the committee in respect of the capitalisation of staff salaries as described in the external audit report and in ensuring that the Right Care Right Here funding would be consistently reflected in the audit opinion going forward providing external assurance.
Positive highlights of note	The committee wished to put on record it's thanks to the Finance Team for the work put in to pulling the accounts together early and for the constructive working relationship between the team and auditors. The auditors commented on having received the draft accounts prior to the deadline and the ongoing improvement in quality of the accounts.
Matters of concern or key risks to escalate to the Board	There were no specific matters of concern or key risk that the committee wished to escalate to the Board. The committee recommends to the Board the adoption of the Trust's Annual Accounts.
Matters presented for information or noting	There were no additional items presented.
Decisions made	The Committee approved the accounts recommending adoption by the Board. In doing so the committee: 1. reviewed the draft Letter of Representation challenging and confirming its contents and satisfying itself that: a) the application of a general hospital approach by the trust's professional valuer in arriving at his MEA valuation was an appropriate representation of the existing service potential of current land and buildings b) There were no significant events occurring between 31.03.16 and 02.06.16 which were material to the financial statements as presented c) All relevant related parties are disclosed in the financial statements d) The proposed representations are fair & complete
Actions agreed	The membership and scheduling of the Audit and Risk Committee would be reviewed prior to the next meeting.

Robin Russell
NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT AND RISK COMMITTEE
For the meeting of the Trust Board scheduled for 2 June 2016

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MPA COMMITTEE UPDATE	
Date of meeting	24 June 2016
Attendees	Mr Richard Samuda, Mr Mike Hoare, Mr Toby Lewis, Mr Tony Waite, Ms Rachel Barlow, Mrs Raffaela Goodby, Mr Alan Kenny, Mr Mark Reynolds and Mr Duncan Whitehouse.
Apologies	All members were in attendance.
Key points of discussion relevant to the Board	An update was provided on progress in Q1 and the key deliverables for Q2 in terms of the Midland Metropolitan Hospital, Sandwell Treatment Centre and the MES. The committee had a detailed discussion regarding interdependencies across the schemes. Two issues discussed were the closure of the switchboard and telecoms rooms and the reduction in Medical Records capability. In terms of the switchboard and telecoms room consideration was being given to re-routing and additional hardware which whilst incurring additional costs may yield benefits in terms of the timetable being brought forward. Decisions would impact upon the timing of the availability of surplus land at the City site. In terms of Medical Records the programme would significantly reduce the requirement for paper records. One of the key issues around timetabling would then be in respect of timescales being aligned in terms of the Trust's workforce consultation process. An update was provided on the workforce timescales and the four transformational themes of clear employee voice; attracting developing and retaining the best 2020 workforce and beyond and leadership at every level coaching and stretching and leading and managing performance, reward and challenge. Delegated thresholds would be revised to ensure ongoing timely and effective decision making.
Positive highlights of note	As set out above.
Matters of concern or key risks to escalate to the Board	Further progress was needed in terms of detailed alignment of the schemes. Focussed work would take place over the coming weeks to more effectively define the 2017-18/ 2018-19 plans. The timetabling of EPR and the workforce consultation had been mapped to ensure they were not in conflict with each other.
Matters presented for information or noting	There were no additional items presented for information to the meeting.
Decisions made	The committee endorsed the direction of travel as set out in the papers whilst wanting further assurances in terms of the alignment of the schemes to enable interdependencies to be flagged and risks mitigated.
Actions agreed	There would be full alignment of the three schemes (Workforce, Digital and Estates) by the time of the August Board meeting.

Richard Samuda
CHAIRMAN AND CHAIR OF THE MPA COMMITTEE

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MPA Committee - Minutes

Venue D29 Meeting Room, City Hospital **Date** 30 March 2016, 10:30am – 14:00

Members Present:		**In Attendance:**	
Mr Richard Samuda	Chair	Mr Martin Evans	Deputy Director - Systems
Mr Mike Hoare	Non-Executive Director		
Mr Toby Lewis	Chief Executive		
Ms Rachel Barlow	Chief Operating Officer		
Mr Tony Waite	Director of Finance and Performance Management		
Mrs Raffaela Goodby	Director of Organisation Development		
Alan Kenny	Director of Estates and New Hospital	**Committee Support:**	
Mr Mark Reynolds	Chief Informatics Officer	Mr Duncan Whitehouse	Head of Corporate Governance

Minutes	**Paper Reference**
1. Apologies	**Verbal**
All members of the committee were in attendance.	
2. Minutes of the previous meetings – 17 November 2015	**SWBCC (01/16) 080**
The minutes of the former Configuration Committee meeting held on the 22 January 2016 were accepted as a true and correct record of the meeting.	
Matters arising from previous meeting	**SWBCC (01/16) 082**
The actions arising from the previous Configuration Committee had been captured in the reports included on the agenda for this meeting in particular the key deliverables Q1 – 16/ 17 paper. It was agreed the dates of future meetings be forwarded to the other Non-Executive Directors (NEDS) so they were in the diary but that individual confirmations would be sent when items were of specific interest to a particular NED who was not a member of the committee.	

3. Capital Development Control Plan (CDCP)	**SWBCC (01/16) 082**
Mr Kenny introduced the paper stating that the plan had been devised to provide the committee with a concise update on programme milestone delivery dates and critical interdependencies which until now had not been mapped in one place. The CPCP provided the minimum information needed for the committee and included Gantt charts for each scheme consistent with key milestones. These would be updated and tracked monthly. Mr Waite added that the CDCP provided a detailed summary of each scheme and provided an early warning mechanism around key interdependencies and would highlight where expenditure was being channelled and importantly where progress was on or off track in respect of the overall programme. In response to a challenge from Mr Samuda as to whether all critical interdependencies had been identified Mr Kenny responded by stating that not all had been completely scoped. The work he and Mark Reynolds were doing provided a level of understanding around IT interdependencies which the Trust was not sighted on previously. The Finance and Investment Committee also retained an important role as it was responsible for oversight of the Capital Programme. Mr Reynolds highlighted two categories of interdependencies which were timings and phasing to ensure all interdependencies were adequately mapped and mitigated. He used the example of the potential sale of land and the subsequent need to move data centres and switchboard facilities. Mr Lewis highlighted the previous history of poor engagement and communication between IT and Estates and that the MPA Committee provided an open forum to debate progress and identify ongoing obstacles and importantly the actions needed to overcome these. He queried the timescales set out in the paper stating that the STC changes marked for 2020 and the CPU changes in March 2017 could not be correct. Mr Kenny responded by saying that more work was needed to rationalise the timescales across the programme. Ms Barlow also stressed the importance of clinical and operational engagement to ensure effective leadership of any potential interdependencies. Executive leads needed to be at Director level. Mr Hoare highlighted the need to mark as completed progress against each of the projects as they progressed with the RAG rating also indicating a direction of travel. He also felt that the committee needed to be very clear as to how projects would be promoted into the programme and signed off and moved out of the programme. Mr Lewis reiterated the need for the committee to retain oversight of the full 4 year programme and not focus just on the next one or two quarters. There had been numerous occasions where programmes had started late or had drifted and it was important given the interdependencies that the committee had clear line of sight of progress over the whole programme. Whilst technically everything within the Capital Programme was in the scope of the committee the focus needed to be retained around the big ticket items for Estates, IT and workforce transformation. Mr Waite opened up the conversation by asking how best to structure the conversation around status, risk	

and mitigation points for each of the projects and that this would shape the paperwork that the committee needed to consider. The workforce transformation project would be included in greater detail in future iterations of the report. Mr Lewis stated that the milestones needed to be reviewed to ensure accurate dates were included with the preference to a standard form of reporting for each of the programmes. In terms of the interdependencies then consideration would be given to how these would be best presented. He highlighted the need for precision and pace to take forward these matters as there was only a short window to ensure progress was being made. The Board also needed to be explicit about what constituted sign off and assurance of delivery which would be discussed further by the Executive.	
Actions: • **That the report continued to evolve and include additional workforce information in its next iteration.**	
4. Addressing space and funding gaps in Midland Metropolitan Hospital business case	**SWBCC (01/16) 083** **SWBCC (01/16)083a**
Mr Kenny advised the committee that in December 2015 a review was undertaken to confirm the floor areas of three of the major projects being progressed by the Trust, these being: ▪ Midland Metropolitan Hospital ▪ Planned estate to be retained at City Hospital ▪ Planned estate to be retained for the Sandwell (STC) Development The review identified that an additional floor area of 26,500m² was planned to be provided over and above what was reflected in the Trust's LTFM. The additional floor area was primarily associated with the Sandwell (STC) development. This created a potential operating cost pressure for the Trust estimated at £4m. It was recognised that £1.2m of the £4m was attributable to a revised assessment of PDC dividend costs associated with increased retained estate. It was accepted that a plausible route to mitigating this impact was provided by reconsidering the prudent use of DV valuation and asset revaluation method options. The Estates Department considered a series of options/measures which could reasonably be implemented to remove the residual funding gap of £2.8m. These options/measures included: 1. Forecast utilities costs associated with MMH were reviewed against current market costs /procurement practices. This identified the scope for savings of **£1,015,000**. **2.** A similar exercise was undertaken considering the retained estate associated with the City Hospital and Sandwell STC sites. This identified the scope for savings of **£659,000.**	

3. An option whereby Carillion purchase utilities and recover VAT rather than the Trust identified the scope for savings of **£303,000**. 4. Plans for the 2nd floor of Sandwell STC are designated as future expansion space. The floor area is circa 2000m². It is assumed that any business case to bring the 2nd floor into operational use would incur the associated operating costs which are estimated at **£161,000**. 5. An Estates Rationalisation exercise of the Sandwell STC site which targeted standalone/peripheral buildings has been undertaken. This identified the scope to reduce the floor area of the estate by 6,222m² providing a benefit of **£502,000.** 6. The current plan is for the 9th floor of MMH to remain as a shelled ward. Estimated operating costs of **£70,000** would be avoided, until the floor is fitted out and occupied. It is assumed that any business case to bring the 9th floor into use would incur the estimated operating costs. 7. The relocation of the Audiology Department on the City Hospital site, potentially into the BTC could release **£25,000** of utilities and maintenance costs. 8. A review of soft FM services/costs to be undertaken to identify the balance of £65,000. Where "Utilities" costs have been identified this included gas, electricity, water and uniform business rates. Other options considered but not currently proposed included: • Use the benefit associated with the reduction in the Unitary Payment associated with MMH secured at Financial Close. Appendix 1 of the report set out the impact in terms of the additional costs of the retained estate and provided an audit trail as to how this variance would be mitigated. Mr Lewis commented that whilst it was unfortunate that the gap in floor space had been found late in the day, once identified, the issue was quantified and the financial gap closed. He and the Board would seek further assurances that there were no other issues that may surface of the same magnitude.	
5. Midland Metropolitan Hospital. – close down arrangements following procurement phase.	**Verbal**
Mr Kenny introduced the item which set out a clear position statement in respect of the closedown arrangements leading to the contract signing of the procurement phase. The report set out progress against the conditions attached to the approval letter and the key issues that required further work after contracts had been signed as well as changes to the project team and advisors. Mr Robin Russell was to be the nominated observer for the Board meetings of the MMH Project Company with his observer status having been approved by the Department of Health. Performance was being monitored through regular operational meetings. Carillion took on sole responsibility for the Grove Lane site from the 4 January 2016. Highways scheme specifications had been drawn up and costed and the Trust was progressing agreements with utility suppliers. There were also some changes to advisors for the project with the intention to move to Capsticks delivering legal advice rather than	

Pinsents. This was because Capsticks could provide a fresh perspective on the agreements made and signed during previous phases of the project.	
6. Midland Met: Key deliverables Q1-16/ 17	
Mr Kenny introduced the paper which set out progress and key deliverables for Q1. The Liaison Committee would meet quarterly and included Mr Samuda, Mr Lewis, and Mr Kenny. The MES contract was with the TDA with a recommendation through to its Investment Committee for approval. Were this to be agreed then work would start in May and was already underway in terms of procurement. The Arts Strategy was in hand as was consultation with transport providers. A Master Plan was being developed for the City Hospital site to progress surplus land with the intention that an application be submitted by July for conclusion in December. In regard to delegated thresholds Mr Kenny stated that control totals of £2m had been set for MMH on a cumulative basis. All projects had pre tender estimates against them with 5% contingency set aside. Where projects were underspent then these should be assigned to projects within the same category with Mr Lewis having the ability to flex ring fenced contingencies which would then be reported to the Finance and Investment Committee and the Trust Board as appropriate. Mr Lewis stated that the Capital Programme had well defined delegated arrangements which stood. There would be a need to consider revenue variations in respect of the unitary payment. He requested a report back to the next meeting of the committee in terms of revenue delegations. He considered it sensible to agree a maximum limit with the ability to differentiate judgements across schemes. Ms Barlow also highlighted the need to link in the new Deputy Chief Operating Officer thorough the proposed meeting structures.	
Action: a further report on delegated thresholds to be brought to the next meeting of the committee.	
7. Workforce transformation	
Mrs Goodby provided a verbal update on the progress of the workforce transformation project. The Easter consultation phase would start the following week with a focus on corporate roles which would be a precursor to the wider consultation that would take place over the summer. In response to a question from Mr Samuda Mrs Goodby stated that there was still more work to do around pathways, workflows and different ways of working across the whole of the Trust.	
8. EPR Programme	
Mr Reynolds introduced the report stating that, subject to approval by the Trust Board on the 7 April, Cerner had been recommended as preferred bidder based on the qualitative aspects of the submissions. There would now be a 3 month approval process through the TDA during which time work was ongoing to agree an implementation plan and work up further detail of the future state transformation.	

Mr Samuda sought assurances around timescales given the changes in structures and personnel nationally over the coming months. Mr Reynolds stated that TDA would be reviewing the numbers over the coming week and HCIC would undertake a review of the scheme. Mr Lewis stressed the importance on engaging partners as the timescales become more complicated should the Trust submit an annual plan with a deficit figure which may prompt challenge back from national bodies. Pre contract mobilisation hence needed to commence quickly. Mr Waite highlighted that it was in the Trust's gift to appoint a preferred bidder but that in doing so it was important to be explicit in the level of costs incurred during the pre-contract period and to account for these appropriately. Mr Lewis highlighted the need to agree as a Board the sum that was at risk if the contract was to fall through. The Board additionally needed to be explicit in articulating what good looked like. Mr Samuda stressed the need for effective communication across the organisation with staff receiving a clear message that reinforced the Trust's direction of travel. Mr Lewis agreed, highlighting the need to work through the different audiences and to tailor the communication messages accordingly.	
9. Meeting effectiveness	
It was agreed that the first meeting of the new committee had been effective.	
10. Matters to raise to the Board and Audit and Risk Management Committee	
The EPR Programme would be discussed at the next Board meeting	
11. Any other business	
There were no other items of business discussed	
12 Date of next meeting	
The next meeting would be held on the 24 June 2016 from 08:30-10:00 at the Anne Gibson Committee Room, City Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

WORKFORCE & OD COMMITTEE	
Date of meeting	27 June 2016
Attendees	Mr Harjinder Kang, Mr Richard Samuda, Dr Paramjit Gill, Mr Toby Lewis, Ms Rachel Barlow, Mrs Raffaela Goodby, Mr Colin Ovington and Mr Duncan Whitehouse.
Apologies	All members were in attendance.
Key points of discussion relevant to the Board	The committee devoted the whole meeting to challenging the proposals in respect of the summer workforce consultation. The Quality and Safety Committee would separately be working through the quality and safety impacts of the scheme. There remained a £9m gap that still needed to be bridged with the shortfall largely falling in 2017-18. Work was underway to ensure no duplication of schemes. There was also work underway to ensure schemes were not being put forward which risked the quality of patient care suffering. The timeframe for the consultation was considered. It was essential that there was clear alignment with schemes and that the overall ask would be delivered through the consultation. The decision to go out to consultation would be led by those assurances being in place.
Positive highlights of note	Detailed challenge of the proposals was necessary to ensure scheme alignment and delivery without impacting upon patient safety or the quality of care.
Matters of concern or key risks to escalate to the Board	There needed to be absolute clarity at the Board in terms of the sign off process and governance around delivering the full requirements of the consultation.
Matters presented for information or noting	There were no additional items presented for information to the meeting.
Decisions made	The committee endorsed the direction of travel as set out in the papers having worked through them in detail but there remained questions about delivery against the full financial target and hence the timing of implementation.
Actions agreed	Further work would be undertaken to address the matters raised.

Richard Samuda
CHAIRMAN AND CHAIR OF THE MPA COMMITTEE
For the meeting of the Trust Board scheduled for 7 July 2016

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE TRUST BOARD HELD IN PUBLIC

Chief Executive's Report –July 2016

I am proud to be able to report continued success in the work of Trust staff being recognised for its excellence. It has long been our view that there is some outstanding care and innovation being delivered at the Trust and that we need to be bolder in celebrating that work: Two Trust services (cardiology and diabetes) have been nominated for national patient safety awards in the latest HSJ ceremony, and three services, including FINCH, have earned shortlisting in the Nursing Times awards. The Trust's ground-breaking Live:Work scheme delivering employment to young people at risk of homelessness won national acclaim to set alongside the regional awards won earlier in 2016 from HEWM. Meanwhile, we have awarded our first internal monthly staff award, and are now shortlisting for our annual awards ceremony which takes place in October.

Our annual general meeting provided an opportunity of course to scrutinise our work and future plans. This year it showcased our work on Research and Development, with 2015-16 being our best ever year for trial recruitment. It also complemented our recent appearances on BBC Midlands Today around the remarkable Endo-barrier service. This work, done at the Trust, in Glasgow and in south London, shows extraordinary impact on obesity in diabetics patients, thereby helping them to manage their diabetes and their wider life. I am hopeful of confirmation soon of commissioners' long term funding for this programme, which carries a single item cost for the barrier but clearly prevents other costs to UK plc on a much greater scale. As the NHS submits Sustainability and Transformation Plans designed to create long term service and financial balance it is important that these innovations which yield such gain have equal or bigger place against dramatic reorganisations of care provision which do not fundamentally change demand or need.

Since the Board met last, we have agreed our financial Control Total for 2016-2017 with NHS Improvement. This moves us away from the deficit budget plan submitted previously. With transformation funding confirmed for the next twelve months, we are seeking to achieve a surplus of £6.6m, which will be reinvested immediately in patient care. This programme depends on us achieving our cost improvement plans for the year ahead, including the major workforce changes which form part of the Board's papers again this month.

During June, we have faced significant business continuity issues associated with flooding. The response from staff and partners has been quite outstanding. There was a modest service impact, as we faced damage in AMU at City, the basement space at Sandwell, and then in BMEC. Remedial work is ongoing and should be completed by July. We continue to discuss with local authority partners and others drainage on nearby roads which contributed both to our position and that of neighbouring homes.

1. **Our patients**

We have a long-term commitment to discuss the safety and quality of our care in public. One of the reasons we believe that local residents should have confidence in our care is that openness and candour. During the month of June, Colin Ovington, our Chief Nurse, and I met with some patients and their carers whose poor care was reflected in the Sandwell Health-watch report which was published some months ago (reflecting experiences in summer 2015). We will keep in touch with those we met as remedy the issues that they raised, where those issues have not already been addressed. The principal ward described in parts of the report was closed by the Trust in September 2015 after our own surveillance systems identified issues which had to be addressed.

Two Never Events will feature in our discussion, with one discussed in detail. We know the actions we have taken over time to address the varied issues arising, but we have to ensure that our theatres, and our obstetric theatres, are environments that operate with consistency and care. There will clearly be further actions arising from the Board's discussions. In neither case has our patient come to harm. We also discuss the initial review report from the Trust's review of three deaths within our maternity unit over the prior six months. The review is clear that there is no pattern or common cause, but that, as we aim to improve services towards excellence, there is more to do. By using the expertise in our own teams, and involving those from outside, we are determined to address the issues identified for further work.

During 2015-16 and again in our annual plan for this year, we have committed to trying to reduce caseloads and improve productivity among community based staff. The Board will recall a commitment to major changes in throughput in district nursing services planned for the first quarter of this year. We have met our 18% increase in volume through both the introduction of clearer case management arrangements at a staff member level and through introducing community based clinics for some prior home-based services. This switch has been developed after extensive patient consultation and will be subject to ongoing evaluation. At a time when many of our future plans depend on our ability to increase safely the volume of work we do with similar staffing, it is encouraging to see this success. All of our community based services at the Trust are rated good or outstanding, and it will be important to ensure that, as new care models are developed and evaluated, change does not lose the success that we are seeing in Sandwell.

We are confident of meeting cancer waiting time targets for April, May and June, taken together as a quarter. This remains a distinctive position as against some peers. However, we did fail the 62-day standard in May. We can discuss that within our Integrated Performance Report summary. And the Board receives an update this month on our 10 point action plan around cancer services, with internal stress-testing of our Peer Review position having just been completed by the Chief Operating Officer and Medical Director. Discussions continue with NHS England and provider partners around oncology, and services have not been affected nor changed as we move into July.

Frustratingly we continue to fall short of our contracted 92.5% standard for the 4 hour wait in emergency care. Whilst the position in Q1 2016-17 was better than Q4 2015-16, it falls short of each quarter in 2015. This reflects continued rises in demand. There is an overall rise, and then a notable (5%) rise in A&E specific demand at Sandwell. We know that, on that site, our delivery of the standard is directly related in bed flow, and we continue to operate with more beds open than we had expected. I am presenting to the Board work on our bed stock and the journey towards Midland Met. The System Resilience Group for the area needs to work with us to ensure that all parts of the

system are succeeding in meeting the quantity of care needed. Meanwhile, our wider Black Country STP is exploring how we enlarge and sustain the care home sector over the next five years.

2. Our workforce

Sickness absence in the Trust continues to fall. We fell by 0.5% in May compared to April, maintaining trend, and un-validated data for June shows that we are at 3.8% - another fall of 0.5%. This reflects work undertaken over the prior 12 months, but in particular detailed work on long term sickness absence. At the same time, we continue to enhance our staff wellbeing offer, and have just completed staff consultation on enhancements to our well-regarded psychological wellbeing arrangements. The success is grounded in changed behaviours by line managers, which, as we build strong delivery of the basics of good people management, has the potential to drive improvements in other areas such as appraisal and mandatory training. As at the time of writing 9 employees face conduct investigations for failing to heed requests to undertake an appraisal. Although regrettable, this does not underscore our determination to ensure that there are consequences to non-compliance. For professional registration, appraisal, and core training, it is the individual employee who is accountable for ensuring that they are up to date as a condition of working with us.

National policy requires us to recruit a Freedom to Speak Up guardian. We decided to recruit 8 in line with our structure, and to create peer support among that important team. Recruitment has been completed, and with a very strong field, we have made 10 appointments. Over the summer these roles will be introduced, inducted, supported and trained. The new 'service' will be live as we move into autumn, alongside other systems like our whistleblowing model and our work with trade unions. What was encouraging about the applications was that we had a field who understood the need for these roles and accepted the intent of the Trust's leadership to make sure that our culture is open and transparent in addressing issues and grievances. The process for recruiting to the distinct Doctors' Hours Guardian is ongoing. Meanwhile, we are strengthening our medical leadership structure this summer by recruiting to our new 'senior resident' role – a doctor in training who is in a part time seconded leadership role.

Rightly the next two months will see considerable focus on our workforce consultation changes. These, subject to consultation and therefore adaptation, will see changes from October 2016 through to summer 2017. Alongside these changes, we are adapting our job planning model for medical staff to ensure that we are both remunerating staff for the considerable scale and quality of work that they do, and ensuring that that work is focused on what we consider the most important activities we need. We expect to sharpen our focus on both clinical leadership and research. From April 2017 we will be beginning to adapt our out of hours rotas to the model we envisage for Midland Met in 2018, and standing down some historic arrangements in some specialties. Although these changes are quality driven, it is important to be explicit that, just as we have made senior management changes, no part of our organisation, nor role within the Trust, is not involved in the workforce and service transformation our Trust is undertaking. We agreed at the Board's workforce committee that time would be made available over the summer by non-executive colleagues to hear concerns or issues raised by staff as we go through consultation. This, alongside other measures, will ensure that the Board is fully informed of risks and mitigations as we review the outcome of statutory consultation in early September.

The EU membership referendum has understandably been the focus of local and national attention. I can confirm that continued review of European Investment Bank investments around Midland Met suggests no risk of cancellation associated with Brexit. At the same time, we have been active in seeking to reassure staff drawn from across Europe about their value and rights in the current climate. Earlier in 2016 the Board agreed a specific Mutual Tolerance and Respect guidance campaign which we have restated in recent days.

3. Our partners

A great deal of activity in the reported period has focused on the STP plan. The Trust has contributed actively to that work, in an effort to help create long term solutions. It will be important that those solutions are evidenced, and that proceed determinedly but without rush to make change happen. As an integrated care provider the Trust is well placed to work to prevent use of hospital care where an alternative option may be best. The STP process is also the mechanism by which the additional funds granted to the NHS by HMG will be distributed in coming years.

We are seeing publicity now associated with Connected Palliative Care service we began in April 2016. Although the Trust is the lead provider for that work, it is a genuine partnership, working alongside the third sector. The hub service provides a 7-day single point of access for stakeholders and patients. This is a long-term contract for the Trust, five years, with a two-year option extension. The emphasis of our work is on improving the client experience, choice around place of death, and supporting more people in their own home. Part of that improvement will be changes in day hospice services, which are likely to be subject to statutory engagement or consultation over the summer months. We are clear in our view that the stand-alone Bradbury Day Hospice is not the right solution for the years ahead.

4. Our regulators

We have had limited contact with regulators over the last month. As part of work on ambulance service provision, the CQC did visit our innovative ambulance assessment unit at Sandwell.

5. Other matters

Appended to this report is the latest update on equality and diversity, as well as our recruitment trajectory for hard to fill posts. I reported last month we are already behind trajectory in offers made. I am concerned that at band 5 nursing level we are simply not making sufficient offers to applicants. Over the next two months, I will review with the director of organisation development and with the Chief Nurse how we are approaching this work and what further changes need to made to attract applicants and proceed rapidly to appoint.

Toby Lewis

Chief Executive

July 1 2016

FOR INFORMATION

Annex 1

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE NURSE STAFFING UPDATE

Report to Trust Board on 7th July 2016

1 EXECUTIVE SUMMARY

1.1 This report is an update on nurse staffing data collected for May 2016.

2 MAY DATA UPDATE

The national data collection from May has changed and now has an additional data set on Care Hours per Patient Day (CHPPD. There is not yet any benchmark information about how this data sits across the NHS or within the nature of how one ward is staffed to another. Going forward I will work with the data over the next three months to see how it can best be used to help us understand and manage nurse staffing. The demand for additional staff on areas where there additional beds are in operation continues to be the case during May, although the numbers of beds was reducing. We have continued to ensure additional wards have some of our permanent staff on duty to provide shift leadership and continuity. The average fill rates across the trust for registered nurses which includes permanent, bank and agency staff for day shifts is 96.8% and for night shifts is 98.1% which is slightly better than the previous month. For support staff the day time fill rate is 97.9% and the night time fill rate is 99%.

Our community beds have an on-going problem in recruiting staff to vacancies as reported in previous months which is leading to risks on being able to fill every shift adequately with agency staff not turning up for shifts that are booked with them. This has culminated in the need to reduce the available bed stock on McCarthy Ward during June. Additional effort with recruitment using alternative media is underway. I will give an account on progress in this area in next month's report.

Over the last few reports the children's wards have shown a lower staffing number than expected. These wards have a slightly lower summer staffing model than in winter which allows the team to make best use of staff when they are more needed in the winter period. This is quite a typical way of staffing general children's wards. It would appear that our ability to change the ward on the national reporting tool is problematic and this leads to a calculation against winter staffing which is a higher number than in the summer period, thus making it look like we have low staffing. We will make another attempt to correct this.

Table 1. – Three Month Average Fill Rate Percentages For Each Hospital

Safe Staffing Return Summary			Day				Night							
			Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Day		Night	
Month	Site Code	Site Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/m	Average fill rate - care staff (%)	Average fill rate - registered nurses/m	Average fill rate - care staff (%)
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE	555	465	277	221	462	573	157	194	83.8%	79.8%	124.0%	123.6%
Mar-16	RXK02	CITY HOSPITAL	24357	27553	10043	11106	22770	26280	7890	8653	113.1%	110.6%	115.4%	109.7%
	RXK10	ROWLEY REGIS HOSPITAL	3936	3194	4367	4836	2625	2530	3224	3693	81.1%	110.7%	96.4%	114.5%
	RXK01	SANDWELL GENERAL HOSPITAL	28158	25581	13813	13543	23643	21025	10958	10617	90.8%	98.0%	88.9%	96.9%
			57006	56793	28500	29706	49500	50408	22229	23157	99.6%	104.2%	101.8%	104.2%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE	450	457	225	206	555	555	148	175	101.6%	91.6%	100.0%	118.2%
Apr-16	RXK02	CITY HOSPITAL	28863	27928	11830	10759	27267	25879	9244	8557	96.8%	90.9%	94.9%	92.6%
	RXK10	ROWLEY REGIS HOSPITAL	4185	3631	4702	5260	2790	2754	3417	3881	86.8%	111.9%	98.7%	113.6%
	RXK01	SANDWELL GENERAL HOSPITAL	27066	24907	13360	13080	21663	20686	10532	10611	92.0%	97.9%	95.5%	100.8%
			60564	56923	30117	29305	52275	49874	23341	23224	94.0%	97.3%	95.4%	99.5%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE	435	435	217	195	536	536	166	185	100.0%	89.9%	100.0%	111.4%
May-16	RXK02	CITY HOSPITAL	29134	29287	11975	11748	27549	27239	9115	8696	100.5%	98.1%	98.9%	95.4%
	RXK10	ROWLEY REGIS HOSPITAL	4323	3879	4858	5417	2883	2871	3605	4005	89.7%	111.5%	99.6%	111.1%
	RXK01	SANDWELL GENERAL HOSPITAL	28077	26369	14260	13294	22336	21643	10737	10506	93.9%	93.2%	96.9%	97.8%
			61969	59970	31310	30654	53304	52289	23623	23392	96.8%	97.9%	98.1%	99.0%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE	480	452	240	207	518	555	157	185	94.2%	86.5%	107.1%	117.6%
3-month Avges	RXK02	CITY HOSPITAL	27451	28256	11283	11204	25862	26466	8750	8635	102.9%	99.3%	102.3%	98.7%
	RXK10	ROWLEY REGIS HOSPITAL	4148	3568	4642	5171	2766	2718	3415	3860	86.0%	111.4%	98.3%	113.0%
	RXK01	SANDWELL GENERAL HOSPITAL	27767	25619	13811	13306	22547	21118	10742	10578	92.3%	96.3%	93.7%	98.5%
	Total	*Latest 3 month average====>*	59846	57895	29976	29888	51693	50857	23064	23258	96.7%	99.7%	98.4%	100.8%

Table 2. The Care Hours per Patient Day average calculation by hospital

Safe Staffing Return Summary			Care Hours Per Patient Day (CHPPD)			
Month	Site Code	Site Name	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
May-16	RXK03	BIRMINGHAM MIDLAND EYE CENTRE	192	5.1	2.0	7.0
	RXK02	CITY HOSPITAL	8856	6.4	2.3	8.7
	RXK10	ROWLEY REGIS HOSPITAL	2624	2.6	3.6	6.2
	RXK01	SANDWELL GENERAL HOSPITAL	9535	5.0	2.5	7.5

3 RECOMMENDATION

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

Colin Ovington,

Chief Nurse

29th June 2016

Appendix 1 – May 2016 ward nurse staffing data

May 2016 Safe Staffing Data									
		Percentage fill rate				Actual Care Hours Per Patient Day (CHPPD)			
Ward Name	Number of beds	Day Average fill rate - registered nurses/ midwives	Day Average fill rate - care staff (%)	Night Average fill rate - RN/ RM (%)	Night Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered Nurses/ midwives	HCA Staff	Overall
CCS SGH	7	100.60%	91.60%	96.00%	91.60%	233	30.9	6.8	37.7
AMU A	32	97.40%	105.40%	100.00%	102.20%	736	7.6	3	10.7
Lyndon 1	26	54.80%	48.40%	99.90%	71.90%	414	5.4	1.8	7.2
Lyndon 2	24	94.10%	93.10%	92.30%	95.60%	687	3.8	2.4	6.3
Lyndon 3	33	94.80%	95.20%	100.00%	99.00%	782	3.5	3.1	6.6
Lyndon 4	34	94.20%	91.10%	89.50%	117.70%	1014	2.9	2.1	5
Lyndon Ground	14	95.20%	135.60%	95.20%	87.10%	247	6.9	2.6	9.5
AMU B	20	95.90%	100.00%	100.00%	100.00%	584	4.2	1.2	5.4
Newton 3	33	95.20%	97.10%	100.00%	99.00%	900	3.1	2.7	5.8
Newton 4	28	98.40%	94.10%	97.50%	96.80%	866	3.2	2.4	5.6
Newton 5	15	111.20%	75.80%	100.00%	96.90%	414	3.6	1.5	5.1
Priory 2	20	99.70%	100.00%	100.00%	100.00%	656	4.3	2.7	7.1
Priory 4	25	98.60%	89.80%	89.80%	95.70%	703	5.7	2.8	8.6
Priory 5	34	97.10%	101.60%	99.20%	98.30%	987	3.2	1.8	5
SAU	20	90.60%	100.70%	99.20%	96.90%	312	10.7	3.4	14.1
CCS City	7	98.00%	82.80%	98.50%	89.20%	214	36	8.6	44.6
D5	13	98.70%	95.20%	100.00%	-	430	7.4	0.8	8.2
D11	21	100.00%	96.80%	100.00%	100.00%	609	3.5	1.7	5.2
D12	10	99.20%	100.00%	100.00%	96.90%	241	5.9	2.9	8.8
D15	24	102.70%	91.80%	111.80%	93.70%	522	4	2.1	6.1
D16	21	98.40%	99.20%	97.80%	100.00%	615	3.4	1.7	5.1
D19	8	80.00%	151.90%	98.70%	58.10%	197	7.2	1.6	8.8
D21	23	101.30%	95.10%	100.00%	93.50%	396	5.2	3.4	8.6
D26	21	100.00%	100.00%	100.00%	100.00%	632	3.4	1.7	5.1
D27	18	93.70%	101.40%	93.50%	93.50%	396	3.1	2	5.1
AMU 2	19	96.80%	127.50%	78.70%	106.50%	474	6.6	1.8	8.4
D43	24	96.80%	98.70%	98.90%	100.00%	798	2.5	2	4.5
D47	20	101.80%	-	100.00%	-	580	2	0	2
D7	19	98.60%	93.50%	100.00%	-	555	7	0.6	7.6
D17	19	91.50%	103.80%	99.00%	98.20%	387	6.1	3.2	9.3
Labour Ward	17	113.10%	135.30%	108.70%	125.00%	265	25.4	5.4	30.8
City Maternity	42	115.80%	104.00%	101.20%	109.20%	864	4.8	2.3	7.1
AMU 1	41	101.20%	95.20%	99.20%	76.60%	615	9.3	4	13.3
Serenity Birth Centre	5	95.70%	69.30%	87.10%	122.80%	66	29.6	14.1	43.7
Ophthalmology Main W	10	100.00%	89.90%	100.00%	111.40%	192	5.1	2	7
Eliza Tinsley Ward	24	95.10%	100.00%	100.00%	100.00%	707	2.4	3.8	6.2
Henderson	24	97.30%	98.90%	98.40%	98.40%	674	2.7	3.3	6
Leasowes	20	66.70%	117.80%	100.00%	100.00%	568	2.5	3.5	6
McCarthy	24	99.40%	135.60%	100.00%	158.60%	675	2.6	3.8	6.5

ANNEX 2 – Board Equality and Diversity Plan

Public Health Plan Diversity Pledge	Detail	Update
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, this was completed in December 2014. A comparative exercise will be undertaken in regard to overall band staff profile. A draft should be completed in time for the annual declaration.	Taken to Education Committee December 2014 Expected end of April 2016 for all training requests during 2015/2016 financial year.
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.	'Educate and Celebrate' Ellie Barnes LGBT Speaker is attending April 2016 Trust Board development session.	This will happen during April 16th Board Development Session.
We would undertake an EDS2 self-assessment for every 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.	Chief Nurse to update as part of EDS Review
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. From July 2016 the kiosks will automatically update in to CDA and IPM.	Developed and included in declaration statement to all employees during April 2016 with specific guidance on purpose and use of data. Outpatient kiosks remains outstanding action – effective July 2016.
Undertaking monthly characteristics of emphasis in which we host events that raise awareness of protected characteristics (PC)	Use CIPD Diversity Calendar resources to communicate campaigns through internal communications and social media channels. Mutual Respect and Tolerance Guidance launch will be first 'positioning' campaign. February Campaign around Deaf Awareness	Deaf Awareness Campaign February 2016 Mutual Respect and Guidance campaign March 2016 onwards. Gender Equality March 2016

	March Gender Equality	(international women's day)
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.	Wider diverse leadership programme being developed (not just BME colleagues) - design phase March / April delivery from May 16.
We proposed and agreed with staff-side that Harjinder Kang, as JCNC independent chair, would review whether our workforce policies and procedures match (if implemented) our ambitions and commitments. This was due to occur in Q2 but will now occur in Q3.	This work has commenced. Critically we are looking to determine not simply whether our policies avoid overt discrimination, but whether they actively take steps to promote diversity. This will be delivered by Alaba Okuyiga, ENEI (Employers Network for Equality & Inclusion) during April and include coaching and training for HR advisors, Staffside if they wish, and HR business partners.	Policies being reviewed on 31st March with feedback and recommendations to Harjinder Kang, Staffside, Raffaela Goodby and Nick bellis on 8th April AM. First HR development session held in March 2016 with further sessions planned for 16/17.
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 (which one?) will review the progress made with Raffaela Goodby in an effort to set a clear timetable for progress. Joint approach with Staffside needed as accessing existing groups has proved fruitless to date.	Will form part of design phase of work with Hay Group during March and April 2016. Clear timetable identified as above.
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.	Data both qualitative and quantitative will be developed during phase one March / April 2016. Clear product output of first phase of work.

Hard to Fill Trajectory
Updated 29th June 2016

Group	Role	Pay Band	Position Title	Occupational Group	Funded Establishment 31.03.16	Staff in Post as 31.03.16	Vacancies as 31.03.16	Number of Conditional Offers made in April '16	Number of Conditional Offers made in May '16	Leavers 15/16	Turnover Rate	Forecasted Number of Leavers by 31.3.17	Estimated Recruitment Target by 31.03.17	Rag Ratiing on difficulty to fill
Community and Therapies	Staff Nurse	5	Community Staff Nurse , Staff Nurse	Nursing and Midwifery Registered	150	119	31	1	1	14	12%	14	34	H
Corporate - Estates & New Hospital Project	Multi Skilled Mechanical Craftsperson	4	Multi Skilled Mechanical Craftsperson	Estates and Ancillary	10	7	3	0	0	4	57%	4	4	H
Corporate - Estates & New Hospital Project	Estates Officer	6	Estates Officer	Estates and Ancillary	4	2	2	0	0	1	50%	1	2	H
Corporate - Operations	Clinical Coder	3	Clinical Coder	Administrative and Clerical	4	2	2	0	0	0	0%	0	2	H
Imaging	Radiographer	5	Radiographer - Generic [PTA0056]	Allied Health Professionals	31	17	14	0	2	11	66%	11	14	H
Imaging	General Manager - Imaging	8B	Group General Manager - Imaging [C1302]	Administrative and Clerical	1	0	1	0	0	1	100%	1	1	H
Imaging	Consultant	Consultant	Consultant (Radiology)	Medical and Dental	26	23	3	0*	0	2	9%	2	2	L
Imaging	Sonographer	7	Sonographer	Allied Health Professionals	14	12	2	0	0	2	16%	2	3	H
Medicine & Emergency Ca	Group Director of Operations- M&EC	9	Group Director of Operations- M&EC	Administrative and Clerical	1	0	1	0	0	0		0	1	H
Medicine and Emergency Care	Staff Nurse	5	Staff Nurse	Nursing and Midwifery Registered	454	379	75	4	3	69	18%	69	124	H
Medicine and Emergency Care	Emergency Medicine Consultant	Consultant	Consultant	Medical and Dental	18	12	6	0	1	2	14%	2	8	H
Medicine and Emergency Care	Acute Physican	Consultant	Consultant	Medical and Dental	8	6	2	0	0	2	36%	2	2	H
Medicine and Emergency Care	Emergency Medicine SAS Doctor	SAS Doctor	Specialty Doctor, Trust Grade Doctor - Specialist Registrar Level (Closed)	Medical and Dental	17	13	4	5	4	6	45%	6	5	H
Pathology	Biomedical Scientist	5 to 6	Biomedical Scientist across all directorates	Healthcare Scientists	83	70	13	4	0	14	20%	14	11	M
Surgery A	Staff Nurse	5	Staff Nurse	Nursing and Midwifery Registered	207	180	27	0	2	17	10%	17	26	H
Surgery A	Consultant (Anaesthetics)	Consultant	Consultant	Medical and Dental	43	39	4	0	0	3	8%	3	3	M
Surgery A	Group General Manager	8B	Group General Manager	Administrative and Clerical	3	1	2	0	1	1	100%	1	1	H
Surgery B	Staff Nurse	5	Staff Nurse	Nursing and Midwifery Registered	34	33	1	0	1	9	26%	9	4	L
Women and Child Health	NeoNatal Nurse	6	Sister Charge Nurse	Nursing and Midwifery Registered	20	16	4	0	1	2	14%	2	4	M
Women and Child Health	Community Midwife	6	Community Midwife	Nursing and Midwifery Registered	79	57	22	0	5	13	22%	13	31	H
Women and Child Health	Health Visitor	6	Health Visitor	Nursing and Midwifery Registered	76	61	15	2	0	0	0%	0	18	M

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Never Event Briefing
SPONSOR (EXECUTIVE DIRECTOR):	Roger Stedman, Medical Director
AUTHOR:	Allison Binns, Assistant Director of Governance
DATE OF MEETING:	7 July 2016

EXECUTIVE SUMMARY:

The report presents a briefing on the facts known from the investigation into a retained vaginal pack following emergency caesarean section.

The investigation has found that the following root cause:

- Failure to document and handover the number of intentionally retained packs

A number of remedial actions have already been carried out. The investigation is now complete and a learning event involving all stakeholders took place on the 29th June 2016.

REPORT RECOMMENDATION:

The Board is recommended to:

- **RECEIVE and DISCUSS** the Never Event and the actions proposed.

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 quality and safety agendas.

PREVIOUS CONSIDERATION:

Never Event Briefing

Report to the Trust Board on 7 July 2016

1. EXECUTIVE SUMMARY

1.1 This report provides the Board with a briefing on the recent retained vaginal pack, defined as a Never Event, which occurred on 6 June 2016 in Obstetrics at City Hospital.

1.2 The investigation is on-going with staff involved in the incident being interviewed individually. An investigation review meeting has taken place to discuss the events surrounding the incident and a learning event for all staff involved will be led by the Clinical Director for Obstetrics.

1.3 The patient is a non-English speaking woman who was in her third pregnancy. Her previous two children had been delivered by caesarean section. She was a known placenta praevia and had admissions during her antenatal period.

2. TIME LINE OF EVENTS

2.1 4 June 2016 - patient attended Maternity services with antenatal bleeding. She was 30+1 gestation and was admitted for observation.

2.2 During the early hours of the day the patient continued to intermittently experience vaginal bleeding but remained an in-patient for observation.

2.3 5 June 2016, during the early hours the patient began bleeding again and a decision was taken that she required caesarean section. The night had been busy with a number of emergencies.

2.4 At approximately 3.00 am the on-call Consultant was contacted regarding the pending emergencies. The Consultant advised that they would come in and the second theatre team were requested.

2.5 There were two registrars on during the night of 4/5 June 2016. When the Consultant attended, the senior registrar carried out one of the emergency sections with the primary theatre team and the Consultant carried out the section on the patient with the assistance of the junior registrar.

2.6 At 4.05am the baby was safely delivered and is currently on the Neonatal Unit. The Consultant observed bleeding so placed some haemostatic sutures. Following closure of the uterus, but prior to closure of the abdomen, a vaginal examination was carried out.

2.7 During this examination it was noted that there was bleeding from the cervix so a bakri balloon was inserted and packing applied. A request was made for a large pack, but this was unavailable so the registrar was handed two similar but smaller packs, normally used for throat packing. Both were placed into the patient's vagina one after the other.

2.8 The fact that 2 packs were placed was recorded on the white board in theatre; as per policy.

2.9 The Consultant closed the abdomen and the patient was transferred to Maternity High Dependency Unit (HDU). The theatre care plan detailed "vaginal pack x2". The operation notes were completed by the Consultant, but there was no mention of the vaginal packs.

2.10 At approximately 6am the registrar who had been in theatre with the Consultant completed the notes on Badgernet (maternity EPR) and recognised that the Consultant had not mentioned that packs remained in situ. She added to the operation note stating "vaginal pack in situ".

2.11 Handover mentioned a vaginal pack.

2.12 Later that morning on the ward round a request was made for the vaginal packs to be removed the following morning. No change was made to any of the documentation (manually or electronically) to amend the singular vaginal pack to 'two vaginal packs in situ'.

2.13 That night the same two registrars were on shift. The requirement to remove the vaginal pack was handed over. The content of the handover is still being investigated.

2.14 6 June 2016, the senior registrar was on HDU when the patient woke up. He therefore removed the bakri balloon and the vaginal pack then. The junior registrar attended shortly after to remove the balloon and pack and when advised that this had already been done left the HDU and thought nothing further of it.

2.15 The patient was transferred to the postnatal ward that morning before the ward round and later requested to be discharged.

2.16 The patient discharged herself against medical advice later that evening.

2.17 8 June 2016, the patient during a shower in the early hours, noticed that she had something protruding from her vagina. She removed this and called an ambulance and was brought to City Hospital.

2.18 The pack the patient removed was thought to be from her earlier operation. She was assessed, given antibiotics and discharged. She was advised that this was a serious incident for us and that we would investigate and meet with her to discuss our findings.

3. NOTABLE PRACTICE

3.1 During the discussion regarding her wish to be discharged and during the Duty of Candour discussion an interpreter was used.

4. INTERIM CONCLUSIONS

4.1 Root cause was:

- Failure to document and handover the correct number of packs left in situ

4.2 Contributing factors were:

- Lack of process for reporting, escalating and correcting non-available stock items

4.3 As with most serious incidents there were a number of opportunities for this incident to be averted. Problems with the supply of large packs meant these were not available necessitating the use of an alternative. It is also unusual practice to use more than one vaginal pack following obstetric operations.

4.4 Despite correctly documenting that there were two retained vaginal packs in situ on both the white board in theatre and in the theatre care plan, this did not translate onto the operation notes, the electronic patient record or verbally during handovers.

5. ACTIONS

5.1 Immediate

- Removed all throat packs from Maternity theatres
- Escalated requirement for large pack availability

5.2 Proposed

- System for notifying staff when there is a supply issue and approved alternatives to be used
- Safety briefings over a month to highlight documentation and handover issues
- Reiterate to staff that if more than 1 pack is used it must be tied together

6. RECOMMENDATION(S)

6.1 The Board is recommended to:

- **RECEIVE and DISCUSS** the Never Event and the actions proposed.

Allison Binns
Assistant Director of Governance

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Maternity Review
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Elaine Newell, Director of Midwifery
DATE OF MEETING:	Thursday 7th July 2016

EXECUTIVE SUMMARY:

There have been three intrapartum deaths (stillbirths occurring during labour) between January and May 2016. It is always a difficult time for families when this happens and our condolences are offered to all. Because we have seen three cases in a short period of time this has made us ask questions of ourselves about the safety of the service. We had no concerns in the lead up to the last occurrence and our analysis has not led us to believe that the service is unsafe, however to provide additional reassurance we have commissioned an external review of operational and cultural aspects of the service, this will be concluded by August.

These deaths occurred in families who had received some aspects of their care within the Serenity Birth Centre setting. The report will seek to provide information on the actions that have been taken in response to these events. These actions have included a detailed external secondary analysis of cases, an internal review of care provision within the unit and an audit of clinical practice against key local and national guidelines. The report will include information on review methodology and will summarise the findings from the review, identifying emerging themes, demonstrating the actions undertaken to reduce the risk of reoccurrence and to share lessons learned.

REPORT RECOMMENDATION:

To receive an update at the September 2016 Board Meeting.

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

Accept	Approve the recommendation	Discuss
X		**X**

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

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

Comments:

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

Safe high quality care

PREVIOUS CONSIDERATION:

Report to Trust Board 7th June 2016

Serious Untoward Incidents in Maternity

Report Author – Elaine Newell, Director of Midwifery

1. Report Outline

This report aims to provide information and updates to the Trust Board following 3 intrapartum deaths (stillbirths occurring during labour) between January and May 2016. These deaths occurred in families who had received some aspects of their care within the Serenity Birth Centre setting. The report will seek to provide information on the actions that have been taken in response to these events. These actions have included a detailed external secondary analysis of cases, an internal review of care provision within the unit and an audit of clinical practice against key local and national guidelines. The report will include information on review methodology and will summarise the findings from the review, identifying emerging themes, demonstrating the actions undertaken to reduce the risk of reoccurrence and to share lessons learned.

The report was commissioned by the WCH leadership team, led by the director of midwifery, after the sequence of events was discussed with the Chief Nurse and Chief Executive. The Board was briefed orally on the initiation of this work.

2. Background:

Maternity Services within SWBH have shown significant and measurable improvements in recent years. The service currently holds Maternity CNST level 3 accreditation (Feb 2014) and was assessed as 'good' over each of the 5 key domains by the CQC in 2015. The service has received national awards - by the RCM in 2014 for promoting normal birth and in 2015 was shortlisted by the British Journal of Midwifery for innovation in practice. The service also achieved Stage 3 WHO Baby friendly accreditation in October 2015.

The Serenity Birth Centre is a co-located midwife-led unit situated within the City Hospital site. It is in close proximity to the Obstetric Delivery Suite and provides intrapartum care for women whose contemporaneous risk assessment identifies this to be the most appropriate place for them to receive care, and who accept this as their preferred place of birth. The unit is staffed by experienced midwives who rotate on a regular basis into other areas of the service including Delivery Suite.

Community Midwives rotate into the Birth Centre to update their intrapartum skills. Rotation into the centre is otherwise limited. Between May 2010 and 31st May 2016, the unit has conducted 6805 births.

During the period 1st January 2016 to 31st May 2016, the maternity service reported 3 serious incidents relating to intrapartum stillbirths. Intrapartum stillbirths are recognised as rare incidents and are usually associated with unpredictable emergency events during labour. Each case was immediately investigated in accordance with established Risk Management processes. Whilst some elements of good practice were evident, root cause analysis demonstrated aspects of suboptimal care (not exclusive to Serenity), which potentially contributed to the poor outcome in each of the 3 cases. Each family concerned have subsequently been appraised of the findings by the Director of Midwifery.

An internal review was initiated to identify any wider/thematic issues which may have impacted upon care provision. This internal review has included input from outside the Trust, to offer expert objective challenge.

In addition, we have commissioned a wider external review of midwifery care across all areas of service delivery. This covers: Examination of clinical practice / processes

- Processes / arrangements which support local governance.
- Multi professional team dynamics / relationships and the impact upon clinical care
- Operational arrangements.

This review has commenced and is being led by Dr Tracey Cooper, an experienced Consultant Midwife from University Teaching Hospital, Lancashire, who has a highly regarded national profile, being a regular expert advisor to NICE, the RCM and having advised on the National Maternity Review. The report is expected by the end of August 2016) and will be discussed on receipt within the Board's quality and safety committee and the wider executive.

A number of other immediate actions have been implemented to ensure the midwifery team were appropriately supported to continue to provide high quality, safe care to women and babies. These are:

- Immediate support for staff including Occupational health and BDMA support where necessary.
- Introduction of rotation of midwives **into** Serenity to provide additional support to core staff and enhance working relationships / shared experiences.
- Review of evidence to support identification and management of the latent phase of labour to clarify and amend the clinical guideline.

- Planning of orientation for all Delivery Suite shift coordinators to Serenity to facilitate a programme of rotation.
- Communication with midwifery teams regarding rationale for and process of the review.
- Regular input from Delivery Suite shift leader to Serenity to provide support and monitor activity and staffing across all intrapartum areas.

3. Methodology

The collective internal review incorporated three separate processes of scrutiny:

1. Panel review (with external expert clinical representation) of all stillbirths and neonatal deaths which have occurred on Serenity or where care has been provided on Serenity since it opened in May 2010 (7 cases).
2. Review of perinatal mortality rates on Serenity.
3. Audits to analyse and measure adherence to guidelines in relation to:
    I. Risk assessment criteria
    II. Latent phase of labour
    III. Normal Birth
    IV. Transfer policy
    V. Escalation policy

Sample groups included:

- Cases of babies who have been transferred to NNU or have had low Apgar scores following delivery on Sserenity over the last 6 months.
- A 10% sample of all Serenity deliveries over the last 6 months.
- A 10% sample of all transfers from Serenity over the last 6 months.

Panel Review:

A group was set up to collectively review all of the stillbirths and neonatal death cases where care had been provided on Serenity since it opened in May 2010 up to June 2016 (7 cases), in order to establish any collective themes and / or trends. The panel review team consisted of multidisciplinary senior clinical members from within the Group. External expert opinion and assistance was also provided by an experienced Head of Midwifery from another Trust to ensure a robust, objective review.

The panel review team consisted of:

Gabrielle Downey –	Divisional Director for Obstetrics and Gynaecology
Elaine Newell -	Director of Midwifery and Supervisor of Midwives SWBH
Carmel McCalmont –	Head of Midwifery and Supervisor of Midwives, University Hospital of Coventry and Warwickshire
Shereen Meher –	Consultant Obstetrician
Rachel Carter –	Deputy Head of Midwifery and Supervisor of Midwives (New in post to the Trust <2 weeks at time of review)
Nicola Robinson –	Maternity Clinical Governance / Risk Lead and Supervisor of Midwives

The cases were reviewed using the NPSA Fishbone Diagram to establish cause and effect (See appendix 1). Unique contributory factors had been detailed and actioned within the original individual case reports. The panel agreed with all of the findings from the initial reviews with no significant additional findings being identified, thus providing assurance regarding the quality of the original review process.

4. Findings from the review: Common Themes

There was no single notable factor or common theme which featured across all of the cases reviewed. However, issues which were identified as having occurred in 2 or more cases are identified below. Recommendations have been made to reflect the outcomes of this collated review. The audits undertaken can be found with the resulting action plan included in Appendix 2.

Common themes identified across 2 or more cases:

1. A lack of consistent identification and recognition of latent and active 1st stage of labour and subsequent care planning, care provision and documentation specific to the early phase of labour. It is important to note that there is a significant diversity in terms of professional opinion on this subject. A lack of national policy and evidence base to support clinical practice in the latent phase of labour has undoubtedly contributed to this inconsistency in care. Since the incidents and in response to midwife requests, a local guideline has been developed to assist midwives to more accurately/confidently identify the latent phase of labour and thereby provide consistent care against a locally agreed pathway. The guideline has since been approved in line with recognised governance processes.

2. Individual (staff) factors were identified in one case. These issues are being managed via established supervisory and management processes and restorative programmes are in place where appropriate.

3. In 2 cases, common issues relating to the management of hypertension in pregnancy were identified as a feature involving clinicians in both Serenity and Delivery Suite. These issues related to a disparity in two different guidelines. The guidelines were quickly reviewed, discrepancies identified, addressed and communicated to the relevant clinicians. In addition interactive small group teaching sessions for all staff across all maternity clinical areas has been initiated by Consultant Obstetricians to ensure staff are updated regarding changes to the management of hypertension in pregnancy guideline and to refresh and update knowledge on expected management

4. Issues relating to communication factors were identified in several cases, these included:

- Inter-professional team communication issues whereby standardised handover (SBAR) was lacking.
- Poor documentation (including inconsistencies in recording information within the electronic patient records).

In a number of cases these issues were felt to have had a negative impact on the subsequent planning and implementation of ongoing care

5. Team factors featured in two of the cases raising questions regarding the professional relationships between clinicians in Triage / Delivery Suite and Serenity. The external maternity review will provide further objective intelligence into these and other cultural issues, including professional dynamics which may impact on the effectiveness of team working within Maternity, and the potential impact of this on clinical practice and care.

5. Review of perinatal mortality rates

SWBH, alongside its West Midlands peers, have historically experienced perinatal mortality rates (PNMR - deaths which occur from 24 weeks of pregnancy up to and including 7 days post-delivery) which are higher than UK average. This is largely attributable to poor social demographics with high rates of non-English speaking and medically complicated women within the inner-city population we serve. MBRRACE-UK (2014) reported Trust specific adjusted PNM rates of 5.73 per 1000 births (Crude rate -=8.43 per 1000) which represents a significant fall of 0.6/1000 births on 2013 figures and supports our own internal data showing a consistent fall in perinatal mortality at SWBH over the

last 5 years. There is no national or regional data to reflect comparative PNM rates within low risk groups, however, based on the total delivery numbers since opening in May 2010, the adjusted perinatal mortality rate for Serenity Birth Centre is 0.88 per 1000 live births (Crude rate = 1.02 per 1000). This figure is and should be considerably lower than the total PNMR as the criteria for delivering on Serenity Suite self-selects low risk women.

6. Audit outcomes

A total of 85 sets of records (randomised by the Clinical effectiveness team) were identified within the audit cohort. Of these, 2 were excluded as they did not meet the agreed criteria. The audits reviewed 3 areas of practice on Serenity to assess compliance with the guidelines:

- Care in labour (Risk assessment, labour identification and care)
- Transfer of care from Serenity to Delivery Suite (maternal / fetal reasons)
- Transfer of care from Serenity owing to neonatal care requirement

Compliance with the escalation policy between January 2016 and May 2016 was also audited. Findings of the audits are summarised below.

Areas of good practice:

- Whilst there was a lack of standardisation regarding electronic documentation, risk assessment and observations on admission reflected compliance with established guidance.
- Maternal and neonatal transfers within the audit group were undertaken in accordance with established guidance.
- On occasions where minimum staffing levels were not met, escalation and contingency plans were implemented 100% of the time.
- Incidental findings highlighted a good standard of record keeping by community midwifery staff.

Issues identified largely correlated with findings from the thematic case reviews and included:

- Lack of standardisation in recording within electronic patient records (Badgernet)
- Identification and management of latent phase of labour was inconsistent (as previously stated there is a widely acknowledged diverse professional opinion regarding this issue with no national guidance and a very limited evidence base).
- Observations not always recorded in accordance with guidance (although reasons for exceptions documented in a number of cases)

7.Other observations (soft intelligence)

It is important to acknowledge the emergent themes that were not outcomes from the examination of hard evidence (i.e. audit and case review) but were notable through intuitive and experiential observation. Although no contributory staffing issues were identified in relation to the cases examined, it was apparent that the threshold of staff tolerance during periods of heightened activity may have altered; staff appeared to be less inclined to request additional support when required. This may be attributable to a shift in culture after the particularly challenging summer / autumn where staffing was challenging owing to vacant posts and high sickness absence rates.

There is a view that professional relationships and decision making appear to be influenced by very subtle hierarchies between teams in different clinical areas.

It should also be acknowledged that, despite best efforts, there were incidences of disparate communication which may be partly attributed to several changes in senior midwifery leadership within the last 12 months. A substantive senior team is now in place.

8. Recommendations

The recommendations from this review are outlined below and are reflected in the resulting action plan shown in Appendix 2.

1. Provide clarity for midwives across all areas to ensure consistent identification of latent phase and active stage of labour.
2. Inter-midwifery teams to have a working knowledge and understanding of the clinical and operational pressures within each area and support one another at all times in order to enhance professional working relationships.
3. All midwifery documentation to be entered into BadgerNet in a consistent manner to produce a clear record of clinical assessment, decision making, care planning and provision to women and babies.
4. Provision of a regular, structured forum for review of Serenity cases to afford peer review of care provided to women in labour; to celebrate good practice; to identify areas of concern.
5. Ensure use of SBAR handover tool is embedded into practice across all areas and evident in documentation of routine clinical care and emergencies.
6. Revised multi-disciplinary team teaching sessions, led by senior clinicians, to provide clarity regarding the management of hypertension in pregnancy

7. All telephone communication with women where clinical advice is sought must be referred to a registered midwife and documented appropriately in a timely manner.
8. Explore the introduction of the Birthrate acuity tool to better inform need for escalation, trigger responsive deployment of staff and provide real time evidence for review.
9. Provide assurance of improved compliance with the clinical guidelines audited and associated documentation within 6 months of recommendations being implemented.
10. Improve standard of record keeping across all care settings ensuring a consistent approach to the documentation of risk assessments and management plans
11. Undertake annual, collective review of serious untoward incidents for Maternity and Perinatal Medicine to identify themes and trends and present to multi-disciplinary team as opportunity for shared learning.

8. Monitoring Arrangements

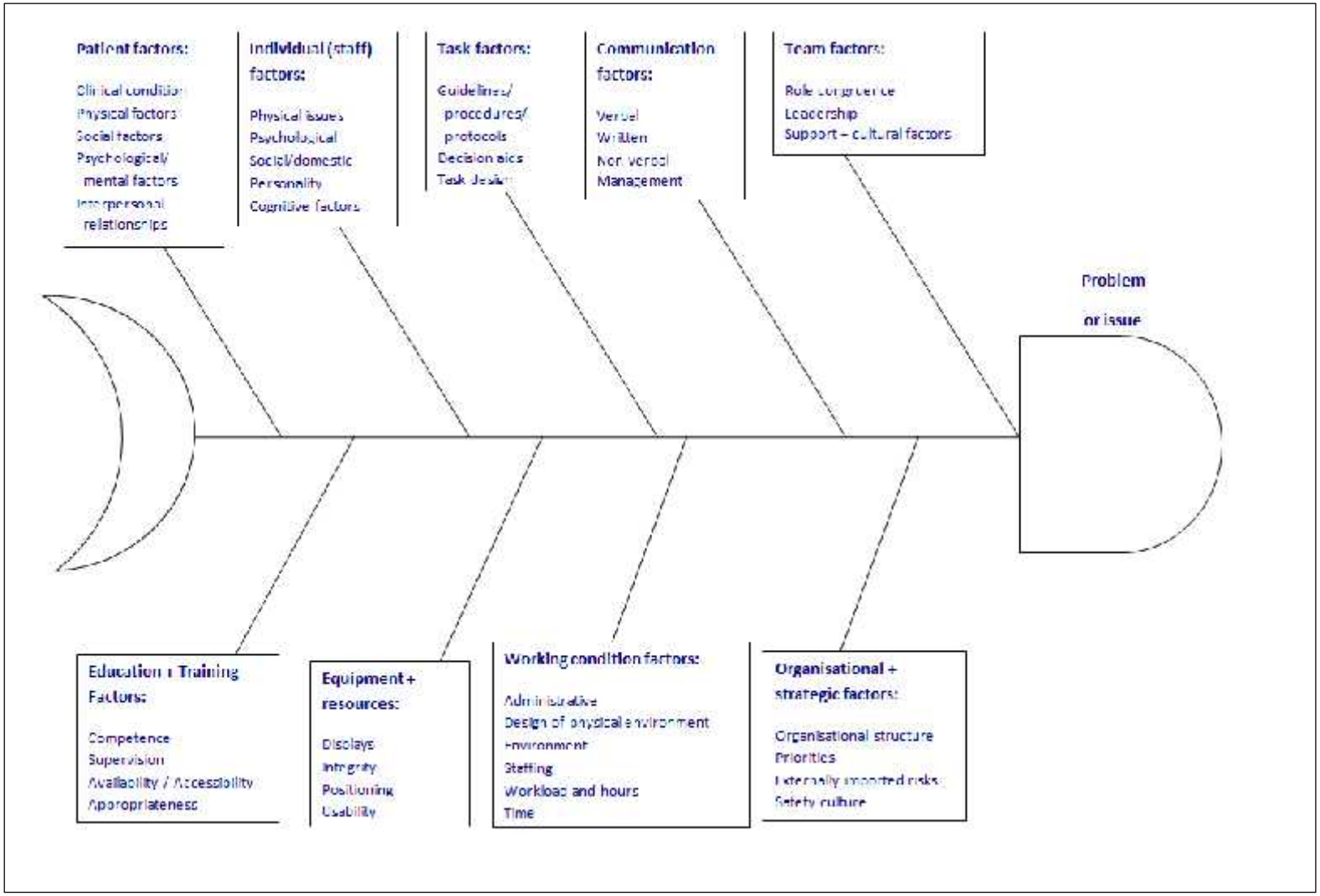
Monitoring of associated action plans will be undertaken monthly by the Maternity, Health Visiting and Perinatal Medicine Directorate Governance Group. Exception reports will be received monthly by the Group Governance Board. Corporate updates / monitoring arrangements to be advised.

9. Summary / conclusion

Whilst acknowledging the undisputed and regrettable tragedy relating to the recent 3 cases, the overall perinatal mortality rate associated with women using the Serenity Birth Centre is shown – as expected, to be low. Whilst this provides reassurance regarding the quality and safety standards within the unit it is acknowledged that there are some wider issues - not exclusive to the Birth Centre, which have potentially impacted upon care outcomes in these cases. Immediate action has been taken to address these concerns throughout the service to ensure that safety continues to be optimised. An external review of the wider service will seek to provide further objective examination and where necessary recommendations will be addressed swiftly.

The Maternity Management Team is confident in providing assurance to the Board regarding the immediate quality and safety of care being provided throughout the service.

APPENDIX 1. National patient Safety Authority Fishbone Diagram



APPENDIX 2: Action Plan

Key to RAG rating:

Not yet commenced	1	Significant delays	2	Delayed, but will complete	3	On track	4	Completed	5

	Issue/ Concern/ Recommendation	Action	Timeframe	Responsible	Evidence	RAG rating
1	Provide clarity for midwives across all areas to ensure consistent identification of latent phase and active stage of labour.	Review evidence base for identification of each stage of labour and care provision Amend guideline to provide clarity Communicate changes to Multi-disciplinary Team	20th June 2016 July 2016 July 2016	Consultant Midwife/ Deputy Head of Midwifery Consultant Midwife/ Deputy Head of Midwifery Consultant Midwife/ Maternity Matrons	Evidence Based guideline Revised guideline Communication with MDT (Effective Handover, meeting notes)	4
2	Inter-midwifery teams to have a working knowledge and understanding of the clinical and operational pressures within each area and support one another at all times in order to enhance professional working relationships.	Introduce formal rotation of band 7 Delivery Suite coordinators to Serenity ensuring appropriate coordination and orientation	End July	Delivery Suite Manager Serenity manager Maternity Matron (Inpatients)	Duty roster: rotation Orientation checklist	4
3	All midwifery documentation to be entered onto electronic patient records (BadgerNet) in a consistent manner to produce a clear record of clinical assessment, decision making, care planning and provision to women and babies.	Develop Standard Operating Policy (SOP) for completion of documentation onto BadgerNet. Implement SOP into practice across Maternity in all clinical settings	September 2016 October 2016	BadgerNet Lead Midwife BadgerNet Lead Midwife/ Maternity matrons/ Ward & Team managers	Standard Operating Policy approved and available on intranet Training records	4

	Issue/ Concern/ Recommendation	Action	Timeframe	Responsible	Evidence	RAG rating
4	Provide a regular, structured forum for case review of Serenity cases to afford peer review of care provided to women in labour; to celebrate good practice; to identify areas of concern	Establish forum at least weekly, to be led by Senior Midwife Identify and share good practice Identify, investigate and address any areas of concern	July 2016	Matron for maternity Inpatients/ Consultant Midwife/ Serenity Team Leader Matron for Maternity inpatients/ Supervisor of Midwives/ Governance Lead	Attendance record Case audit proforma Lessons Learnt proforma	4
5	Ensure use of SBAR handover tool is embedded into practice across all areas and evident in documentation of routine clinical care and emergencies.	Remind all staff that SBAR handover tool is to be used in all care settings Monitor compliance (case note review/ observation in clinical practice)	July 2016 Weekly	Serenity Team Leader/ Delivery Suite Ward Manager Serenity Team leader/ Delivery Suite Ward Manager	Communication with staff (Effective Handover, meeting notes) Record of case note review/ observations	4
6	Revised multi-disciplinary team teaching sessions, led by senior clinicians, to provide clarity regarding the management of hypertension in pregnancy	Revise teaching sessions to incorporate lessons learned Promote MDT teaching sessions Monitor and address attendance	June 2016 June 2016 Monthly	Lead Consultant Lead Consultant/ Ward Managers Clinical Director/ Inpatient Maternity matron	Revised teaching session programme and content Communication with clinical and midwifery team Attendance record and communication records	4

	Issue/ Concern/ Recommendation	Action	Timeframe	Responsible	Evidence	RAG rating
7	All telephone communication with women where clinical advice is sought must be referred to a Registered midwife and documented appropriately in a timely manner.	Remind all staff maternity support workers cannot provide clinical advice to women making contact by phone. Monitor compliance. (Case note review/ observation in clinical practice)	July 2016 Weekly	Serenity Team Leader/ Delivery Suite Ward Manager Serenity Team leader/ Delivery Suite Ward Manager	Communication with staff (Effective Handover, meeting notes) Record of case note review/ Observations	4
8	Explore the introduction of the Birthrate acuity tool to better inform the need for escalation, trigger responsive deployment of staff and provide real time evidence for review.	Review Birthrate plus acuity tool and explore potential benefits of implementation and resulting data in comparison with current scorecard in use. Continue to complete and monitor scorecard and impacts on care at monthly governance meetings.	July 2016	DS Ward manager/ Maternity Matron (inpatients)/ Governance Lead Maternity matron (Inpatients)	Formal communication with Birthrate plus team Report to summarise comparison of benefits and resulting data between current tool and birthrate tool. Agenda Meeting notes	4
9	Provide assurance of improved compliance with the clinical guidelines audited and associated documentation within 6 months of recommendations being implemented.	Re-audit 10% case notes to review care in labour and transfer from serenity Share outcome of audit at Quality Improvement Half Day	April 2017 (dependant on #3) May 2017	Senior Midwifery Team	Audit proformas Audit outcomes QIHD agenda	1

	Issue/ Concern/ Recommendation	Action	Timeframe	Responsible	Evidence	RAG rating
10	Improve standard of record keeping ensuring consistent approach to the documentation of risk assessment and management plans in all care settings.	Develop Standard Operating Policy (SOP) for completion of documentation onto BadgerNet. Implement SOP into practice across Maternity in all clinical settings	September 2016 October 2016	BadgerNet Lead Midwife BadgerNet Lead Midwife/ Maternity matrons/ Ward & Team managers	Standard Operating Policy approved and available on intranet Training records	4
		Provide training and communication to midwives in relation to mandatory areas of assessment and documentation to improve safety to all women in particular: Risk Assessment Management Plans Examinations Observations	September 2016	Practice educators Supervisors of Midwives Ward Managers	Training records (agenda and attendance) Supervisory Records Documentation	1
11	Identify themes and trends from Serious untoward incidents within Maternity and perinatal Medicine and identify opportunity to share learning with the Multi-disciplinary.	Undertake annual, systematic review of serious untoward incidents for Maternity and perinatal medicine. Identify themes and trends and present to Multi-disciplinary team as opportunity for shared learning (i.e. QIHD).	June 2017	Risk & Governance Lead Midwife Risk & Governance Lead Consultant	Annual report QIHD agenda and notes	4

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Registers
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Mariola Smallman, Head of Risk Management
DATE OF MEETING:	7 July 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 June meeting and Executive Director updates are highlighted where these were provided.

REPORT RECOMMENDATION:

- **RECEIVE** monthly updates on progress with treatment plans from risk owners for risks on the Trust Risk Register.
- **APPROVE** the risk proposed for removal from the Trust Risk Register.

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

FOR APPROVAL

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Risk Register

Report to the Trust Board on 7 July 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 and Clinical Leadership Committees. There are no additional risks escalated to The Board from Risk Management or Clinical Leadership committees.

2.2 The CIO has carried out an initial review of Informatics risks and there is one risk proposed for removal from the Trust Risk Register as the risk is now controlled (transfer onto a virtual server and business continuity arrangements are in place):

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 unusable (e.g. CDA, eMBS, etc). **(755)**

2.3 The Trust Risk Register is at **Appendix A**.

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

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

3. ELECTRONIC RISK SYSTEM

3.1 Implementation of the electronic risk system is ongoing. Risk register reports at various levels, including the Trust Risk Register, are available for all staff to access on the Connect Intranet System. Additional risk reports include archive summaries at ward/department level and a detailed risk report, which includes status of individual actions and a summary of risk review

history. Risk review and action notification emails are now in place. Where risk leads have determined that a generic risk exists that is managed at specialty level but is relevant for several wards/departments, then the risk features on the specialty risk register, unless risk leads have decided to duplicate the risk for each ward / department. (This is because the system mapping is linear.) Risk leads are being advised to include all wards / departments affected by the generic risk in the "scope" data field, which is the same approach as the previous paper based risk assessments.

3.2 Further development of the risk report library is planned.

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.
- **APPROVE** the risk proposed for removal from the Trust Risk Register.

Kam Dhami, Director of Governance

7 July 2016

Appendix A: 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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
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. An update has been requested through the CCG and a response is awaited. Tier 4 beds are being reviewed nationally.	Rachel Barlow	30/04/2016	04/04/2016	Monthly	4x4=16	Tolerate
566	Live (With Actions)	Emergency Care		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. Leadership development and mentorship. Programme to support staff development.	Recruitment ongoing with marketing of new hospital. CESR middle grade training programme to start in April as a "grow your own" workforce strategy.	Rachel Barlow	30/09/2016	18/03/2016	Monthly	3x5=15	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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
							Robust forward look on rotas through leadership team reliance on locums (37% shifts filled with locums). Registrar vacancy rate 59%. Consultant vacancy rate 35%.							
1603	Live (With Actions)	Finance		Costs Not Planned	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.	**4x5=20**	Routine medium 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.	Tony Waite	31/03/2018	22/01/2016	Quarterly	**3x5=15**	**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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
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.	Confirm plans for a joint health and social care ward to be established and funded on the City site in 2016. Nursing home capacity also a risk and currently unmitigated. EAB and nursing home capacity remain unmitigated risks. System Resilience partners will review demand and capacity of interim bed base and recommend future requirements by end Q1 2016-17.	Rachel Barlow	30/06/2016	18/03/2016	Bi-Monthly	3x4=12	Treat
121	Live (With Actions)	Maternity_ Health	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. Risk proposed for removal from TRR when 2016-17 SLA is signed.	Rachel Barlow	30/04/2016	04/04/2016	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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
771	Live (With Actions)	Theatres	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	Surgery A Group Director of Operations attending Pan-Birmingham Management Board to escalate issues. Contract review planned Q1.	Rachel Barlow	30/06/2016	18/03/2016	Quarterly	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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
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.	4x4=16	Recruitment of suitably skilled specialist resources for EPR Programme and Infrastructure Stabilisation Funding allocated to LTFM Delivery risk shared with supplier through contract Project prioritised by Board and management.	Complete procurement and business case approval to schedule. 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	Mark Reynolds	30/06/2016	18/03/2016	Monthly	3x4=12	Treat
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	Complete actions from information security assessment. Complete rollout of Windows 7. Upgrade servers from version 2003	Mark Reynolds	30/09/2016	04/04/2016	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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
						Information security assessment completed and actions underway.							
331 Live (With Actions)	Maternity_ Health	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. 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	IT Service Desk liaising with maternity and CSUs to install BN client onto GPs PCs. CIO now leading on mitigation plan.	Mark Reynolds	30/06/2016	18/05/2016	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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
410	Live (With Actions)	Ophthalmology	Outpatients - EYE (S)	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	Department reconstruction at SGH with the exception of theatre location. (May 2016)	Rachel Barlow	31/05/2016	13/05/2016	Quarterly	3x4=12	Treat
1643	Live (With Actions)	Operations		Incident	Unfunded beds staffed by temporary staff in medicine place an additional ask on substantive staff elsewhere, in both medicine and surgery. This reduces time to care, and raises experience and safety risks.	4x4=16	Overseas recruitment drive (pending) Use of bank staff including block bookings Close working with partners in relation to DTOCs	Review bed plan and clinical team model in March 2016. Fully implement the assessment for discharge bundle in AMU by May 2016.	Rachel Barlow	01/06/2016	18/03/2016	Monthly	3x4=12	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
							Close monitoring and response as required.	Develop a plan for the closure of the unfunded beds by the end of March.						
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.	Remaining ask to be identified by the ongoing programme. Early planning & engagement on 2016/2018 workforce change Workshops, consultation and engagement	Raffaela Goodby	31/05/2016	04/04/2016	Quarterly	**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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
329	Live (With Actions)	Maternity_ Health	Ante-Natal (C)	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; 2 vacancies currently with potential recruits in progress. Training programme in place with other specialties. Vascular sub-specialty dependent on agency. Workforce strategy to be determined in April. Training being scoped to support the development of Sonographers and other disciplines in house. Programme to start Q2 2016-17	Rachel Barlow	31/03/2017	04/04/2016	Monthly	5x2=10	Treat
119	Live (With Actions)	Maternity_ Health	Maternity Theatres	Incident	There is not a 2nd on call theatre team for an obstetric emergency between 1pm and 8am. Risk initially red, downgraded to amber due to reduced frequency. In the event that a 2nd woman requires an emergency c/s when the 1st team are engaged, there is a risk of	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. RMC / CLE discussion with a view to removal from TRR.	Rachel Barlow	30/04/2016	04/04/2016	Monthly	2x5=10	Tolerate

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
				delay which may result in harm or death to mother and/or child.		Good labour ward management practices and good communication between teams.							
755 Live (With Actions)	Informatics	Informatics Systems (S)	IT Hardware - Clinical System Failure / Issue	*** RISK PROPOSED FOR REMOVAL FROM TRR *** 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.		Mark Reynolds	31/08/2016	21/06/2016	Monthly	**2x5=10**	**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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
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 Deputy COO for Planned Care appointed.	Recruitment to Medicine Director Operations in train. Deputy COO planned care recruited. Deputy COO for Urgent Care vacant and uncovered in Q4.	Rachel Barlow	31/08/2016	04/04/2016	Quarterly	3x3=9	Treat
768	Live (With Actions)	Operations	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	Historical backlog of open referrals closed in Q3 2015. SOP and training in place as part of actions at time. Audit of current open referrals open pathways completed and shows some remaining inconsistencies in referral management practice.		Rachel Barlow	30/04/2016	18/03/2016	Monthly	3x3=9	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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
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.	**3x4=12**	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	Complete network and desktops refresh	Mark Reynolds	30/06/2016	18/03/2016	Monthly	**3x3=9**	**Treat**

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
						Infrastructure work to refresh networks and desktops is underway.							
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 Substantive Deputy COO for Planned Care appointed and new Head of Elective Access in place. Improvement plan in place for elective access with training being progressed. 52 week breaches continue to be an issue for the Trust. The RCA identified historical incorrect pathway administration and clock stops. There has been no clinical harm caused to patients. The 52 week review was completed with TDA input. The action plan is focused on prospective data quality check points in the RTT pathway,	Implement full action plan by Q2 Source e-learning module for RTT with a competency sign off for all staff in delivery chain by Q2 Data quality process to be documented and KPIs to be published from April.	Rachel Barlow	01/07/2016	18/03/2016	Monthly	**3x3=9**	**Treat**

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
						competency and training.							
533 Live (With Actions)	Scheduled Care	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	Roger Stedman	30/06/2016	04/04/2016	Monthly	**3x3=9**	**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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
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	18/03/2016	Monthly	2x4=8	Treat
534	Live (With Actions)	Scheduled Care	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.	Recruit to revised clinic footprint across multi-provider partnership.	Roger Stedman	30/06/2016	04/04/2016	Monthly	2x4=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	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
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. Progressing strategy with Black Country Alliance stakeholders for stroke services locally.	Continued monitoring through SSNAP Progress strategic plan for stroke in the BCA in 2016.	Rachel Barlow	30/04/2016	04/04/2016	Monthly	2x4=8	Tolerate
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.	BCA plans to be delivered to commence in April 2016. PPAC & staff currently being consulted and volunteers for rotas sought. Working on Rota to cover our first commitment Saturday 30th April.	Rachel Barlow	31/03/2016	06/05/2016	Bi-Monthly	2x3=6	Treat

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
						Locum arrangements in place to support workforce plan. Two consultants recruited who will start in 2017.	Short term increased risk with planned sickness and leave to be reviewed urgently and mitigation determined. Locum cover being investigated Request for carers leave under review. Pilot to cover Satureday and Sunday 9-5pm at SWBH, Wolverhampton and Dudley with BCA commenced April 16; SWBH has received it's first OOH patient. To be done on a rotational basis						
332 Live (With Actions)	Maternity_ Health		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.	Mitigation plan up to end March successfully completed, however another national shortage is likely.	Rachel Barlow	30/09/2016	15/06/2016	Monthly	**2x2=4**	**Treat**

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current 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. Backlog reduced. All parents offered appointment by end of Feb						
538 Live (With Actions)	Scheduled Care	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.	New system being introduced to equalise waits from beginning of May.	Roger Stedman	31/07/2016	04/04/2016	Monthly	**1x4=4**	**Treat**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework 2016/17**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Executive Group**
DATE OF MEETING:	**7 July 2016**

EXECUTIVE SUMMARY:

Attached is the draft Board Assurance Framework for 2016/17.

The BAF was developed from a Board Development Session held on the 10 June 2016. Since then Directors have reviewed the major risks to the delivery of the Trust's annual priorities for the year as outlined in the annual plan. The controls in place to manage the risks and the assurances that the controls are working effectively are also included as key elements of the BAF, alongside any action plans to address any gaps in control or weak /absent assurance.

Final revisions will be made post the discussion at the Board and the BAF will be presented quarterly to the Board to ensure effective oversight as well as the relevant priorities being monitored by the appropriate Board committee.

REPORT RECOMMENDATION:

- The Trust Board is asked to review and accept the Board Assurance Framework, subject to any final revisions.
- The Board to receive quarterly updates on the Board Assurance Framework.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

The BAF is aligned to all strategic objectives and annual priorities.

PREVIOUS CONSIDERATION:

The Board annually reviews the Board Assurance Framework with reports to the Board and the relevant Board committees.

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan as at 31 March 2016	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions as at 31 March 2016	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	There is a risk that readmission rates will remain above national norms caused by a lack of clinical engagement or effective partnership working with GPs and Social Services. This represents poor care and also carries a significant financial risk if the terrify rules are strictly applied.	Q&SC	4	3	12	An ongoing integration into the Urgent Care Delivery Programme ensuring effective end to end care. Community proposal for pilot expansion of iCARES in-reach to AMU. Controls include: • Operational Management	IPR Local action plan Papers to sub committees and Trust Board Minutes of meetings	3	3	9		Deputy COO for Urgent Care to start in September 2016 will provide increased senior leadership capacity to ensure pace and execution of delivery System response to aspects delivery plan Consistent LACE discharge bundle applied in all wards	31/3/17	2	3	6
COO	002-SHQC	Improve the experience of outpatients through implementing our outpatient transformation programme	There is a risk the full intended benefits of the programme are not delivered leading to poor patient experience and wasted capacity	Q&SC	3	4	12	YOOP programme board chaired by the CEO. Project groups with governance infrastructure reporting to YOOP including partial booking, electronic referral management, and speech recognition. Controls include: • YOOP • Operational Management Committee • Group reviews • Performance Management Group	IPR – waiting times, DNA and cancellation rates Project reports and delivery of associated KPIs Minutes of YOOP Trust Board Patient survey	2	4	8		Deputy COO for Planned Care starts in July 2016 will provide increased senior leadership capacity to ensure pace and execution of delivery	31/03/2017	2	4	8
CN	003 -SHQC	Achieving the gains promised within our 10/10 programme	There is a risk that 10/ 10 will not be consistently embedded across the Trust caused by a lack of clinical engagement or effective business change capability which will result in inconstant high standards of patient safety and high quality care.	Q&SC	3	3	9	Key risk controls and treatment include: • 100 day implementation project • Group Reviews • The Safety Plan and key performance indicators against each standard	Group review process to check on progress and achievement Internal audit of assessment units following the 100 implementation programme	2	3	6	3	Minutes of Board meeting evidencing effective challenge including the Trust Board, Quality and Safety Committee, Patient Safety Committee and Performance Management Committee Gaps include effective staff training in business change and ongoing effective targeted communication.	31/03/2017	1	3	3

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
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. In-house inspections with external engagement and the analysis of key themes. The existing team of 50+ staff inspectors is to be strengthened with the introduction of 20-25 people from the NHS Retirement Fellowship and partners, which will give us more bandwidth of experienced NHS staff.	March 2017	**1**	**4**	**4**
COO	005 -SHQC	Tackling caseload management in community teams	There is a risk that the 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	3	3	9	Programme detailed for adult services with delivery reporting via Clinical Group Review process Additional controls include: • Quality and Safety Committee • Trust Board	Project update Group and Trust Board / subcommittee review minutes	3	3	9		Women and Children's programme for 2016-17 to be defined. Presentation to Quality and Safety in July 2016.	31/3/17	2	3	6
COO	006-AR	Meet national wait time standards and deliver a guaranteed maximum six week outpatient wait	There is a risk that the Trust will not meet national waiting time standards and deliver a guaranteed six week outpatient wait. This will be caused by an overreliance on key staff, data fragmentation and ineffective competencies through the delivery chain to deliver the plans pertaining to patient activity at access standard level. This will result in target failure.	Q&SC	4	4	16	Demand and capacity plan triangulated and integrated with delivering contracted activity and performance standards. Controls include: • Operational Management Committee • Group reviews • Performance Management Group • YOOP	IPR Delivery against trajectory plans Minutes of meetings	3	4	12		Deputy COO for Planned Care starts in July 2016 will provide increased senior leadership capacity to ensure pace and execution of delivery	31/3/17	3	4	12

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 risk that the doubling of safe discharges is not achieved caused by weaknesses in partnership arrangements, ineffective ward team and ward manager leadership and inadequate training which would result in targets to deliver improved care not being achieved and the subsequent financial implications for the Trust.	Q&SC	4	5	20	ADaPT project plan revised for this year. Sponsored by COO and has supporting delivery infrastructure. Ward leadership development programme to ensure capability in ward team leadership in train. Controls include: • Urgent Care Delivery • Operational Management Committee • Group reviews • Performance Management Committee • System Resilience Group	IPR Capacity data set Minutes of meetings	4	4	16		Revised approach to effective relationship with new SMBC arrangements. Assurance capacity and demand alignment in residential, nursing and enhanced assessment beds. Data set and performance framework for clinical ward teams and ward leaders. Deputy COO for Urgent Care to start in September 2016 will provide increased senior leadership capacity to ensure pace and execution of delivery.	31/3/17	3	4	16

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	008-AR	Deliver our plans for significant improvements in our universal Health Visiting offer, so 0-5 age group residents receive a high standard of professional support at home	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	Local delivery programme and recruitment plan in place. Controls include: • Group performance review • Quality and Safety	Group review Minutes of meetings	3	3	9		Workforce design through integration with midwifery.	31/3/17	3	3	17
COO	009-AR	Work within our agreed capacity plan for the year ahead, thereby cutting Did Not Attend rates, cancelled clinic and operation numbers, largely eliminate use of premium rate expenditure and accommodating patients declined NHS care elsewhere	There is a risk that the agreed capacity plan is not achieved, including the cutting of Did Not Attend rates, caused by system demand, an ineffective Better Care Fund and ineffective forecasting and BIU which will result in the trajectory to Midland Metropolitan Hospital alignment not being achieved.	FIC	3	5	15	Demand and capacity plan that triangulates with contracted activity and performance plan. Controls include: • Planned Care Project review weekly • Operational Management Committee • Group reviews • YOOP • Performance Management Group • FIC	Planned care dashboard Monthly activity and income Minutes of meetings	3	3	9		Deputy COO for Planned Care starts in July 2016 will provide increased senior leadership capacity to ensure pace and execution of delivery New planned care PMO to be established in July	31/3/17	3	3	9
COO	010-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 the Trust does not deliver against this ambition caused by ineffective mobilisation of the contract, weak partnership arrangements, ineffective recruitment or stakeholder engagement which will result in patients being unable to die in a location of their choosing	Q&SC	3	3	9	End of life strategy and delivery plan in place. Controls include: • Peer review • Contract management • Quality Plan • Group review • Quality and Safety Committee	Contract review via performance dashboard Peer review outcome	3	3	9		Commercial contract expertise within the Clinical Group who have a new commissioning role	31/3/17	2	3	6

COO	011-CCH	Respiratory medicine service sees material transfer into community settings, 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	Respiratory COPD and discharge bundle (pathway) in place Controls include: • Future Hospitals Project and Programme Board with executive sponsor Group Review	Delivery of KPIs identified in project	3	4	12		Project dashboard	31/3/163	3	3	9

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOFP	012-GUR	Create balanced financial plans for all directorates and deliver Group level I&E balance on a full year basis	There is a risk that the identified opportunity for financial improvement is insufficient to deliver financial balance across all directorates. There is a risk that the scale & pace of financial improvement delivered is insufficient. This is caused by 1). a lack of necessary capacity and capability 2). The risk of compromise to the safety and quality of services provided. This risk could result in a failure to generate those financial surpluses necessary to underpin the approval and delivery of key strategic investments.	FIC	4	5	20	Effective use of comparative information including peer benchmarking, best practice review and expert scrutiny. Expedited recruitment to fit for purpose senior management structures and follow through on leadership development programme. Utilisation of necessary & sufficient expert support and establishment of fit for purpose PMO & change team. Routine timely reporting & performance management of plan delivery at devolved [directorate / scheme specific] level. Timely escalation and intervention to remedy any shortfall in delivery. MPA established to assure coherence and delivery of key strategic change programmes.	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	-5	Treatment plan actions: Completion of necessary recruitment and leadership development programme. Confirmation and effective execution of workforce change consultation at necessary scale and pace. Embedding new Clinical Operating Model supported by effective Change Team and underpinned with common change methodology. Design and establishment of fit for purpose Business Intelligence Unit function delivering timely, relevant and influential information. Confirm downside contingency plan to deliver trust level I&E balance. Confirm plan to restore cash balances / liquidity consistent with FSRR level 3. Control & assurance actions: Effective PMO in place. Implementation of 'Strategic IPR' supported by lead indictor dashboard [MMH approval condition 46 compliance].	Sept 2016	2	4	8
COO	013-GUR	Reform how corporate services support frontline care, ensuring information is readily available to teams from ward to Board	There is a risk that reforming how corporate services support frontline care is not achieved caused by the BIU not functioning correctly, data invisibility, data integrity concerns or inappropriate culture which does not promote shared learning which will result in there being a disconnect between the ward and Board impacting on effective assurance of the delivery of high quality and financially sustainable care.	TB	4	4	16	Executive focus group to determine next stage of development for this objective FIC	Report to Trust Board	4	4	16		• Leadership capacity and capability to deliver next stage development	31/3/17	3	4	12

DOFP	014-GUR	Reform how corporate services operate to create efficient transactional services that benchmark well against peers within the Black Country.	There is a risk that the reform of how corporate services operate is not achieved at necessary scale and pace. This is caused by 1). Lack of sufficient capacity and capability to design & effect necessary reform 2). Delay in implementation of system replacement 3). Requirement to reform corporate services across organisations [BCA / STP] 4). Timescale for required reform is inconsistent with effective implementation of necessary improvement methodology [Lean / 4DX]. This could result in variable corporate service delivery with consequent disruption to care delivery and obligations to 3rd parties and delay in the achievement of necessary cost reduction in corporate services.	TB	4	4	16	Conclude work on revised corporate team structures and effect through workforce change consultation. Recruitment to residual gaps in corporate team infrastructure. Progress implementation of improvement methodology [Lean / 4DX] in F&P and consider roll out across corporate functions.	Management assurance. Routine reporting of transactional KPIs at CEO performance review meetings and relevant Board Committees. Independent assurance. Internal audit review of core systems and processes including performance management and data quality assurance programme. Regulator scrutiny of 'well led' assessment.	4	4	16	-	Treatment plan actions: Determine footprint and scope of services for corporate function consolidation [BCA / STP]. Determine way forwards for core system replacement. Establishment of effective transactional excellence improvement programme. Undertake baseline assessment and pilot diagnostic to include definition of what excellence looks like. Procure delivery partner to implement full diagnostic, solution design and change programme delivery. Control & assurance actions: Effective PMO in place.	Sept 2016	2	4	8
MD	015-21CI	Get NHSI approval for EPR full business case, award contract and begin implementation, whilst completing infrastructure investment programme.	There is a risk that the EPR procurement process and infrastructure investment programme is not achieved caused by too many competing demands, supplier management issues ,ineffective stakeholder engagement or data transition which will result in ineffective benefits realisation including diminished transformation of improved patient care and financial sustainability	MPA	3	3	9	Controls include: • Integrated PMO • MPA • SRO/ CRO relationship • Capital controls	Internal reporting to Informatics Committee & External Gateway review	3	3	9	0	Effective challenge through MPA of the following in respect of Estates, Workforce and Digital: • Progress reports • Risks/ benefits • Financial performance • Milestones		3	3	9

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DENHP	016-21CI	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 was 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. Although there has been some progress, further work is still needed before we can agree and publicise final location plans for services. The work should be completed in Q2.	31 March 2017	**3**	**3**	**9**
COO	017-21CI	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	There is a risk that the implementation of our RCRH plan for the Sheldon block is not achieved caused by changes to CCG commissioning intentions or workforce implications which will result in financial risks including contract sums being lower than Long Term Financial Plan and subsequent reputational risks.	FIC	4	5	20	Local plan includes workforce, clinical and estates plans proposals Controls include: • FIC • Trust Board • MPA Group review	Activity and contract monitoring	4	5	20		No firm commissioning commitments	31/3/17	3	5	15

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 as at 31 March 2016	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOD	018-EEO	Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness	There is a risk to cutting sickness absence below 3.5% caused by a lack of manager engagement, vacancies not being filled, turnover increasing, workforce consultation impact, a lack of effective communication and staff not abiding by policies which will result in short term sickness not falling and the knock on implications of the Trust's financial performance and wellbeing of those staff in work.	W&O DC	**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	019-EEO	Finalise our long term plan explaining how we will safely remove the pay-bill 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&O DC	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	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**
DG	020 -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	There is risk to creating the time to talk within the Trust caused by ineffective communications channels that are not accessed by or accessible to a proportion of our workforce, frontline/ offline staff having limited opportunity to engage, poor visibility of local leadership and lack of prioritization about time to talk among local managers. The risk is that the numbers of disengaged staff do not reduce and therefore the transformation programme becomes more difficult to implement.	WODC	4	3	12	Risk controls include • Audience segmentation and channel analysis • QIHD programme • First Friday • Leadership programme • Monthly briefing system • Your Voice survey • NHS Staff Survey • Recognition and reward schemes •	Internal Independent	3	3	9	3	Assurances include: • QIHD attendance register and outputs from QIHDs • Your Voice response rate and engagement scores • National staff survey results • Hot Topics attendance and feedback Gaps include: • Links to other workforce metrics • Local leadership	31 March 2017	3	3	9

Key		
	Safe, high quality care	Quality and Safety Committee
	Accessible and responsive	Quality and Safety
	Good use of resources	Finance and Investment Committee/ MPA Committee
	21st Century Infrastructure	Trust Board
	Engaged and effective organisation	Workforce and OD Committee

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Cancer Services: 10 point plan
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Barlow - Chief Operating Officer
AUTHOR:	Rachel Barlow - Chief Operating Officer
DATE OF MEETING:	7th July 2016

EXECUTIVE SUMMARY:

In Quarter 4, the Trust Board supported the establishment of 10 improvement goals for Cancer services designed to be delivered over the next 1-3 years. This paper provides an update on progress establishing the Cancer Board, the emerging programme of work and senior leadership appointments including a new non-executive director sponsor for cancer.

The inaugural meeting of the Cancer Board served as a mobilisation and engagement event for key clinicians and operational managers. There was great positivity about the remit of the leadership forum for cancer with regard to partnership working and delivering the improvement programme. Discussions included the importance of the culture and climate that we form through the Cancer Board to ensure effectiveness and success.

The 10 improvement goals have intended timelines for delivery by 2019. Benchmarking of the current state is in progress to inform a dashboard and a delivery trajectory. As the Cancer Board continues to form, the detail of the 3 year programme with key milestones and trajectories for improvement will be determined. Additional areas of focus for the Cancer Board and associated leadership team will include:

- Improved partnership working – with specialist providers, local community and the 3rd sector
- A focus on clinical psychology provision
- Improving diagnostic pathways
- Developing the survivorship strategy
- Staff experience and well fair
- High performing multi-disciplinary team function

REPORT RECOMMENDATION:

The Trust Board is asked to reflect on:

- the delivery timelines for the improvement goals
- the available benchmarking
- the further areas of focus identified through the forming Cancer Board

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	X	Patient Experience	X
Clinical	X	Equality and Diversity	X	Workforce	X
Comments:					

Cancer Services: 10 point plan

1. Introduction

Our strategic vision for cancer services at Sandwell and West Birmingham is to provide comprehensive and state of the art surgical and medical cancer services to the people of Sandwell, West Birmingham and the wider Black Country as locally as possible - through a number of strategic service and academic partnerships within the Black Country Alliance, regional cancer centres and local universities.

In Quarter 4, the Trust Board supported the establishment of 10 improvement goals for Cancer services designed to be delivered over the next 1-3 years. This paper provides an update on progress establishing the Cancer Board, the emerging programme of work and leadership appointments.

2. Improvement goals

In Quarter 1 the Cancer Board was established, with the aim to deliver a programme of improvement. The inaugural meeting served as a mobilisation and engagement event for key clinicians and operational managers. Terms of reference and additional membership confirmed. There was great positivity about the remit of the leadership forum for cancer with regard to partnership working and delivering the improvement programme.

The table below indicates the intended timelines for delivering the goals by 2019. Benchmarking of the current state is in progress to inform a dashboard and a delivery trajectory.

Improvement goal	**Expected completion**		**Update**
	2016-17	**2017-19**	
Improvement goal 1: access to chemotherapy within 30 minutes of appointment time	**x**		New pathway in place; Q1 performance and audit due in July to inform future development plan
Improvement goal 2: access to chemotherapy within 7 days of decision to treat	**x**		New pathway in place; Q1 performance and audit due in July to inform future development plan
Improvement goal 3: resolve the current inequity between our sites in terms of oncology admissions, in which patients known at SGH are admitted there, and those visiting City attend the UHBFT.	**x**		For progression with UHB in Q2
Improvement goal 4: achieve tumour level compliance with the 62 day treatment target		**x**	4/9 tumour sites meet the 62 day standard. Plans to be designed in 2016 to achieve this across all tumour pathways.
Improvement goal 5: agree and publish pathways for all tumour sites	**x**		Internal pathways designed for 8 pathways: • Breast • Lung • Colorectal • Prostate • Bladder • Gynae

			• UGI • Haematology At a Network level the Breast pathway is likely to be signed off regionally in July, upper GI and colorectal in September. Haemotology and gynae workshops will take place in Q3.
Improvement goal 6: Cancer patients that we treat will have some of the best health outcomes in the UK, with SWBH being among the top 20% of comparable NHS Trusts.		**x**	Benchmarking 2015 position to inform trajectory
Improvement goal 7: to increase the number of patients recruited to clinical studies		**x**	Benchmark for 2015/16 = 206. Trial recruitment for cancer has reduced by 50% over the last 5 years. A programme to inform improvement will be designed through the cancer board this year.
Improvement goal 8: By April 2017, all patients diagnosed with Breast, Prostate, Lung or Bowel cancer will receive a Holistic Needs Assessment with their allocated Key Worker (Clinical Nurse Specialist) within 3 months of their initial diagnosis, which will be recorded in their clinical notes and shared with the patient and GP.		**x**	Benchmark in Q3
Improvement goal 9: change our MDT structure, to reduce the very high proportion currently taking place on a Thursday, which makes it impossible for either oncologists, radiologists or pathologists to provide cross cover during leave of absence.	**x**		Progress with partners in Q2
Improvement goal 10: Create by July 2015 both an acute oncology and CUP MDT	**x**		Progress in Q2

A wider discussion took place at the Cancer Board within the multi-professional team pertaining to their aspirations as a leadership team of the function and outputs of the Cancer Board. In addition to the stated improvement goals, themes included:

<u>Improved partnership working – with specialist providers, local community and the 3rd sector</u>

- The Cancer Board should be a positive forum through which to progress good partnership working with UHB and other key partners
- Reach out to work with the diversity our local communities in relation screening uptake, early diagnosis opportunities and survivorship

- Getting patient ideas in how best to design services was seen as essential

Clinical psychology – capacity was considered variable

The role of psychology was seen as essential in supporting patients, carers and staff. There is variable access and provision to this service across specialties

- Review psychology capacity pan trust and SLA
- Consider BCA opportunity

Diagnostic pathways – diagnostics was seen as key to pathway improvements.

Imaging have made good progress in reducing waiting times across all domains and process all Category 7 and oncologist requested scans within 14 days from test request to report. The design of diagnostic access at tumour pathway level is essential to make further progress in waiting times and compliance at tumour level for 62 days.

Developing the survivorship strategy

With more patients surviving cancer, the survivorship agenda is essential. This is largely led by clinical nurse specialists at tumour level, who have a significant role in supporting patients through their pathways of recovery and follow up. We need to make sense of the current work in place and identify a survivorship strategy going forward. This will include:

- A CNS forum will take place in the next 2 months to inform this aspect of a development plan
- Development of the role of volunteers / befrienders – working with 3rd sector partners who do this well already, will strengthen the support to patients and carers

Staff experience and well fair

As a leadership team we will explore how we can better care for our staff's well-being, particularly for those whose work regularly involves breaking bad news. The personal effort in care and support can take it's toll and it was felt that supporting our staff through skills development, debriefing and a supportive network would be a positive contribution to staff well-being.

MDT team function

Team effectiveness and function will likely vary across clinical teams, as each team will be formed of individuals, with different leadership styles and behaviours, both impacting on team 'climate'. The Cancer Board will seek to determine what excellence looks like in respect of multi-professional team effectiveness, to inform an organisational development approach to improving cancer services and outcomes.

The group were keen to create an environment through the Cancer Board in which ideas could be generated and flourish. This cultural approach was seen as important and welcome. We will make time on each agenda for ideas related to the 10 goals to be raised, to listen to best practice and encourage learning a cross the organisation.

3. Leadership roles

The appointment of Olwen Dutton as the non-executive director with an interest in cancer is much welcomed. In establishing the role, Olwen will take an interest in the survivorship agenda, meeting clinical nurse specialists with Rachel Barlow (Chief Operating Officer) over the summer period. A visit to the chemotherapy suites will provide an opportunity to 'go, look and see' the intended improvements in the chemotherapy service this year. The annual well-being events are a fantastic opportunity to meet our patients and carers, to hear directly their stories and experiences and support improvement ideas.

Over the next 2 months substantive new appointments will be made to the Clinical Lead for Cancer (as Professor David Luesley retires in the autumn) and the Cancer Lead Nurse post. Giles Tinsley joins the organisation in July as Deputy Chief Operating Officer for Planned Care, his remit including pan Trust cancer operational leadership, completing the senior triumvirate for cancer.

The senior triumvirate alongside the named non-executive and executive director roles demonstrates the Trust commitment to taking cancer services forward and delivering on our ambitions to deliver excellence in care to our local community through our improvement goals.

4. Conclusion and recommendations

As the Cancer Board continues to form, the detail of the 3 year programme with key milestones and trajectories for improvement will be determined.

The Trust Board is asked to reflect on the delivery timelines for the improvement goals, the available benchmarking and the further areas of focus identified through the forming Cancer Board.

Sandwell and West Birmingham Hospitals NHS
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TRUST BOARD

DOCUMENT TITLE:	Learning Disability promises
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Debbie Talbot – Deputy Chief Nurse
DATE OF MEETING:	July 2016

EXECUTIVE SUMMARY:

SWBH CEO attended the 'people's parliament' in June 2014 and committed to a range of actions to improve the experience of patient's with Learning Disabilities in our organisation. Enclosed is a progress report to date which includes progress on actions arising from the Confidential Enquiry into Premature Deaths of Patients with LD 2014. This will support data quality assurance kitemark assessment .

REPORT RECOMMENDATION:

Discuss and note progress

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

Comments:

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

High Quality Care for All
LD kitemark compliance ratings

PREVIOUS CONSIDERATION:

None (to be included in future Adult Safeguarding reports to PSC , CQRM and Q&S)

Learning Disabilities Service Up-date June 2016

Introduction

- Confidential Inquiry into Premature Deaths in People with Learning Disabilities
- 'People's Parliament' -
- *The Healthcare for All* report by Sir Jonathon Michael (July 2008) is an independent inquiry into access to healthcare for people with Learning Disabilities (LD) in response to Mencap's report *Death by Indifference* about the experiences of six families whose relatives had died .

Definitions

Learning Disability:

A vulnerable adult is anyone who is 18 years of age or over who cannot protect themselves because of age, illness, disability (Birmingham Council, 2008).

This may cover service users/ patients with mental health/learning disability needs, older people, and people with physical disability.

SWBH - workforce

Staffing :
1.0 wte learning disability liaison nurse (LDLN) employed for Sandwell site
1.0 wte LDLN appointed for City site commencement date to be confirmed (July)
Both posts report to Debbie Talbot under Safeguarding, to confirm work priorities /objectives and escalate concerns.

Roles /responsibilities:
- Expert advisor
- Staff training- Patient centred care philosophy, communication skills
- Incident monitoring , trend analysis, reporting and action planning
- Standardise practice
- Policy review
- Multi-agency working (integration agenda, seamless pathways)
- Patient information / feedback

Key priorities 2016 include-
Determined as a result of the review of the Confidential Inquiry into Premature Deaths for People with a Learning Disability (CIPOLD) *Enclosure 1*:

Review of patient safety and experience in partnership with Changing our Lives (COL) Voluntary Sector organisation – remit to include 6 case studies including transition between hospital and community services and paediatric and adult services. Special interest in posture support, respiratory and epilepsy services and attitudes and behaviour of Trust staff- timetable to commence July with clinical interviews by COL team and workshop in October to feedback findings and action plan practice change.

Patient Information:
- Generic information needs to be available in Easy Read and other language formats to aid accessibility to patients and public.
- All wards will have general information and contact numbers displayed
- Information available via Information Exchange and internet.

Training:
- Safeguarding level 1 – corporate induction and Conflict Resolution Training day from Oct 08

- Safeguarding level 2 and 3 to be confirmed – following financial investment, requires course commissioning costs.
- Mental Capacity – available to all staff , targeted for internal decision makers band 7 or above, targeted local training as a response to the ward review feedback (medicine in September), included on staff nurse development programme
- Equality and Diversity Agenda

Summary:

There has been some progress in key actions(notifications, education , partnership building , mortality reviews, patient /staff information) to improve the care and outcomes of patients with LD at SWBH however progress has been limited at the City Hospital until the LDLN commences post in July 2016 to ensure equity of service provision.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Title of published report	**Learning Disability –SWBH response to :** Healthcare for All (2008) CIPOLD . 2013 and Sandwell's People's Parliament (PP)- JUNE 2014
Date of publication	**June 2016 progress up-date**
Service lead(s) for the guidance	**Debbie Talbot DCN , Jacque Ennis LDLN**

Ref	Standard	Current Comp-liance	Explanation of Compliance	Action up-date	Lead	Time-frame
1	AHC: Does the NHS trust have a mechanism in place to identify and flag patients with learning disabilities (LD) and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? CIPOLD 1 We need to know if people have learning disabilities. People with learning disabilities should be flagged on the NHS central registration system in all healthcare record systems. [The	3	Identification of patient with a learning disability on the casualty card (including new version) and Patient Assessment Record. Identification of patient with a learning disability flag on the Electronic Bed Management System. (Flag is put on from point of admission to discharge) Learning disability flag available on ICM,	Completed Learning Disability flag continues to be put on at point of admission to discharge. Work to be completed at City Hospital. To continue to gain consent to flag on ICM. 255 people with a Learning Disability will be flagged by end of	LDLN	March 2016

	Department of Health, NHS England and the Health and Social Care Information Centre] PP: 'I will find out the best way to make sure that people with a LD are flagged when in hospital and put this in place'		Pathways for referral to Learning Disability Liaison Nurse (LDN) at Sandwell Hospital and Health Facilitation (HF) at City Hospital however due to changes within the HF team patients are not being seen promptly. Referrals to LDN at Sandwell come via e-mail (also email link from flag on EBMs), staff, carers and providers of services in the community.	December 2015. Same system will be introduced to City when Learning Disability Nurse in post. (To capture patients with a learning disability from Birmingham) Learning disability referrals are picked up at City presently by Learning Disability Liaison Nurse (Sandwell) if Learning Disability flag is put on or through telephone contact. ***June 16 – daily notifications received by LDLN via EBMS , changes made to community assessment process in Sandwell to promote early notification and integrated care. Awaiting City nurse to start to ensure equity .***		
2	CIPOLD 2 Services should make changes called reasonable adjustments. This is so that people with learning disabilities can use them as easily as everybody else. Reasonable adjustments to be audited annually. Examples of best practice to be shared across agencies and organisations	2	Evidence of reasonable adjustments made including longer appointment times, carers in anaesthetic room and recovery in theatre.	Audit of reasonable adjustments required Jayne Leeson has put in a bid to CEO for COL doing an audit of reasonable adjustments. ***June 2016- Bid agreed to undertake 6 person centred case studies commencing in July 2016 and***	COL (TBC)	April 2016 ***Oct 2016***

	PP:' I will ensure that reasonable adjustments are put in place for individuals in hospital and work with others including outside organisations to find ways for this to be audited referencing the Quality of Health Principles'			***outcomes to be reported in October 2016 to determine local actions. Reasonable adjustment, transition, staff attitudes and behavior will be reviewed and reported***		
3	CIPOLD 7 People with learning disabilities should get the same investigations and treatments that other people get. Reasonable adjustments should be made if needed.	2- ***3***	Reduction of concerns raised by other agencies via safeguarding route.	Continues to be a reduction in concerns raised by other agencies. Learning Disability liaison nurse continues to work with SWBH's to make reasonable adjustments. Staff training on learning disabilities awareness addresses reasonable adjustments and advises that any reasonable adjustment made should be documented in medical notes. (Evidence for audit) ***June 2016- continues to be reduction in concerns raised supported by multi-faceted , multi-professional training , E&D agenda.***	LDLN	On-going
4	AHC: Does the NHS trust provide readily available and comprehensible information to patients with learning	2	Photosymbols purchased by SWBH Learning Disability web page	On-going. Wards/department to work with Learning Disability Liaison Nurses to design easy read	LDLN	Feb 2016 ***ongoing***

	disabilities about the following criteria? • treatment options; • complaints procedures; and • appointments.		with a Library to access easy read information for a patient with a learning disability. Easy read information developed by LDN and SALT at Heath Lane Hospital Easy read information given to patients via LDN Sandwell and West Birmingham Hospitals currently producing localised information. No appointment letter / complaints leaflet in easy read	information. Easy read library on the intranet. Continue to update. Will be working with BCPFT to design an easy read website, which will be available to SWBH Easy read appointment letter and complaints letter designed. (Unable to implement, as we could not identify patients with a learning disability. With permanent flagging in place, will need to address this as patients with a learning disability can be identified on ICM.).		
5	AHC:Does the NHS trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	2	Although there is no specific protocol in place there are Evidence of reasonable adjustments via patient and carer stories available. Evidence of referrals via family and friends to LDN following successful patient experience previously. Visiting policy. Carers assessment on PAR and	***June 2016- John's Campaign implemented across the Trust***	LDLN	Mar 2016 ***Sept 16***

			then referral to Social care Highlight of young carers within PAR. Use of relative rooms available and improved parking rates etc			
6	AHC: Does the NHS trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? PP: 'I will put in place actions to increase the awareness and competency of staff working positively with people with LD and using reasonable adjustment'	3	Although no specific protocol for routine training there is Training package completed ensuring consistency across both Sandwell and City Hospitals Ward and departmental training. Learning Disability conference planned for October 2015. Learning Disability month November 2014.	Learning Disability Awareness training continues to be offered to staff at SWBH's and Community staff. Includes reasonable adjustments. Learning Disability Awareness training for Acute Student Nurses for 2016 both at Sandwell and City Hospitals. Working with Skills for Health on an e-learning training package for learning disability awareness training. Conference to now take place in 2016. Workforce Development Plan to confirm staff training expectations ***June 2016- LD staff information leaflet drafted for level 1 awareness – will be disseminated at induction.***	DT/LDLN	Jan 2016 ***Sept 16***

				Training on registrar programme commenced		
7	AHC:Does the NHS trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	3	Confidential inquiry into premature deaths of people with an LD (CIPOLD) group is chaired by a person with a Learning Disability and there are representatives from advocacy group Changing our lives. Patient story to Trust Board LDN offered to attend provider meetings to gather Feedback.	On-going. Dates to be agreed for 2016. Main aim of group is to address recommendations of CIPOLD	CO	March 2016 ***ongoing***
8	AHC: Does the NHS trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	2	Patient survey includes patients with a Learning Disability. Feedback from carers , families and providers. Audit completed in 2012 regarding the care of patients with a learning disability by changing our Lives.	***June 2016 – on recruitment of LDLN for City routine case study review to be undertaken to inform practice***	DT	Feb 2016 ***Sept16***
9	CIPOLD 5 Patient-held health records to be introduced and given to all patients with learning disabilities who have	2	Hospital passports introduced into SWBH.	Passport being used in SWBH's and are promoted with people with a learning disability, families, provider	DT/LDLN	TBC

	multiple health conditions PP:' I will explore options for putting in place patient held records to be developed in co -production for people with LD			services and staff. IT project 'Better Outcomes for People with LD Transforming Care for Health' in conjunction with COL commenced to review access to healthcare support for patients with LD on epilepsy and respiratory pathways ***June 2016 – meeting with COL – project ongoing attendance by LDLN***		
10	CIPOLD 10. Mental Capacity Act advice to be easily available 24 hours a day	4	Legal team available 24 / 7	Legal team available 24/7.		
11	CIPOLD 12 There is a need for good quality training about the Mental Capacity Act. This must be regularly updated for staff that work in health or social care.	4	Mandatory training for band 7's and above. Ward based training available and access to Adult Safeguarding team	Safe-Guarding team. MCA covered in Learning Disability Awareness training.		
12	CIPOLD 13 Do Not Attempt Cardiopulmonary Resuscitation Guidelines (DNACPR) to be more clearly defined and standardised across England	N/A	National development SWBH policy	National development. Evidence of practice. SWBH policy. Need to address training on DNAR/CPR for medical staff.	Resuscitation team	
13	CIPOLD 14 There is a need for good long-term planning for people's health needs. This must look at the whole person. Advanced health and care	N/A		Annual Health checks to be completed by GP practices. Work to be completed by Health Facilitation Nurses in Sandwell.		

	planning to be prioritised. Commissioning processes to take this into account, and be flexible and responsive to change.			Meeting with the team in January 2016 to move forward.		
14	CIPOLD 15 When someone is near the end of their life they should get help from specialists. This can help make sure people with learning disabilities get good care when they are dying. The Mental Capacity Act must be followed. [National End of Life Care Programme and the Department of Health]	2-***3***	Palliative care specialists available 24/7 Continues to be joint working with Palliative care specialists including joint training initiatives and individual patient advice	Further developments required to ensure PCT have skills to meet needs of patients with LD and LD community are accessing specialist PCT More written information required (available from Macmillan on cancer related issues) ***June 16 – further education to community teams to meet EOL care needs for patients with LD ,. LDLN at Swell attends community nurse meetings to discuss cases and support care planning*** ***EOL needs reviewed at mortality group represented by DCN and Palliative Care Consultant***	DW/AL	TBC
15	CIPOLD 16 We need a system nationally for recording the deaths of all people with learning disabilities. Some of the deaths would need to be investigated. This will help us to learn more about the reasons why people with learning disabilities die.	2-***3***	All patient deaths are reviewed individually to determine if death was preventable and any learning opportunities	Data checked not all patients identified were patients with a learning disability. Data checked by Learning Disability Liaison Nurse. Action presented at MQUAC Dec 17th and agreed to retrospectively review deaths this year . future MQUAC reports would identify patients with	LDLN SP	Feb 2016

	CIPOLD 17 Systems in place to make sure that there is local data about deaths of people with learning disabilities. This should be published on population profiles and Joint Strategic Needs Assessments			LD as co-existing condition and analysis of findings report submitted ***June 2016 – care of people with LD recognized locally and nationally all deaths reviewed by medical consultant and presented at multi-professional mortality meetings for discussion and action as indicated. Preventable deaths are recorded and investigated as SUI's***	DT	
16	CIPOLD 9 A lot of people with learning disabilities have serious chest infections. People with chest infections need to see a doctor quickly and get the right treatment. Adults with learning disabilities to be seen as a high risk group for deaths from respiratory problems.	3	Patients who present are triaged according to category of assessment need. Patients are nursed on appropriate speciality cared for by MDT with expert knowledge in respiratory medicine.	We need to collect and collate data regarding patients with LD accessing respiratory pathways IT project 'Better Outcomes for People with LD Transforming Care for Health' in conjunction with COL commenced to review access to healthcare support for patients with LD on epilepsy and respiratory pathways. Initial meetings undertaken and contacts with respiratory team and IT required	DT/LDLN	
17	PP: ' I will increase the numbers of people with LD employed by SWBH by focusing on people in transition'	2	Easy access to work experience and apprenticeship opportunities and dedicated specialist support facilitated by Learning Works	Active promotion of opportunities to local organisations supporting candidates with LD. Use of appropriate graphics and visual material to support access to all candidate groups. Continue to	***Maxine Griffiths Widening Participation Manager***	***ongoing***

			Individuals currently supported through a combination of apprenticeships, work experience and work club with disabilities including Autism and Asperger's Syndrome	challenge service providers within our organisation to remove barriers to host candidates identifiable as eligible. ***June 2016-During the month of June we have seen an increase with supporting people with dyslexia in particular, along with social needs, mental health problems, hearing impairment and Asperger's Syndrome.*** ***An example of support- an apprentice showing signs of dyslexia in her off the job training sessions in particular with her English skills so we supported her to obtain a formal assessment and now has a recognised diagnosis***.		

Other CIPOLD recommendations for national / community services					
N/A	CIPOLD 3 NICE Guidelines to take into account multi-morbidity.		National Development.		

N/A	CIPOLD 4 A named healthcare coordinator to be allocated to people with complex or multiple health needs, or two or more long-term conditions		National Development.		
N/A	CIPOLD 6 Standardisation of Annual Health Checks and a clear pathway between Annual Health Checks and Health Action Plans [Department of Health and NHS England]		National Development.		
N/A	CIPOLD 8 Some people with learning disabilities have difficulty using medical services. When this happens the person should be quickly referred to Community Learning Disability Teams who should help these people.		National Development.		
N/A	CIPOLD 11 The definition of Serious Medical Treatment and what this means in practice to be clarified		National Development.		
N/A	CIPOLD 18 A National Learning Disability Mortality Review Body be established		National Development		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PUBLIC TRUST BOARD

DOCUMENT TITLE:	**Long Term Workforce Plan - Paybill position 16-18**
SPONSOR (EXECUTIVE DIRECTOR):	**Raffaela Goodby – Director of Organisation Development**
AUTHOR:	**Raffaela Goodby – Director of Organisation Development**
DATE OF MEETING:	**7th July 2016**

EXECUTIVE SUMMARY:

This paper sets out the next steps in the Trust's well publicised long term workforce plan that reflects the workforce changes and reductions required. The long term financial model requires the Trust to save £30m in pay reductions during 2016-2108. The Trust Board committees have followed a robust assurance process during Q1 of this year in developing workforce schemes that will safely remove c450 WTE posts during the 2 year period.

REPORT RECOMMENDATION:

The Board is asked to:

1. REVIEW and CONFIRM SUPPORT to the long term workforce plan, and note the 2016-2018 workforce impact and schemes developed to date.
2. RECONFIRM delegated authority to the Chief Executive and Director of Organisation Development to proceed with the workforce consultation in July 2016.
3. NOTE the assurance process including executive and board committees that has been followed to date, and will take place before the consultation launches.

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 and High Quality Care
Board Assurance Framework 15-16 and 16-17

PREVIOUS CONSIDERATION:

Background

1. The transformation of services set out in the Trust's Board's well publicised and known long-term financial and workforce plans. This report gives an update on the 2016-2018 delivery of the long term plan which seeks annual recurrent efficiencies of the order of £45-50m by the end of 2017/18. This necessitates change across all resources, including pay and workforce. Spend on our workforce accounts for 68% of all our Trust costs. The Trust aim to deliver a £30million-plus recurrent saving in pay and workforce costs; and to deliver £10m-plus of the in-year pay CIP in 2016/17. Approximately 80% of the pay and workforce savings will be delivered through headcount reductions.

2. The Trust launched a small consultation on 6th April 2016, the 'Easter' consultation, which is now concluded and in implementation. The outcome is an expected reduction of 24 WTE with a financial impact of £1.1m. The outcomes from these schemes were approved for implementation at June 2016 Trust Public Board following a recommendation from the Trust Workforce and OD Committee.

3. The Trust are now preparing to launch a larger workforce consultation on approx. 450 WTE , this will launch between 19th - 31st July for a statutory 45 days. To minimise impact on our staff and create as much certainty as possible, the aim is for this to be the only major consultation in financial years 2016-2018.

4. The workforce schemes developed to date have been subject to scrutiny from the Quality and Safety Board Committee and the Workforce and Organisation Development Board Committee during June 2016. The schemes are also validated and scrutinised weekly at an executive led PMO.

5. There will be a further consultation in April 2018 that will consult on the reconfiguration workforce changes as a result of moving to Midland Metropolitan Hospital in October 2018. The long term workforce and financial model predicts this will total approx. 400 WTE.

Sources of assurance

6. In addition to Board, Committee and Executive oversight, assurance on the process and outcomes will be provided as follows:

    a. Robustness of the consultation process. The Trust has relevant recent experience in running successful consultations over the last two years, in the 'Safe and Sound' and 'Easter' consultations. This consultation will use the same subject matter experts, Staffside representatives and consultation process, albeit at a greater scale.

    b. Quality Impact Assessment. All change schemes affecting workforce have a QIA signed off by the relevant local director; and by the Medical Director and Chief Nurse.

    c. Equality Impact Assessment (EIA). Scheme leads are required to complete a quality impact assessment of their scheme that details the likely impact on safety (if any) and the quality of patient care, including how these concerns could be mitigated. This is then considered by the group director, to identify any cross dependencies and feel assured that all risks have been identified and mitigated. The group director can ask for

more information or challenge. This information is reported on TPRS with the scheme information for the medical director or chief nurse to sign off at executive level. The schemes can then be scrutinised at a Trust level, and additional challenge back to the group to consider before being approved for consultation.

d. The robustness and deliverability of group schemes have been reviewed regularly over the last 6 months via Project Management Office (PMO) and Executive reviews. There will be an ongoing quality impact milestone assessment developed and led by the Trust's executive director of governance process will develop 'red flag' indicators that are indicators of whether the scheme is on or off track from a quality and safety perspective. This will be developed in time for scheme implementation from September 2016.

e. Seek board to reconfirm delegated authority to the Chief Executive and Director of Organisation Development to approve the launch of the 45 day consultation when they are assured that the workforce and financial ask is sufficient and can be safely achieved.

f. The proposed schemes will not be implemented until the public Trust Board approves their content and impact following the consultation period.

Process and key milestones

7. Work continues at pace to finalise the 200+ schemes making up the consultation, and to complete all Quality Impact Assessments. The current schemes captured show an estimated pay bill reduction of £26m. Work is ongoing to fill the gap before the consultation can proceed.

   <u>Key schemes in summer consultation:</u>

   Medical Records
   This is a significant scheme affecting approx. 50 WTE posts. The medical records staff currently manage paper records across the hospital sites, and ensure that all patient records are stored, filed and recovered for patient activity. When the new electronic patient record is implemented in 2017, the need for this role will decline. The Trust's intention is to consult this summer on changes to be implemented in 2017. This means that the Trust can provide a personalised approach to the staff who need to be retrained and supported in to other roles in the Trust. It gives a clear 12 months to offer development, taster sessions, retraining and placements in other roles. The Trust are considering a specific retention plan for this group of valued colleagues to support them through this transient period.

   Beds
   There are a number of schemes that relate to the Trust's bed base in the workforce change. This involves reducing the length of stay, and delivering on extant plans to reduce the bed capacity and numbers. This will have the impact of reducing the number of people who staff those wards currently, moving them to other vacancies in the Trust, and reduce the agency and bank spend that is used to cover those temporary wards. There are bed schemes in Medicine, Surgery A and Surgery B.

Ward Support Officers
This scheme has been developed through the corporate nursing and facilities directorate with significant support through CLE and previously discussed at Trust Board. This will consult on moving the accountability for the cleanliness of the ward, to the Ward Sister or Charge Nurse. This means that the ward support officer (who clean the ward) will have their work allocated and supervised by the ward leader who is present and managing the ward. This works well in other organisations. The consultation will also consider the shared / corridor areas and consult on the arrangements for those.

Theatre Efficiencies
The summer consultation will consult on the proposals to increase our use of our theatres to ensure we are using them to their full capacity. This will involve staffing changes, but importantly aims to make the best use of the skills and time of each clinician and supporting member of staff during each theatre session to be productive.

Agency and Bank Spend
The summer consultation will consult on a significant scheme that aims to reduce agency and bank spend by around £6m FYE. This will focus on robust governance, a full review of the booking and approval process for agency spend, and a review of the staffing ratios to ensure they are still aligned to the national norms and guidance. The review will take an in depth look at our 'specialling' arrangements, ensure that there is consistency in the way that bank or agency shifts are booked, and implement new (tougher) arrangements for booking temporary staff in advance. It will also eradicate use of off framework agencies for nursing and move towards that position for medical staff under the NHSI guidelines.

8. Recommendations

The Public Trust Board is asked to:

4. REVIEW and CONFIRM SUPPORT to the long term workforce plan, and note the 2016-2018 workforce impact and schemes developed to date.

5. RECONFIRM delegated authority to the Chief Executive and Director of Organisation Development to proceed with the workforce consultation in July 2016.

6. NOTE the assurance process including executive and board committees that has been followed to date, and will take place before the consultation launches.

Raffaela Goodby
Director of Organisation Development
30th June 2016

		Lead
Scheme Preparation - Phase 1	**Q2 Schemes: Groups/TSO to confirm 'state of readiness' to proceed.**	**HR**
	Group Directors and scheme leads informed of project timelines and expectations.	**HR**
	Executive Group to review Q2 proposals.	**CEO**
	Scheme Leads to undertake pre-consultation with relevant depts/teams.	**Group Leads/HR**
	Scheme leads prepare supporting paperwork in readiness for consultation.	**Scheme Leads/HR**
	Group Directors and HR Business Partners to prepare consultation paperwork	**GDOp's/HR**
	Consultation Scheme Sheet submission deadline.	**Scheme Leads**
	Scheme leads and line managers attend preparatory briefing sessions.	**HR**
	L&D provide management of change support sessions for scheme leads and line managers.	**L&D**
	Publish Management Resource Guidance	**HR**
	GDOp's to attend project launch meeting.	**GDOp's/HR**
	Scheme leads/line managers to attend project launch meeting.	**Scheme leads/HR**
	GDOp's to attend weekly project oversight meetings.	**GDOp's/HR**
	Scheme Leads/Line Managers attend weekly HR Management Briefing Sessions	**HR**
	Scheme Sheet - check fitness for publication on Connect.	**HR**
	Scheme Sheet - Publication on Connect	**Scheme Leads**
	Scheme Leads to attend bespoke redundancy selection interview training (if required).	**Scheme Leads/L&D**
	Scheme leads - Plan selection panels, proposed selection tests and interview questions. Book venues for interviews	**Scheme Leads/GDO's**

Consultation/Selection /Appeals	**Formal Consultation Launch - Special Meeting JCNC**	**HR**
	Undertake formal consultation (assuming 45 days statutory consultation).	**HR/Scheme Leads**
	Undertake Local consultation - recording of issues/concerns on issues logs	**Scheme Leads**
	Identify 'at risk' employees in accordance with Organisational Change Policy	**HR**
	Issue 'At Risk' Notification Letters	**HR/Scheme Leads**
	Consider individual feedback regarding proposed selection pools.	**HR/Scheme Leads**
	Hear Pooling Appeals	**Exec's**
	Undertake Selection Interviews.	**Scheme Leads**
	Undertake Individual Consultation Meetings	**Scheme Leads**
	Complete quality check of selection interview process.	**GDOs**
	Notify selected employees of Selection Outcome	**GDOp's/Scheme Leads**
	Hear Final Appeal Hearings	**Executive Group**
	Complete Consultation and Review Scheme Changes/Issues Logs - Finalise Scheme Proposals	**Scheme Leads/HR**
	Trust Quality and Safety Committee Approval	**RG**
	JCNC - Confirmation of Outcome of Consultation Process	**RG/LB**
	Trust Level Approval to Proceed	**CEO/RG**

Redeployment	**Deliver training on interview skills for At Risk employees**	**L&D**
	Employees Selected for Redeployment Apply for Internal Vacancies.	**HR**
	Managers Shortlist	**Recruiting Managers**
	Interviews for vacancies ring-fenced for At Risk employees	**Recruiting Managers**
	Completion of pre-employment checks	**Recruitment**
	Commencement of Redeployment Trial Periods	**Recruiting Managers/HR**

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Redeployment	Deliver training on interview skills for At Risk employees	L&D
	Employees Selected for Redeployment Apply for Internal Vacancies.	HR
	Managers Shortlist	Recruiting Managers
	Interviews for vacancies ring-fenced for At Risk employees	Recruiting Managers
	Completion of pre-employment checks	Recruitment
	Commencement of Redeployment Trial Periods	Recruiting Managers/HR

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:	7 July 2016

EXECUTIVE SUMMARY:

The report is presented to inform of the performance for the Trust for the period to May 2016.

IPR – Summary Scorecard for May 2016 (In-Month)

Summary Scorecard

Section	Red Rated	Green Rated	None	Total
Infection Control	1	5	0	**6**
Harm Free Care	5	8	2	**15**
Obstetrics	2	5	6	**13**
Mortality and Readmissions	1	1	11	**13**
Stroke and Cardiology	4	7	0	**11**
Cancer	0	10	4	**14**
FFT. MSA, Complaints	11	5	5	**21**
Cancellations	4	5	0	**9**
Emergency Care & Patient Flow	7	7	4	**18**
RTT	6	2	6	**14**
Data Completeness	1	9	8	**18**
Workforce	11	1	10	**22**
TOTAL	**53**	**65**	**56**	**174**

- May performance has 53 exceptions (red rated indicators) (45 last month)
- Relevant recovery plans are overseen through the executive Performance Management Committee.
- Exception reporting is provided to CCG and NHSI as required. Currently focus RTT 52 week breaches and anticipated May 62 Day Cancer breach
- The Trust has 2 outstanding exceptions to the CCG (both are RTT 52 week breaches for Cardiology and Dermatology – Feb16)

Matters to draw to the Committee's attention :

May Delivery

× **62 day cancer** target non-compliance in May (validation ongoing but expected at 84.3%) – June month and Q1 period anticipated to deliver to standard.

✓ **RTT** (incomplete pathway) delivered to 92.5% standard; however, with 2 patients **breaching 52 wk wait stnd**

✓ **Acute Diagnostic waiting times** continue to consistently operate within the 1% tolerance

× **ED 4 hour** performance in May was 92.9% just below the NHSI target of 93.1% and below the national target of 95%. May resulted in 1,451 breaches.

× **Hip fractures** – 53% in month and representing third consecutive month of failing target

Other – positive delivery

✓ **Infection control** delivers across all indicators in May and well within targets

✓ **VTE** in April delivery 96.0%

✓ **Staff sickness** in –month rate reduces to 4.1% in May (from 4.85% March)

Requiring attention

- Hip fractures – 53% in month and representing third consecutive month of failing target against good past performance – good imaging and reporting practice to be reinforced including ED processes and trauma co-ordinator nurse; June predicted to fail against the 85% target
- Cancelled operations (particularly multiple) and theatre utilisation remain above / below expected levels. Full end to end process has to be reviewed to ensure that admin processes are in place and working as well as good cancellation procedures are followed – a remedial action plan is recommended to drive out the various issues for improvement that the group are looking at
- Harm free care – ongoing marginal non-compliance with national standard - Pressure ulcers and falls
- Stroke performance to be reviewed to ensure it starts delivering the 'within 4 hours to stroke unit' and scan within 24 hours targets; this is not regularly breaching
- Ensure thrombolysis continuous to recover and good practices need to continue
- VTE Assessments – continued attention to delivery to improve consistency of delivery across all groups; medical director to focus on improving non-compliant areas
- Mortality reviews at 61% - renewed focus required to improve this to deliver CQUIN
- CQUIN delivery and Q1 reporting
- Trust local quality requirements and resulting fines to be embedded within senior management teams to ensure recovery progresses

Forward Look – NSHI Improvement Trajectory - Key Access Targets:

		Apr-16	May-16	Jun-16
A&E	Projection	92.5%	93.1%	93.4%
	Actual Delivery	91.4%	92.9%	91.2%
CAN (62 Days Referral to Treatment)	Projection	85.0%	85.0%	85.0%
	Actual Delivery	87.5%	84.3%	85.0%
RTT - Incomplete Pathway (18-weeks)	Projection	92.0%	92.0%	92.0%
	Actual Delivery	92.4%	92.5%	92.3%
Patients Waiting >52 weeks (Incomplete)	Projection	2	2	2
	Actual Delivery	2	2	3
Diagnostic Tests	Projection	0.42%	0.42%	0.39%
	Actual Delivery	0.32%	0.1%	0.3%

Failure to achieve the above standards will result in a reduction in the value of Sustainability & Transformation Fund [STF] resources agreed as supporting the trust's financial control total. The financial value at risk remains to be confirmed as the jeopardy regime is finalised.

The STF regime operates such that any financial penalty incurred relating to the above standards is not duplicated by fines levied by commissioners under their contracts. Commissioners will still be entitled to levy fines for failures of all other contract standards [e.g. ambulance handover; information timeliness] and are indicating a more aggressive approach to the identification and pursuit of such fines.

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: May 2016

Reported as at: 29/06/2016

Contents

At Glance - May 2016

Infection Control

No C. Diff cases reported during the month of May;
x2 cases year to date against the 16/17 target of 5 cases up to May
Max x30 cases for the year have been agreed within the CCG Contract 16/17.

No cases of MRSA Bacteraemia were reported in May and therefore zero on year to date basis.

Annual target of zero against this indicator within the CCG Contract 16/17.

MRSA Screening
- Non-elective patients screening 93.1% (compliant with 80% target)
- Elective patients screening 94.0% in month (compliant overall with target 80%);

Elective screening performance compliant in all groups with exception of medicine - scheduled care @ 43% subject to follow up investigation.

MSSA Bacteraemia (expressed per 100,000 bed days) for the month of May at 10.5 against a tolerance rate of 9.42. Year to date the rate is at 5.1 and within target.

Harm Free Care

93.4% (94.96% last month)compliance with NHS Safety Thermometer missing the target 95.0% in May - a worsening on last month where performance was at 94.96%. Mainly driven by falls and pressure ulcers.

x86 falls reported in May with no falls resulting in serious injury. 38 falls within community and 48 in acute.

April pressure sores reported (x14 hospital acquired) have been revalidated post TTR and the revised position April is 11 cases. For the month of May there are 11 avoidable pressure sores reported of which: x9 cases were hospital acquired and x2 cases reported within the District Nursing caseload .

x1 serious incidents reported in May, 3 year to date.

No Never Events were recorded in May - x1 event in June.

There were no medication error causing serious harm in May.

x13 Open CAS Alerts reported at the end of May, of which none were overdue at the end of month.

Venous Thromboembolism (VTE) Assessments in May at 96.0% against the national target of 95% and short of local target of 100%.
On-going focus of attention to secure a more consistent and improved performance this year. Missed compliance in 3 areas and Medical Director is focussing on improvement.

Obstetrics

The overall Caesarean Section rate for May 22.1% meeting the target of 25% in the month and recovering the year to date position now at 24.3%.
.
Elective and Non-Elective rates in month are 7.4% and 14.7% respectively.

Adjusted perinatal mortality rate (per 1000 births) for May is 16.16 (4.37 last month) being above the tolerance rate of 8. The indicator represents an in-month position and which, together with the small numbers involved provides for sometime large variations. There is no underlying, specific cause for this performance from a service perspective.

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 and for May the delivery is 80.3%; The group has been asked to assess performance and report back on reasons as to why consistently below the target; however, performance is consistently delivering to nationally specified definitions in large part due to significant excess of registrations over births in the Trust.

Breastfeeding initiation performance was at 74% on a cumulative basis as at quarter 4, below the target of 77% then, but the target has been revised to 74% based on the Trust's good performance therefore but expected to sustain it.

Mortality & Readmissions

The Trust overall RAMI for most recent 12-mth cumulative period is 103 (latest available data is as at February)
RAMI for weekday and weekend each at 105 and 99 respectively.

The impact of national re-basing previously reported is the subject of a separate paper to the Board.

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

Deaths in Low Risk Diagnosis Groups (RAMI) - month of February 113 - this indicator measures in-month expected versus actual deaths so subject to larger month on month variations. Not a significant cause for concern.

Crude in-month mortality rate for April is 1.5, and is lower to last year same period. The rolling crude year to date mortality rate remains static at 1.3 and also lower than last year same period. There were 142 deaths in the hospital in the month of April.

Mortality review rate in March at 61% a worsening on previous periods, but does follow extremely busy periods for the trust including doctors' strike actions.
A local CQUIN is in place for 16/17 to improve performance compared to Q4 15-16 which now known to be at 68%.
Therefore there is improvement required against this indicator.

Readmissions (in-hospital) reported 7.6% in April (7.9% previous month); [8.0% rolling 12 mnths]. The performance has been coming down slowly over the last few months, however still have compared to the peer group which is at 6.2%.
Readmissions is a local CQUIN in 16/17.

Stroke Care & Cardiology

Stroke data for May indicates 92.3% (97.9% last month) of patients spending >90% of their time on a stroke ward which is in line with the 90% operational threshold;

May admittance to an acute stroke unit within 4 hours 74.4% failing short of the 80% national target. 8 patients breached of which 3 are due to clinical reasons and 5 due to hospital capacity and resulting delays.

Pts receiving CT Scan within 1 hour of presentation is at 77.8% in May (65.9% LM) ; being compliant with 50% standard.
Pts receiving CT Scan within 24 hrs of presentation delivery at 97.8% in month below the 100% target a second month running.

There were no eligible patients receiving thrombolysis within 60 minutes of admission as at May. June eligible patients so far are at 100% compliance.

For May, Primary Angioplasty Door to balloon time (<90 minutes) was at 100% and Call to balloon time (<150 minutes) also at 100% hence both indicators delivering consistently against 80% targets;

RACP performance for May is at 100% exceeding the 98% target.
From 1st April count is being amended to appropriately be 'from receipt' of referral (vs. date of referral).

TIA (High Risk) Treatment <24 Hours from receipt of referral delivery as at May is at 100% against the target of 70%.
TIA (Low Risk) Treatment <7 days from receipt of referral delivery at May is 100% against a target of 75%. Both indicators continue to deliver consistently.

Cancer Care

The Trust has met all its national cancer targets in April and is in line with the NHSI Improvement Trajectory
The 62-day urgent GP referral to treatment target, with overall performance of 87.5% (vs. 85% target). 8.5 patients waited more than 62 days in April. Gynae x3, Upper GI x2, Urology x2,

May 62 day delivery performance is expected at 84.3% so below standard . Subject to ongoing validation (10.5 breaches with 4.5 in Urology); June performance expected to exceed target delivery of 85% and so securing necessary compliance for Q1.
all other targets will be met consistent with national targets.

3 patients were waiting more than 104 days at the end of April
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. There is more focus on the tertiary referral timelines now, within 42 days, in the absence of a national policy on this, the cancer network will work towards an interim framework. The longest waiting patient is at 175 days in April.

Patient Experience - MSA & Complaints

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

-Inpatients FFT for May is below the score and response target, the failure to achieve response rate is a consistent position.
- A&E is missing both targets for scores and response rate in May, which again has been a continuous position during the year. However, type 3 emergency is meeting targets.
- Outpatients FFT is below the required score rates.
- Maternity scores routinely compliant with exception of birth element.

The number of complaints received for the month is at 94 (in line with recent volumes), with 2.9 formal complaints per 1000 bed days.
All have been acknowledged within target timeframes.
The level of responses beyond the agreed timeframe is 5.6 % (2.6% last mnth) above the last two months, but still considered a good performance.

Patient Experience - Cancelled Operations

The proportion of elective operations cancelled at the last minute for non-clinical reasons was 0.7% for May (0.5% previous mnth) meeting the in-month tolerance of 0.8%. Reduction observed over the last 3 months .

No breaches of 28 days guarantee were reported in May and no urgent cancellations took place during the month.

63 [vs. 79 last month] of all cancelled patients were multiple cancellations in May, however this does count patient driven as well as clinical reasons for cancellations including admin issues. Going forward this will be identified separately.
Admin processes, which are a significant root cause issue need an improvement plan. Non-compliance reviews against specific issues will be investigated in detail. A reminder to go out to consultants to remind them of the rules on cancellation and process to follow.

Theatre utilisation is consistently below the target of 85% at a Trust average of 74.3%
The theatre capacity and performance is subject to remedial action through Theatres Board and theatre performance reporting will be part of this review with a specific set of reporting.

Emergency Care

The Trust's performance against the 4-hour ED wait target in May was 92.88% (91.4% in April) against the 95% national target and against the 93.1% NHSI Improvement Trajectory.
1,451 breaches were incurred in the month of May.

WMAS fineable 30 - 60 minutes delayed handovers at 65 in May (81 in April, 117 in March) decreasing significantly month on month.
Over 60 minutes delayed handovers were zero in May - first ever performance at this rate.
Handovers >60mins (against all conveyances) are at 0.0% against the target of 0.02% - again a first performance. This is against a high level of total conveyances of 4,604 in May.

Fractured Neck of Femur patients delivery for May is at 53.0% below the 85% target. Expected to miss target in June too.
TTR undertaken and actions to include re-enforcement of appropriate imaging & review in ED. Trauma Co-Ordinator Nurse to commence to support this process. Feedback awaited.

DTOCs accounted for 494 bed days in May; of which 228 beds were fineable to BCC

Referral To Treatment

RTT incomplete pathway for May currently at 92.5% with a 2,561 patients backlog as at May. Therefore also meeting the NHSI Improvement Trajectory.
Admitted and non-admitted pathways are below the targets but are not nationally monitored.

x26 patient pathways are under-performing of which 3 are failing on the incomplete pathway.
RTT Improvement trajectories have been established for all specialties with recovery from July through December led by the Groups.

There were 2x 52 week breaches on the incomplete pathway for which the trust is held accountable; both were in plastics and both are consultant to consultant referrals internally causing error of RTT rules application effectively stopping clocks inappropriately. This is a regular issue in terms of incorrect clock stops. Constantly striving for improvement in the RTT validation cycle, this is now set for earlier in the month and so far in June we have 1x further 52 week breach in Gynae.

Diagnostic waits beyond 6 weeks were 0.1% for May, remaining well within the operational threshold of 1.00% consistently. Echograms are behind delivery, the service has been asked to address. This indicator meets the NHSI Improvement Trajectory.

ASIs (Appointment Slot Issues) arising from e-referrals indicates that no patients have been left un-appointed above required timelines during the month of May.

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.

The Trust's internal assessment of the completion of valid NHS Number Field within inpatient data sets is below the 99.0% operational threshold (as at May at 96.7%). ED have been informed that we require them to improve their patient registration performance as this has a direct effect on emergency admissions. Patients who have come through Malling Health will be validated via the Data Quality Department. A list of June patient registrations with no NHS number has been forwarded to the ED Department with ED user identified.

Open Referrals without future activity stand at 76,000 as at today (this excludes patients on the RTT pathway e.g. waiting list). The Data Quality Group is driving a focused improvement plan for the last two weeks and aims to: stop new creation of this issue, and to address above backlog whch has been RAG rated (see tab for detail) and aims to fully remove auto-closures currently in place.

Staff

PDR overall compliance as at the end of May is at 91.5% against the 95% target, an improvement again to previous delivery
Medical Appraisal rate as at May is 86.2% being below 90.0% standard.

In-month sickness for April is at 4.1% (4.4% last month and 4.85% month before). The cumulative sickness rate is at 4.9%, but beginning to reduce as in-month goes down for the 3rd months in a row.

The Trust annualised turnover rate is at 12.4% as at May - reducing over the last couple of months. Specifically, nursing turnover has been recorded at 12.6% for the month, a consistent high trend against this staff group, but showing early evidence of reduction and more in line with the overall turnover.

Mandatory Training at the end of April is at 88.0% overall against target of 95%.
Health & Safety (clinical safety training) related mandatory training is at 96.8% and delivering above the 95% target consistently.

Temporary staffing page is under development to incorporate more information about usage combined with vacancies and reasons for use.

CQUINs, Local Quality Requirements 2016/17

2016/17 CQUINs have been signed off with commissioners and the Trust needs to report on Q1 performance (mainly baselining and agreeing trajectories for the rest of the year). CQUIN leads have been identified and engaged for Q1 reporting. The OMC and COO will oversee the delivery of the programme.

Local Quality Requirements 2016/17 are signed off now. This follows detailed Trust reviews over the last few weeks to ensure that the trust and service can deliver without additional resources. National and Operational Quality Requirements for 2016/17 are largely identical to what we have seen in 2015/16. All requirements will be monitored for impacting fines and lack of performance and will report in the form of the SQPR (Service Quality Performance Report) which will be shared with groups and OMC.

Community

Community & Therapies indicators are below target on a number of indicators (C&T Group tab).

- DN assessments (especially Dementia) have continued trending downward due to staff not been aware that previous assessments are no longer valid (because time limitations of 1 year or 6 months for dementia). This has already improved and more is expected.
- A new system-based process has been put in place to alert staff about missing KPI assessments whenever a record is opened, this is expected to dramatically improve upon poor KPI scores seen in March as part of preparation for improvement trajectories over 2016-17. Trajectories are being worked up.

Health Visiting performance are in line with targets across a wide range of indicators. The group has already moved to team-based performance monitoring and this has improved a number of targets in recent months; lack of data completion continuous but is continually addressed. A number of indicators is not keeping up the pace of completion, this will be re-enforced as appropriate.

Summary Scorecard - May (Month)

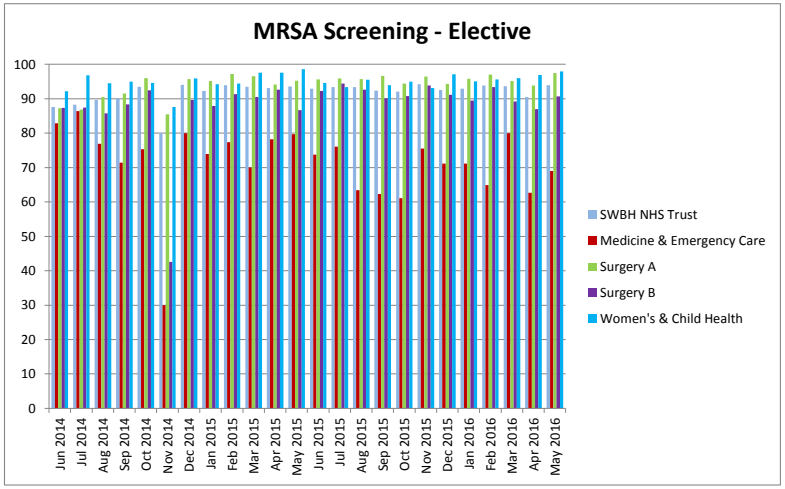
Summary Scorecard

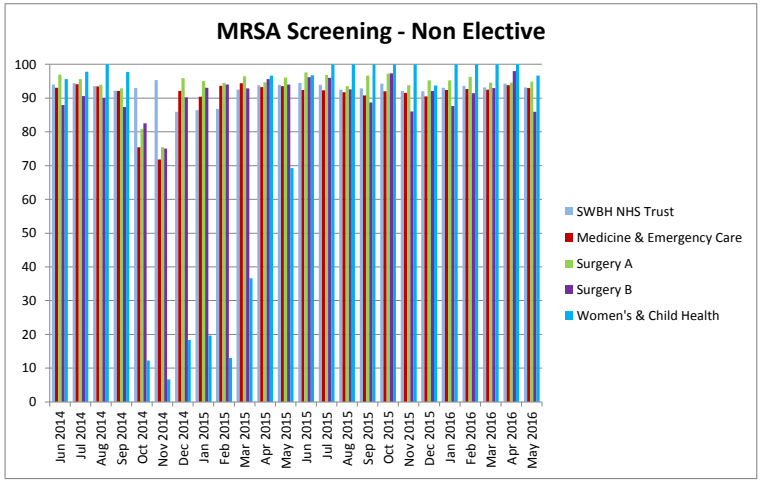
Section	Red Rated	Green Rated	None	Total
Infection Control	1	5	0	6
Harm Free Care	5	8	2	15
Obstetrics	2	5	6	13
Mortality and Readmissions	1	1	11	13
Stroke and Cardiology	4	7	0	11
Cancer	0	10	4	14
FFT, MSA, Complaints	11	5	5	21
Cancellations	4	5	0	9
Emergency Care & Patient Flow	7	7	4	18
RTT	6	2	6	14
Data Completeness	1	9	8	18
Workforce	11	1	10	22
TOTAL	53	65	56	174

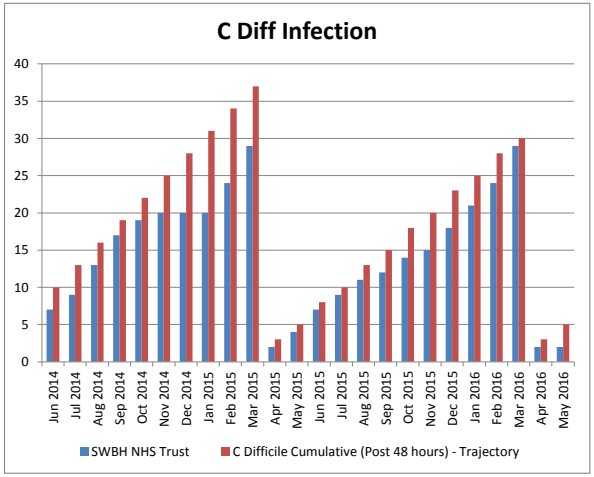
Exceptions are being managed in respective groups and are monitored in Group Reviews and in the Operational Management Committee governed by Performance Committee. There are 2x exceptions outstanding to the CCG at May 2016, there is an agreed return date with CCG.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Dec 2014) D J F M A M J J A S O N D J F M A M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
4			C. Difficile	<= No	30	2.5		May 2016	0	0	0	0					0	2	
4			MRSA Bacteraemia	<= No	0	0		May 2016	0	0	0	0					0	0	
4			MSSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9.42		May 2016									10.5	5.1	
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	94.9	94.9		May 2016									31.5	23.0	
3			MRSA Screening - Elective	=> %	80	80		May 2016	69	97.5	90.7	98					94.0	92.2	
3			MRSA Screening - Non Elective	=> %	80	80		May 2016	92.9	94.9	86	96.7					93.1	93.7	

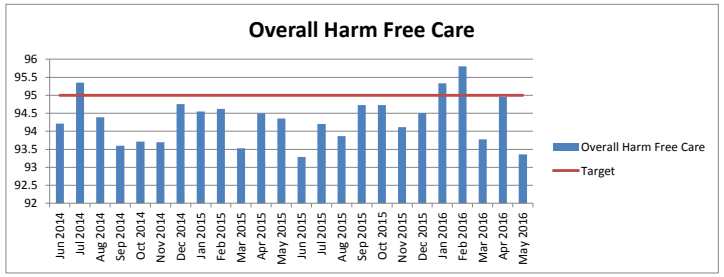


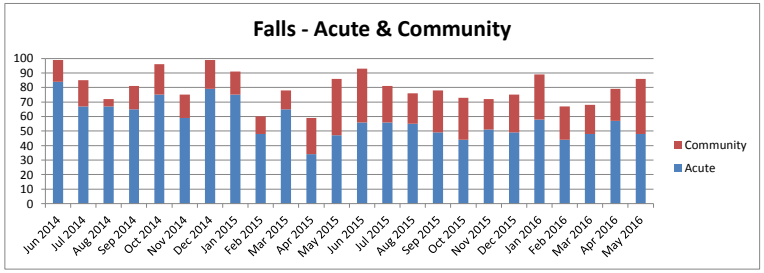


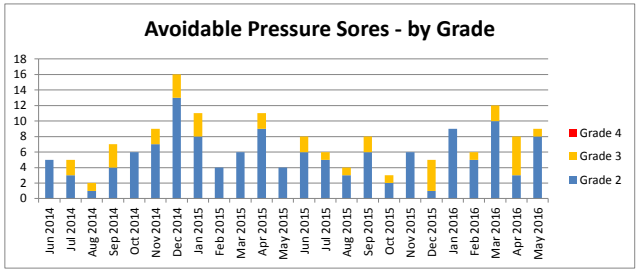


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2014) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
8		d	Patient Safety Thermometer - Overall Harm Free Care	=> %	95	95																			May 2016									93.4	94.2	
8		d	Patient Safety Thermometer - Catheters & UTIs	%			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	4.00	2.00	1.00	3.00	6.00	May 2016									0.52	0.39	
8			Falls	<= No	804	67	99	91	64	78	80	106	90	70	76	78	73	72	75	89	67	68	79	86	May 2016	37	8	1	1	0	0	38		86	165	
9			Falls with a serious injury	<= No	0	0	1	1	0	1	1	1	1	5	0	1	2	3	1	2	2	2	1	0	May 2016	0	0	0	0		0	0		0	1	
8			Grade 2,3 or 4 Pressure Ulcers (Hospital Aquired Avoidable)	<= No	0	0	16	11	4	6	11	4	8	6	4	8	3	6	5	9	6	12	11	11	May 2016	3	2	0	0			6		11	22	
			Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload Acquired)	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	6	2	May 2016							2		2	8	
3		d	Venous Thromboembolism (VTE) Assessments	=> %	95	95																			May 2016	96.6	94.1	97.9	95					96	96	
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	98	98																			May 2016	99.5	99.6	100.0	100.0		0.0			100	100	
3			WHO Safer Surgery - brief (% lists where complete)	=> %	95	95																			May 2016	98	100	100	100		99			99	99	
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	85	85																			May 2016	97	100	100	100		99			99	99	
9		d	Never Events	<= No	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	1	0	0	0	May 2016	0	0	0	0	0	0	0		0	0	
9		d	Medication Errors causing serious harm	<= No	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	May 2016	0	0	0	0	-	0	0		0	0	
9		d	Serious Incidents	<= No	0	0	3	4	4	6	5	4	7	9	7	5	7	6	2	12	8	5	2	1	May 2016	1	0	0	0	0	0	0	0	1	3	
9			Open Central Alert System (CAS) Alerts	<= No			17	10	9	4	8	5	4	8	11	8	7	4	9	7	6	5	1	13	May 2016									13	14	
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	No	0	0	0	1	0	1	0	3	2	0	1	2	2	0	0	2	1	2	0	0	May 2016									0	0	

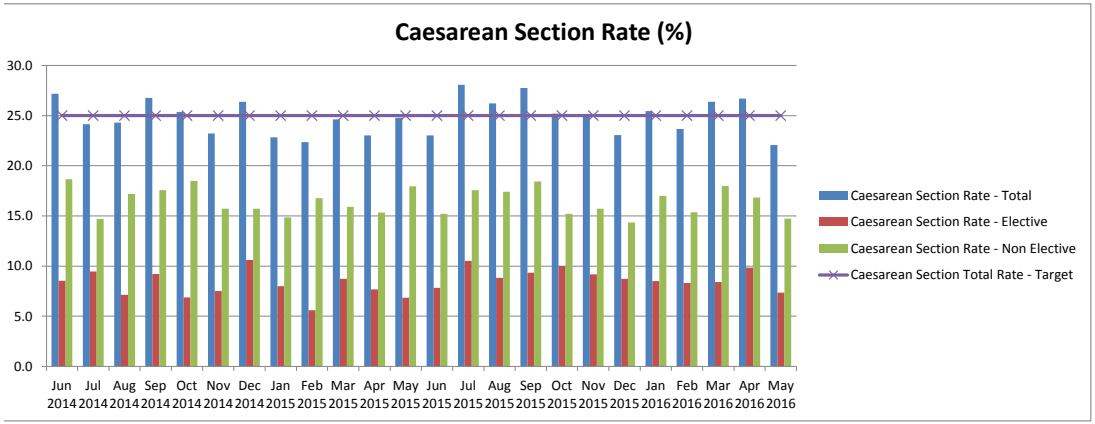


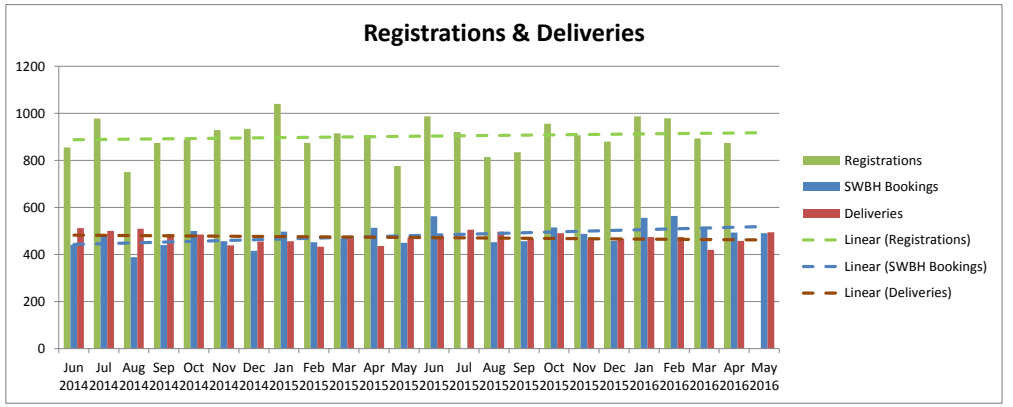




Patient Safety - Obstetrics

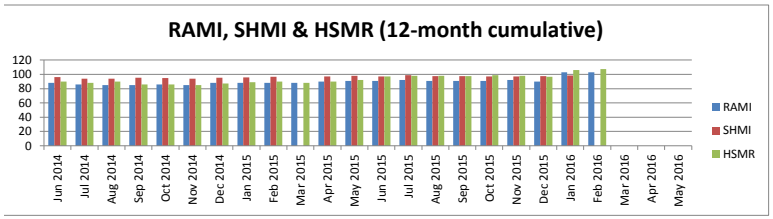
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory 2016-2017 Year	Trajectory 2016-2017 Month	Previous Months Trend (since Dec 2014) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Month	Year To Date	Trend
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			May 2016	22.1	24.3	
3			Caesarean Section Rate - Elective	<= %			11	8	6	9	8	7	8	11	9	9	10	9	9	8	8	8	10	7	May 2016	7.4	8.6	
3				<= %			16	15	17	16	15	18	15	18	17	18	15	16	14	17	15	18	17	15	May 2016	14.7	15.8	
2		d	Maternal Deaths	<= No	0	0																			May 2016	0	0	
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			May 2016	2	4	
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																			May 2016	1.41	1.15	
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			May 2016	16.16	10.49	
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	90.0	90.0																			May 2016	80.3	79.3	
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																			May 2016	137.7	142.6	
2			Breast Feeding Initiation (Quarterly)	=> %	74.0	74.0		-->	-->		-->	-->		-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	May 2016	-	-	
2			Puerperal Sepsis and other puerperal infections (variation 1 - ICD10 O85 or O86) (%) -	<= %			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	0.7	1.6	1.8	1.8	3.7	May 2016	3.72	2.65	
2			Puerperal Sepsis and other puerperal infections (variation 2 - ICD10 O85 or O86 Not O864) (%)	<= %			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	-	0.8	1.5	1.3	3.4	May 2016	3.38	2.21	
2			Puerperal Sepsis and other puerperal infections (variation 3 - ICD10 O85) (%)	<= %			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	-	0.8	1.1	1.0	2.4	May 2016	2.37	1.62	

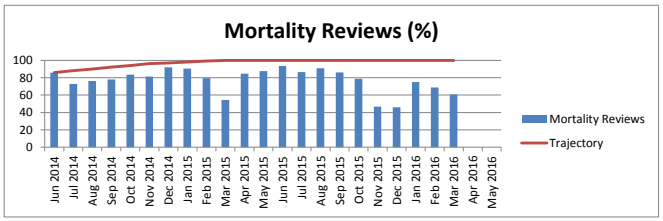


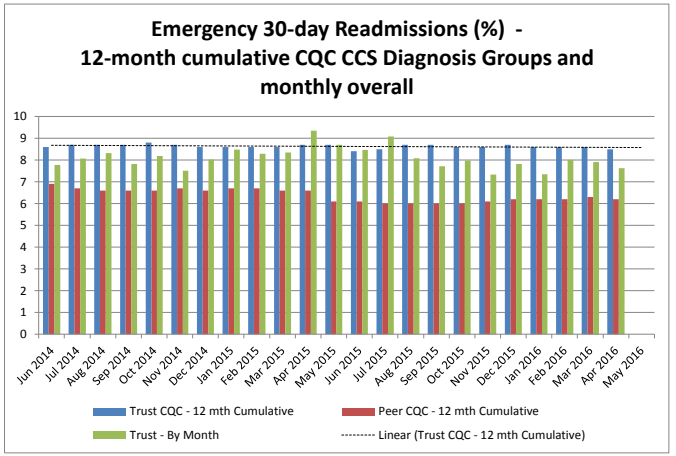


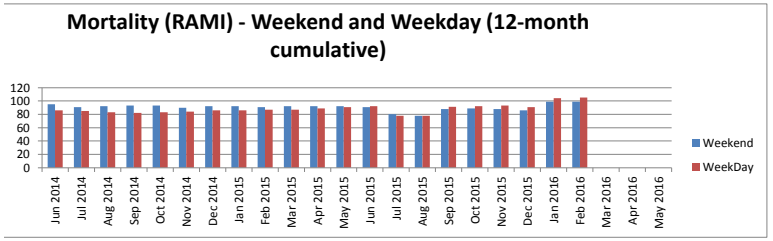
Clinical Effectiveness - Mortality & Readmissions

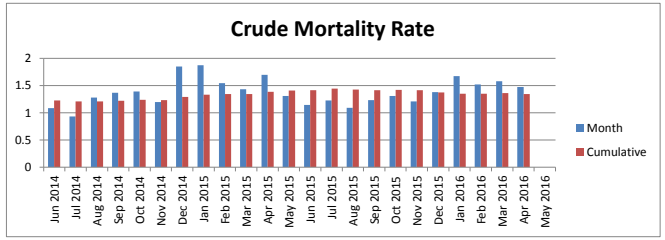
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2014) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	88	88	88	88	90	91	91	92	91	91	91	92	90	103	103	-	-	-	Feb 2016										1025	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	86	86	87	87	89	91	92	78	78	92	92	93	91	104	105	-	-	-	Feb 2016										1004	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	92	92	91	92	92	92	91	80	78	88	89	88	86	99	99	-	-	-	Feb 2016										982	
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	96	96	97	-	97	98	97	99	98	97	97	97	98	98	-	-	-	-	Jan 2016										976	
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			87	89	90	88	90	92	97	98	98	98	99	98	97	106	107	-	-	-	Feb 2016										1079.4	
5		C	Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	111	105	94	93	75	84	53	102	44	80	57	148	40	68	113	-	-	-	Feb 2016									113		
3			Mortality Reviews within 42 working days	=> %	90	90																	-	-	Mar 2016	59	76	0	50					61	74	
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.8	1.9	1.5	1.4	1.7	1.3	1.1	1.2	1.1	1.2	1.3	1.2	1.4	1.7	1.5	1.6	1.5	-	Apr 2016									1.47		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.3	1.3	1.3	1.3	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.3	-	Apr 2016										1.35	
			Deaths in the Trust	No			184	185	142	143	151	122	110	122	98	117	129	116	135	163	146	158	142	-	Apr 2016									142	142	
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			8.0	8.5	8.3	8.4	9.4	8.7	8.5	9.1	8.1	7.7	8.0	7.3	7.8	7.4	8.0	7.9	7.6	-	Apr 2016									7.62		
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			8.0	8.1	8.1	8.2	8.2	8.2	8.3	8.4	8.4	8.3	8.3	8.3	8.3	8.2	8.2	8.1	8.0	-	Apr 2016										8.01	
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			8.6	8.6	8.6	8.6	8.7	8.7	8.4	8.5	8.7	8.7	8.6	8.6	8.7	8.6	8.6	8.6	8.5	-	Apr 2016	-	-	-	-						8.50	





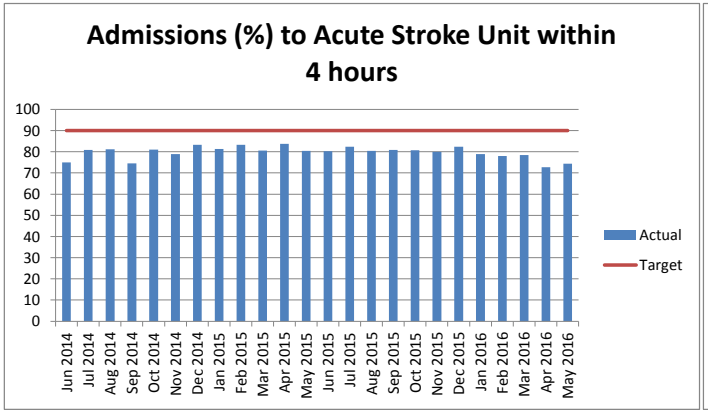


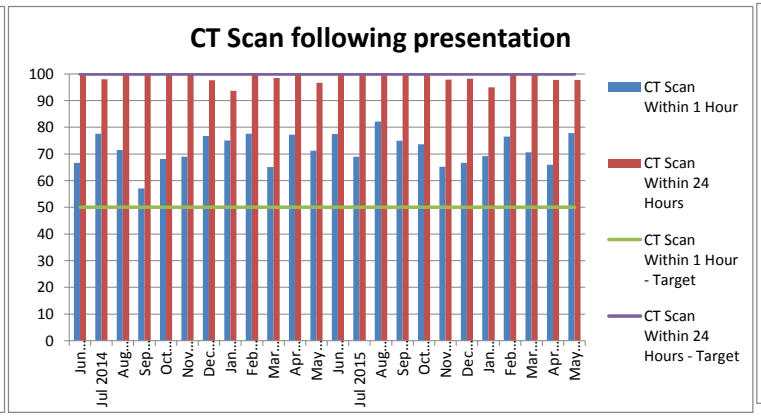


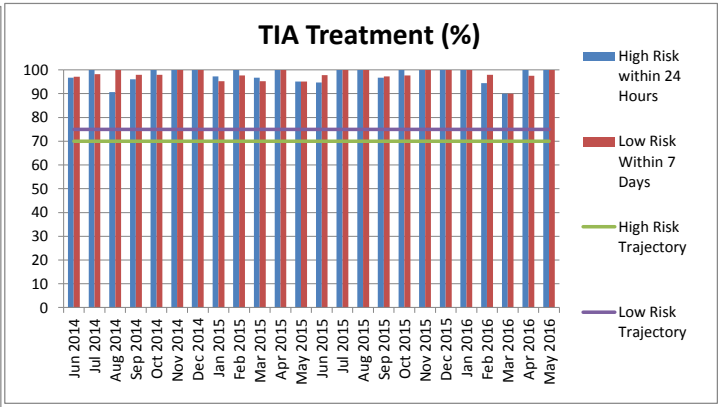


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Dec 2014) D J F M A M J J A S O N D J F M A M	Data Period	Month	Year To Date	Trend
3			Pts spending >90% stay on Acute Stroke Unit	=> %	90.0	90.0		May 2016	92.3	95.4	
3			Pts admitted to Acute Stroke Unit within 4 hrs	=> %	90.0	90.0		May 2016	74.4	73.6	
3		●	Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0		May 2016	77.8	71.9	
3			Pts receiving CT Scan within 24 hrs of presentation	=> %	100.0	100.0		May 2016	97.8	97.8	
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0		May 2016	0.0	40.0	
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0		May 2016	100.0	100.0	
3			TIA (High Risk) Treatment <24 Hours from receipt of referral	=> %	70.0	70.0		May 2016	100.0	100.0	
3			TIA (Low Risk) Treatment <7 days from receipt of referral	=> %	75.0	75.0		May 2016	100.0	98.9	
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0		May 2016	100.0	100.0	
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0		May 2016	100.0	100.0	
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0		May 2016	100.0	100.0	

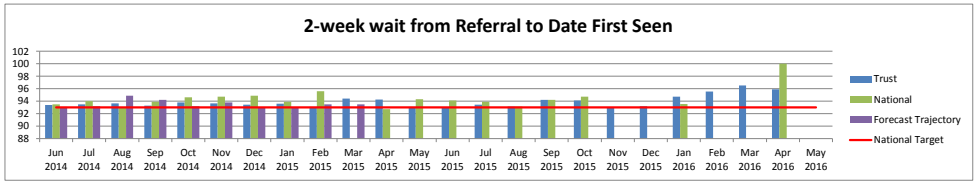


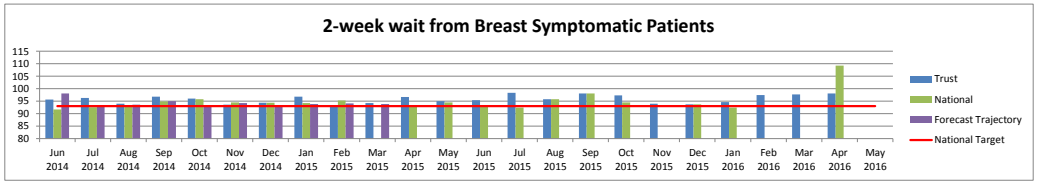


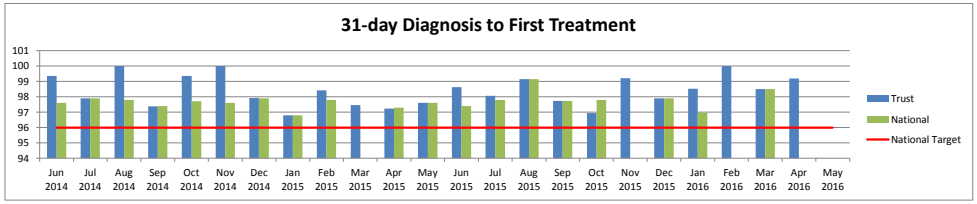


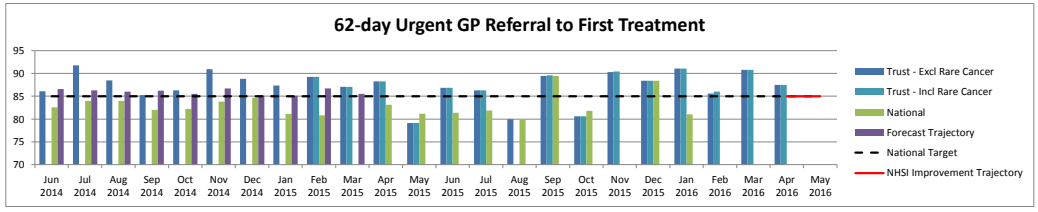
Clinical Effectiveness - Cancer Care

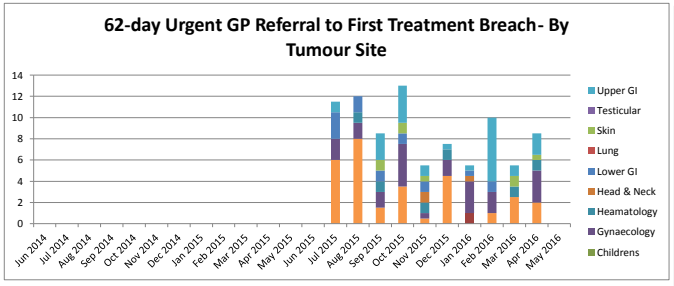
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2014) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
1			2 weeks	=> %	93.0	93.0																		-	Apr 2016	94.4	98.7	94.0	91.8					95.9	95.9	
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		-	Apr 2016		-							98.1	98.1	
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Apr 2016	100.0	98.4	0.0	100.0					99.2	99.2	
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0								N/A										-	Apr 2016									100.0	100.0	
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																		-	Apr 2016									100.0	100.0	
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																		-	Apr 2016									-	0.0	
1			62 Day (urgent GP referral to treatment) Excluding Rare Cancer	=> %	85.0	85.0																		-	Apr 2016	85.1	93.7	100.0	75.0					87.5	87.5	
1			62 Day (urgent GP referral to treatment) Including Rare Cancer	=> %	85.0	85.0	-	-						-										-	Apr 2016	85.1	93.7	100.0	75.0					87.5	87.5	
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																		-	Apr 2016	0.0	100.0	0.0	100.0					100.0	100.0	
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																		-	Apr 2016	100.0	86.7	0.0	100.0					93.1	93.1	
1			Cancer - Patients Waiting over 62 days	No			-	-	-	-	-	-	-	0.0	12.0	8.5	13.0	5.5	7.5	5.5	10.0	5.5	8.5	-	Apr 2016	3.5	2.0	0.0	3.0					8.5	8.5	
1			Cancer - Patients Waiting over 104 days	No			-	-	-	-	-	-	-	4.5	7.0	4.0	8.0	2.0	3.5	0.0	4.5	0.5	3.0	-	Apr 2016	2.0	0.0	0.0	1.0					3.0	3.0	
1			Cancer - Longest Waiter in days	No			-	-	-	-	-	-	-	180	147	228	165	138	167	98	154	98	175	-	Apr 2016	175	73	0	149					175		
	NEW		IPT Referrals - Within 42 Days Of GP Referral for 62 day cancer pathway	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-					-	-	

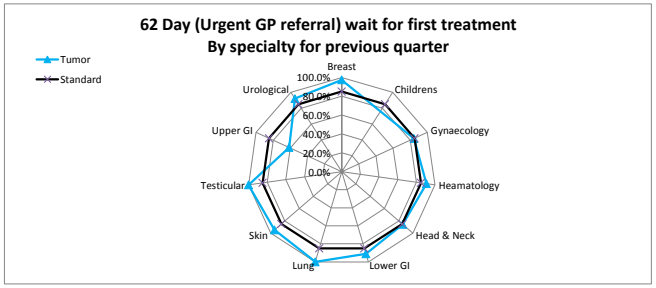


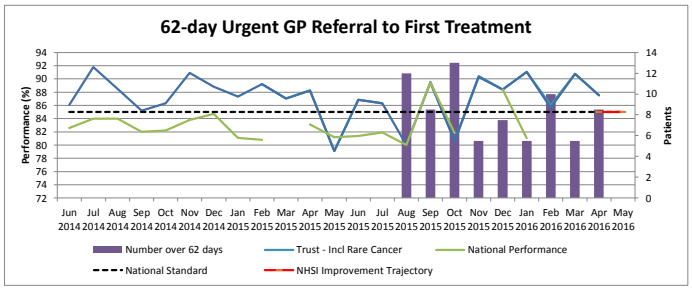






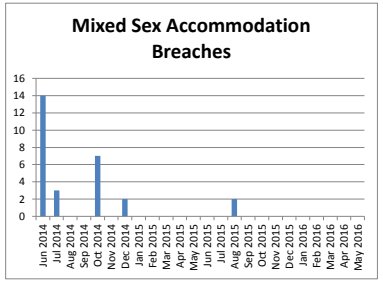


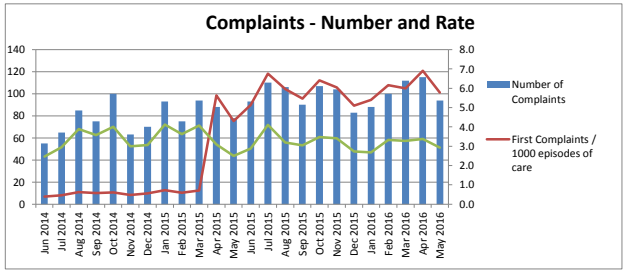


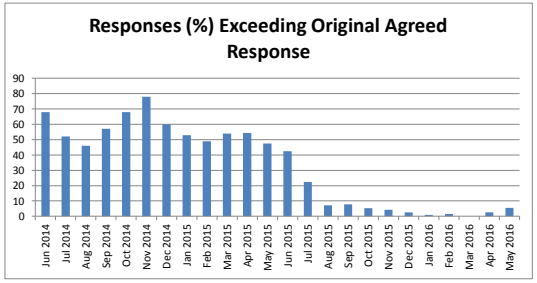


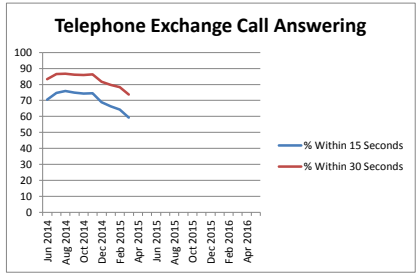
Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2014) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
8		•b•	FFT Response Rate - Adult and Children Inpatients (including day cases and community)	=> %	50.0	50.0	28	33	43	43	29	31	31	28	25	22	27	16	15	15	15	14	17	16	May 2016									16	17	
8		•a•	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95.0	95.0	69	70	68	72	95	95	95	96	95	95	95	93	96	96	95	95	96	90	May 2016									90		
8		•b•	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50.0	50.0	17	18	21	22	9.9	8.4	7.2	9.4	9.6	7.5	6.8	5.9	5.7	6.3	6	5.3	5.1	8.3	May 2016	8.3								8.3	6.8	
8		•a•	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95.0	95.0	49	50	44	52	79	79	79	84	88	83	80	82	81	79	74	74	78	85	May 2016	85								85		
8			FFT Response Rate: Type 3 WiU Emergency Department	=> %	50.0	50.0	-	-	-	-	-	-	-	-	-	-	-	0	0.1	1.5	0.1	0	0.3	2.5	May 2016	-								2.5	1.4	
8			FFT Score - Adult and Children Emergency Department (type 3 WiU)	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	0	50	85	0	0	100	96	May 2016	-								96		
8			FFT Score - Outpatients	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	87	86	90	88	87	87	88	May 2016									88		
8			FFT Score - Maternity Antenatal	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	100	100	96	100	95	100	91	May 2016									91		
8			FFT Score - Maternity Postnatal Ward	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	97	97	95	91	91	97	100	May 2016									100		
8			FFT Score - Maternity Community	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	95	98	96	99	99	99	99	May 2016									99		
8			FFT Score - Maternity Birth	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	86	82	90	94	93	92	90	May 2016									90		
8			FFT Response Rate - Maternity Birth	=> %	50.0	50.0	-	-	-	-	-	-	-	-	-	-	-	28	14	23	15	10	12	9	May 2016									9	11	
13		•a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	May 2016	0	0	0	0		0	0		0	0	
9		•	No. of Complaints Received (formal and link)	No			70	93	75	94	88	78	93	110	106	90	107	104	83	88	100	112	115	94	May 2016	36	15	14	10	4	0	5	10	94	209	
9			No. of Active Complaints in the System (formal and link)	No			219	249	266	265	278	225	186	170	174	143	151	145	121	113	128	147	154	144	May 2016	57	29	23	13	5	1	7	9	144		
9		•a	No. of First Formal Complaints received / 1000 bed days	Rate1			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	2.7	3.3	3.3	3.4	2.9	May 2016	2.3	3.8	19	1.7					2.94	3.16	
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			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	5.4	6.2	6.0	6.9	5.8	May 2016	5.4	7.6	11	2.8			0		5.78	6.34	
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	=> %	100	100	100	99	98	100	99	100	100	100	100	100	100	100	100	100	100	100	100	100	May 2016	100	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	60	53	49	54	54	47	42	22	7.1	7.7	5.3	4.1	2.5	0.9	1.6	0	2.6	5.6	May 2016	8.6	9.4	0	0	0	0	0	0	6	4	
9			No. of responses sent out	No			198	59	52	84	56	115	102	129	77	107	101	94	98	69	81	84	98	81	May 2016	35	22	11	6	0	0	3	4	81	179	
14		•e•	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes																			Mar 2016	N	N	N	N	N	N	N	N	No		



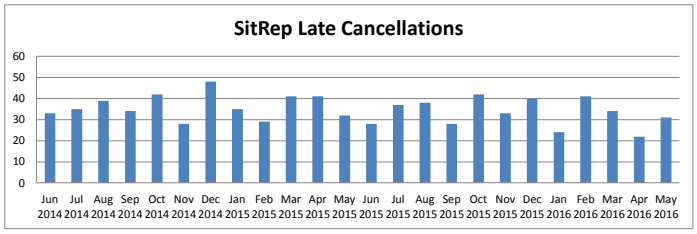


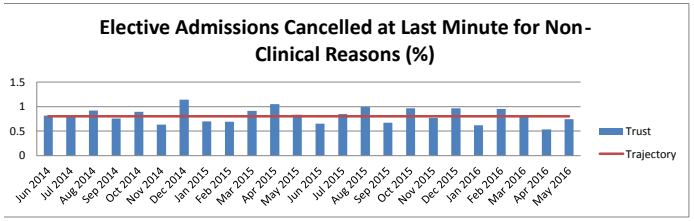


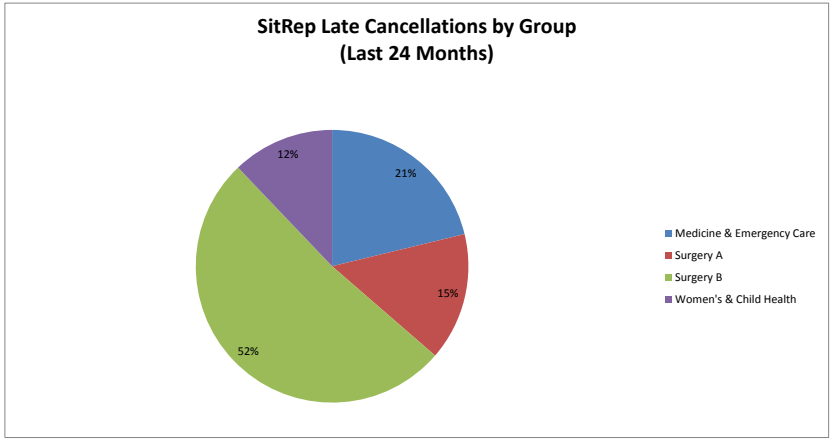


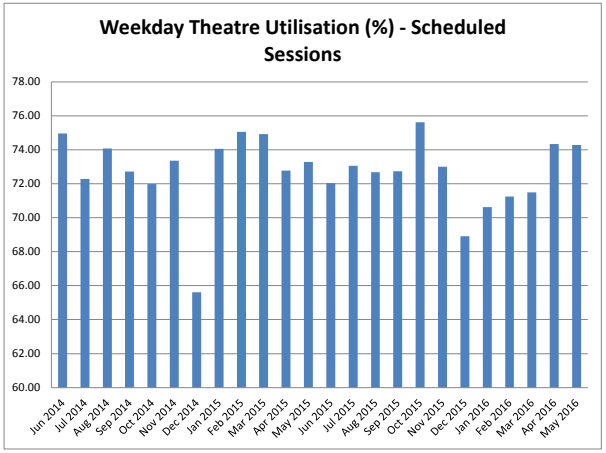
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2014) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
2			Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			May 2016	0.16	0.61	1.19	3.45					0.7	0.6	
2		e	Number of 28 day breaches	<= No	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	May 2016	0	0	0	0					0	0	
2		e	No. of second or subsequent urgent operations cancelled	<= No	0	0	1	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	May 2016	0	0	0	0					0	0	
2			No. of Sitrep Declared Late Cancellations	<= No	320	27	48	36	29	41	41	32	28	37	38	28	42	33	40	24	41	34	22	31	May 2016	3	6	12	10					31	53	
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	<= No	0	0	0	0	0	0	0	4	1	0	0	0	0	0	0	0	0	0	0	0	May 2016	0	0	0	0					0	0	
			Multiple Cancellations experienced by same patient (all cancellations)	<= No	0	0	-	-	-	-	46	52	59	46	39	49	50	57	39	63	56	57	79	63	May 2016	2	36	20	5					63	142	
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	210	228	223	229	257	May 2016	40	111	78	28					257	486	
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0																			May 2016	56.0	76.2	75.0	73.5					74.3	74.3	
2			Urgent Cancellations	<= No	0.0	0.0	-	-	-	-	11	5	6	0	7	3	9	0	0	0	0	0	0	0	May 2016	0.0	0.0	0.0	0.0					0	0	



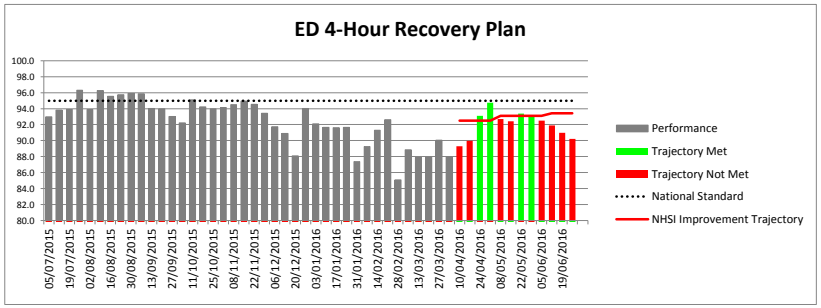


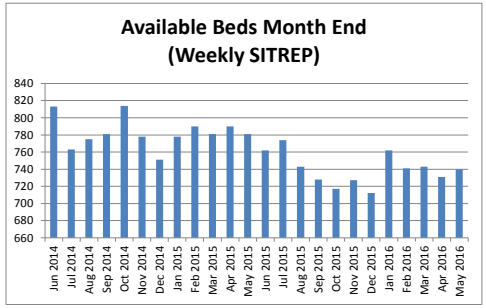


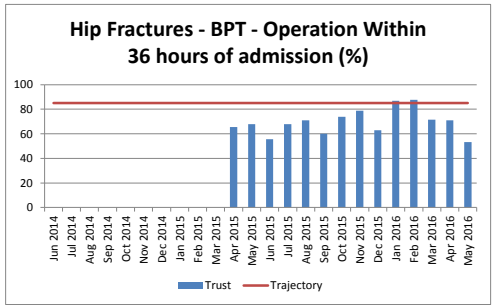


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend
2		e	Emergency Care 4-hour waits	=> %	95.00	95.00																			May 2016	90.3	94.0	97.9	92.88	92.17	
2			Emergency Care 4-hour breach (numbers)	No			2234	1054	1481	1695	1527	1406	1037	1086	741	1138	1106	1103	1715	1757	1956	2342	1608	1451	May 2016	826	575	50	1451	3059	
2		e	Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			May 2016	0	0		0	0	
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			May 2016	17	15	25	16	17	
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			May 2016	50	46	106	54	53	
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			May 2016	7.93	7.65	4.05	7.34	7.47	
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			May 2016	3.05	4.53	2.03	3.62	3.52	
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	282	185	149	164	43	116	90	72	58	76	93	67	121	116	97	117	81	65	May 2016	25	40		65	146	
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	31	7	6	8	9	8	3	3	2	1	1	3	8	10	6	9	2	0	May 2016	0	0		0	2	
11			WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			May 2016	0.00	0.00		0.00	0.02	
11			WMAS - Emergency Conveyances (total)	No			4470	4001	3829	4182	3981	4214	114	4256	4241	4016	4260	4202	4573	4679	3961	4513	4115	4604	May 2016	2087	2517		4604	8719	
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																			May 2016	0.9	3.6		2.0	2	
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	<10 per site	<10 per site																			May 2016	3	9.4		12		
2			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	<= No	0	0	868	1061	922	859	641	698	653	464	494	430	394	497	498	318	426	397	454	494	May 2016				494	948	
2			Delayed Transfers of Care (Acute) - Finable Bed Days (Birmingham LA only)	<= No	0	0	225	292	344	348	283	404	286	212	204	193	110	254	267	185	198	232	234	228	May 2016				228	462	
2			Patient Bed Moves (10pm - 6am) (No.) -ALL	No			699	544	573	634	567	596	502	545	529	588	601	518	540	632	543	546	563	498	May 2016				498	1061	
2			Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units	No			286	214	258	270	237	293	239	240	237	275	261	209	236	320	269	232	255	222	May 2016				222	477	
			Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85.0	85.0	-	-	-	-															May 2016				53	63.2	

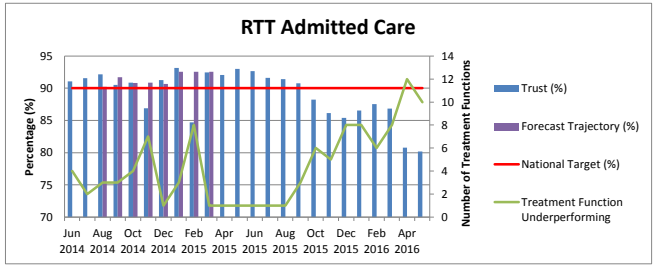


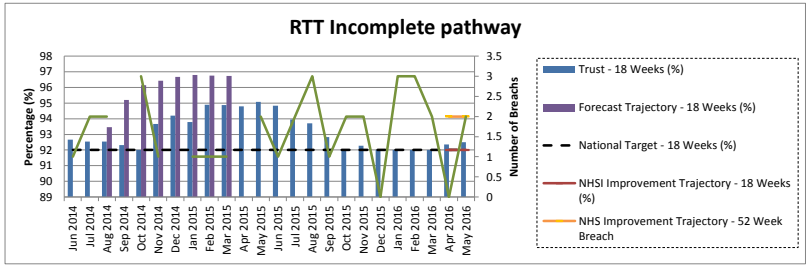


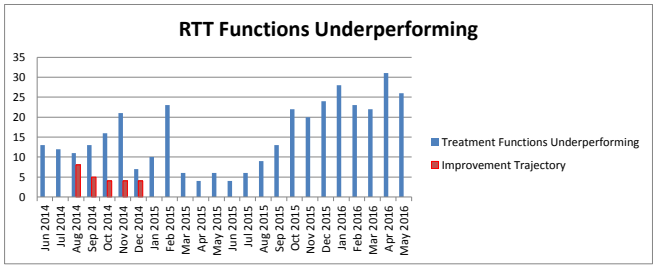


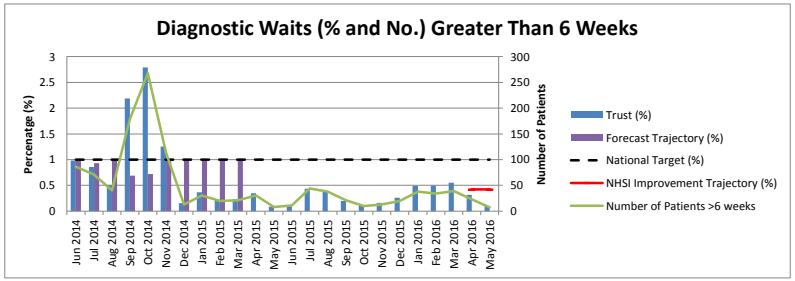
Referral To Treatment

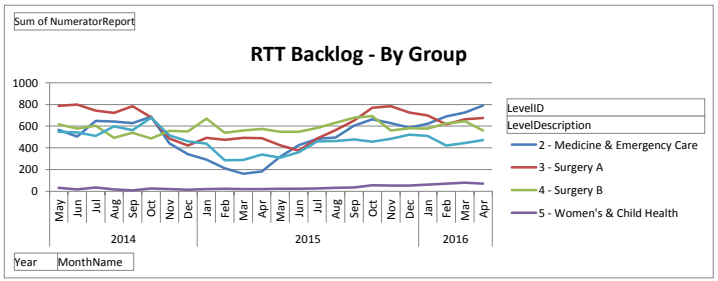
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2014) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
2			RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			May 2016	87.5	67.5	82.0	92.0					80.18		
2			RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			May 2016	80.8	94.5	92.4	95.2					91.01		
2			RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			May 2016	91.3	90.8	93.9	95.1					92.50		
	NEW		RTT - Backlog	No			1787	1911	1534	1519	1601	1619	1727	2034	2181	2444	2635	2512	2463	2468	2423	2557	2566	2561	May 2016	716	636	595	92					2561		
2			Patients Waiting >52 weeks	<= No	0	0	0	4	3	4	1	2	1	3	5	2	4	4	2	4	5	8	3	2	May 2016	0	1	0	0					2	5	
2	NEW		Patients Waiting >52 weeks (Incomplete)	<= No	0	0	0	1	1	1	0	2	1	2	3	1	2	2	0	3	3	2	0	2	May 2016	0	1	0	0					2	2	
2			Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	<= No	0	0	8	10	23	6	4	6	4	6	9	13	22	20	24	28	23	22	31	26	May 2016	11	8	5	0.0					26		
	NEW		Treatment Functions Underperforming (Incomplete)	<= No	0	0	2	2	2	2	2	2	1	3	2	4	6	6	5	4	4	2	3	3	May 2016	1	2	0	0					3		
2			Acute Diagnostic Waits in Excess of 6-weeks (End of Month Census)	<= %	1.0	1.0																			May 2016	0.1	1.0	0.0	0.0		0.0			0.10		
	NEW		Acute Diagnostic Waits in Excess of 6-weeks (In Month Waiters)	No			-	-	-	-	524	511	699	995	2244	2442	2872	2258	1593	1250	273	281	542	480	May 2016	182	174	-	-		124			480		
	NEW		Total ASIs in the month	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	-	-	Mar 2016	0	0	0	0					0	0	
	NEW		Total ASIs - 2WW	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0	-	Apr 2016	0	0	0	0					0	0	
	NEW		Total ASIs - Urgent	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	-	-	Mar 2016	0	0	0	0					0	0	
	NEW		Failed Appointments within required period (2WW, Urgent Pathway)	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	-	-	Mar 2016	0	0	0	0					0	0	

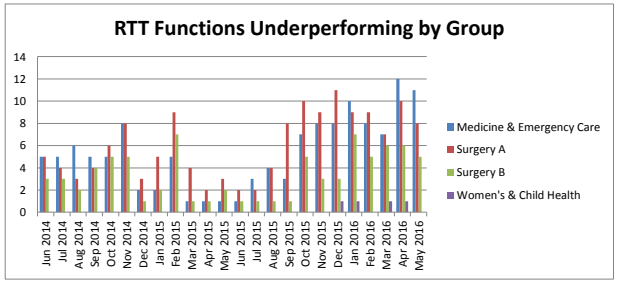






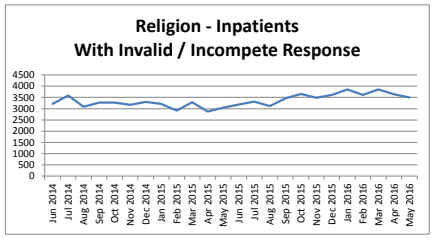


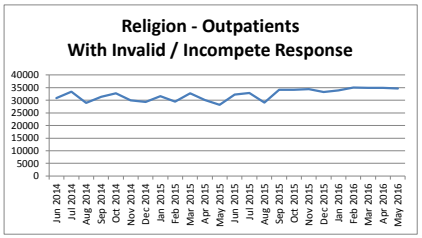


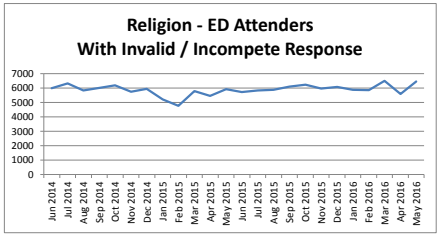


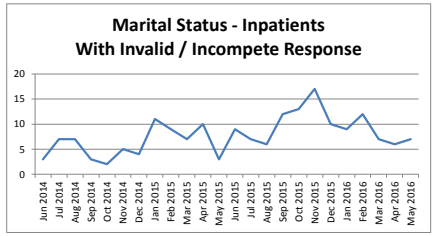
Data Completeness

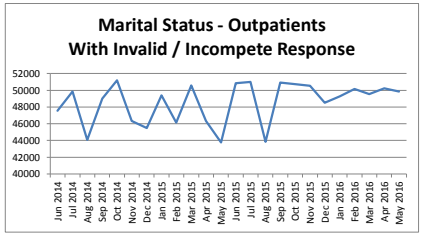
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2014) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
14			Data Completeness Community Services	=> %	50.0	50.0																			May 2016								61	61.2		
2			Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																	-	-	Mar 2016									99.4		
2			Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																	-	-	Mar 2016									99.4		
2			Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																	-	-	Mar 2016									99.5		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=> %	99.0	99.0	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	97.5	96.5	98.1	96.7	96.7	May 2016									96.7	96.7	
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	=> %	99.0	99.0	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	99.5	99.5	99.6	99.5	99.5	May 2016									99.5	99.5	
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=> %	95.0	95.0	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	97.3	97.0	97.1	96.7	96.8	May 2016									96.8	96.7	
2			Ethnicity Coding - percentage of inpatients with recorded response	=> %	90.0	90.0																			May 2016									93.5	93.6	
			Ethnicity Coding - percentage of outpatients with recorded response	=> %	90.0	90.0																			May 2016									90.8	90.7	
			Protected Characteristic - Religion - INPATIENTS with recorded response	%			74.5	74.2	75.1	75.0	75.2	74.7	73.8	73.2	72.9	71.6	70.9	71.2	70.8	68.9	70.3	68.6	69.6	69.9	May 2016									69.9	69.7	
			Protected Characteristic - Religion - OUTPATIENTS with recorded response	%			63.1	62.9	63.2	62.2	62.5	62.6	63.0	62.5	61.3	60.8	60.4	59.9	59.3	59.3	58.4	58.1	58.1	58.2	May 2016									58.2	58.2	
			Protected Characteristic - Religion - ED patients with recorded response	%			63.1	64.2	65.8	64.9	65.5	64.4	65.8	64.1	61.8	61.2	61.8	62.9	62.0	63.9	62.3	62.3	64.8	63.3	May 2016									63.3	64.0	
			Protected Characteristic - Marital Status - INPATIENTS with recorded response	%			100.0	99.9	99.9	99.9	99.9	100.0	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	May 2016									99.9	99.9	
			Protected Characteristic - Marital Status - OUTPATIENTS with recorded response	%			42.8	42.1	42.3	41.7	42.2	41.8	41.6	41.8	41.6	41.6	41.2	41.1	40.7	40.8	40.5	40.5	39.8	39.8	May 2016									39.8	39.8	
			Protected Characteristic - Marital Status - ED patients with recorded response	%			43.8	42.4	42.4	43.5	42.5	41.2	42.6	40.7	40.6	41.1	40.8	42.0	41.5	41.7	42.5	41.2	40.9	41.3	May 2016									41.3	41.1	
2			Maternity - Percentage of invalid fields completed in SUS submission	<= %	15.0	15.0																			May 2016									5.9	5.9	
2			Open Referrals	No			-	-	-	-	173,131	180,758	183,245	191,411	203,025	208,990	214,841	222,779	228,862	192,989	187,876	190,396	194,788	199,207	May 2016	68,646	38,099	64,441	24,026	3,639	298	58		199,207		
	NEW		Open Referrals - Awaiting Management	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	73,627	May 2016	27,219	14,749	19,626	10,111	1,621	265	36		73627		
			Duplicate Entries	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00									-	-	

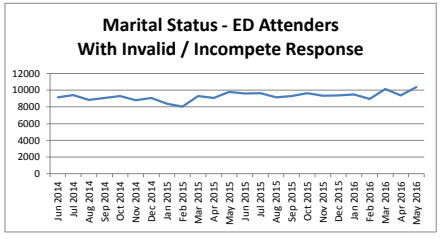


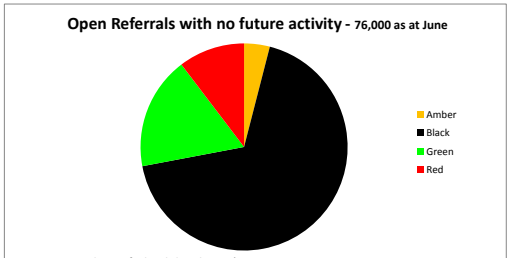










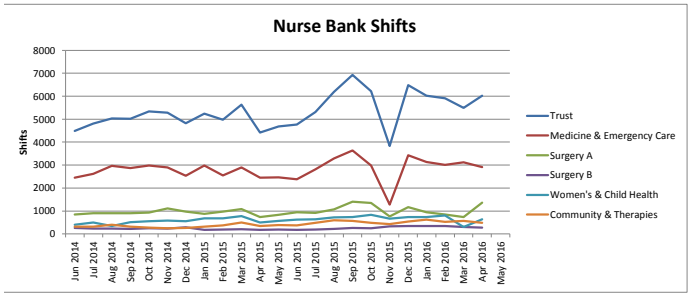


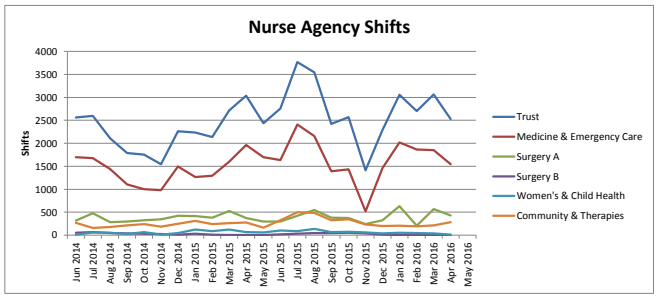
RED : To be Verified and closed By CG's.
AMBER : To be looked at by CG's once RED's are actioned.
GREEN : Automatic Closures.
BLACK- : Not Awaiting Management

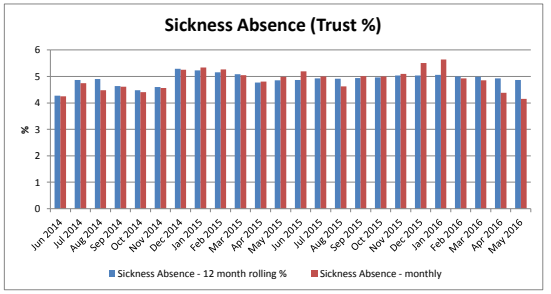
The Data Quality Group is responsible for improvement against these voluymes and is driving a focussed education programme across relevant staffing groups. A dedicated focus week / period is being considered but staff are engaging and progress is monitored weekly.

Workforce

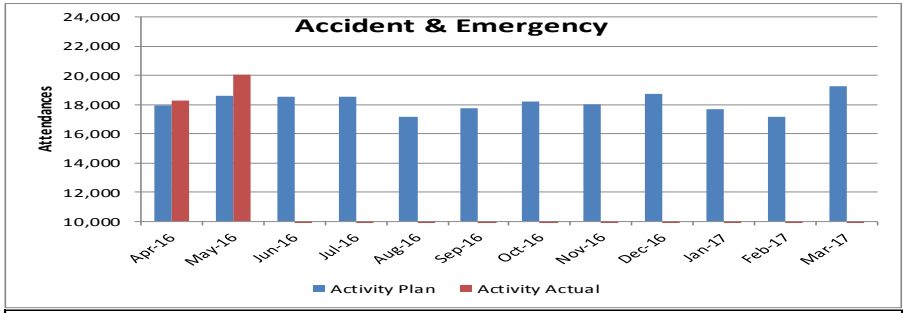
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2014) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
7		b	WTE - Actual versus Plan (FTE)	No			under review																		May 2016											
3		b	PDRs - 12 month rolling	=> %	95.0	95.0																			May 2016	90.6	90.7	95.7	92.0	95.7	90.7	92.6	92.1		91.5	
7		b	Medical Appraisal	=> %	95.0	95.0					-														May 2016	86.7	75.6	93.8	91.3	100.0	83.9	0.0	100.0	86.2	87.0	
3		b	Sickness Absence (Rolling 12 Months)	<= %	3.15	3.15																			May 2016	5.5	5.3	3.3	5.3	4.1	4.7	4.5	4.5	4.9	4.9	
3	NEW		Sickness Absence (Monthly)	<= %	3.15	3.15																			May 2016	4.8	5.2	3.9	3.9	3.9	4.4	3.5	3.5	4.1	4.3	
3			Return to Work Interviews following Sickness Absence	=> %	100.0	100.0	-	-	-		-	-												-	Apr 2016	66.7	77.8	77.3	75.0	80.7	57.4	87.4	78.7	75.0	75.0	
3			Mandatory Training	=> %	95.0	95.0																			May 2016	81.9	87.5	87.7	86.5	94.3	87.4	91.5	93.1		88.0	
3			Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0																			May 2016	95.0	97.0	92.7	95.3	98.7	97.7	98.0	99.0		96.8	
7		b	Employee Turnover (rolling 12 months)	<= %	10.0	10.0																			May 2016									12.4	12.6	
	NEW		Nursing Turnover	%			-	-	-	-	-	-	-	-	-	-	-	14.6	14.7	14.8	13.8	13.6	12.6		May 2016									13	13	
7			New Investigations in Month	No			0	3	4	5	8	11	5	8	4	5	10	6	2	5	12	9	6	4	May 2016	0	0	0	0	0	0	0	4	4		
7			Vacancy Time to Fill	Weeks			20	20	23	22	23	24	26	25	27	25	23	23	23	24	26	23	26	25	May 2016									25		
7			Professional Registration Lapses	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	May 2016	0	0	0	0	0	0	0	0	0	0	
7			Qualified Nursing Variance (FIMS) (FTE)	No			228	238	247	263	221	247	288	303	321	320	279	267	293	272	274	293	292	315	May 2016									315		
10			Nurse Bank Fill Rate	=> %	100.0	100.0	73	78	78	78	75	81	81	79	80	87	82	90	85	89	71	87	87	-	Apr 2016	84.9	86.3	96.4	91.4	100.0	100.0	87.9	100.0	87.2	87.2	
10			Nurse Bank Shifts Not Filled	<= No	0	0	1727	1716	1432	1487	1532	1378	1073	1622	1423	1207	917	780	1178	1356	1069	1128	1100	-	Apr 2016	710	226	12	65	0	0	87	0	1100	1100	
10			Nurse Bank Use (shifts)	<= No	46980	3915																		-	Apr 2016	2913	1370	274	635	12	170	485	156	6015	6015	
10			Nurse Agency Use (shifts)	<= No	0	0																		-	Apr 2016	1546	431	0	8	0	241	282	18	2526	2526	
10			Admin & Clerical Bank Use (shifts)	<= No	0	0																		-	Apr 2016	1102	218	144	98	265	120	211	2492	4650	4650	
10			Admin & Clerical Agency Use (shifts)	<= No	0	0																		-	Apr 2016	83	56	42	40	0	0	0	113	334	334	
15			Your Voice - Response Rate	No			-->	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			-->	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		



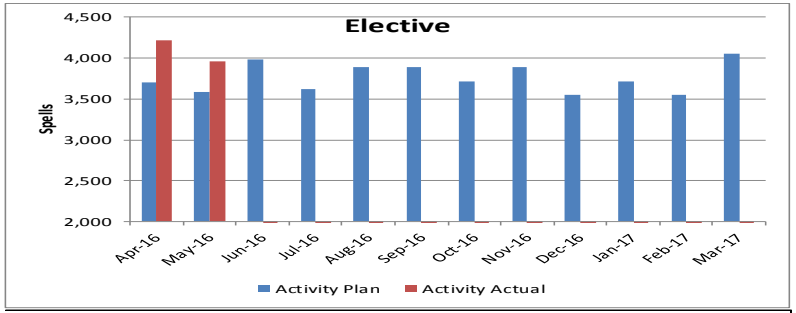




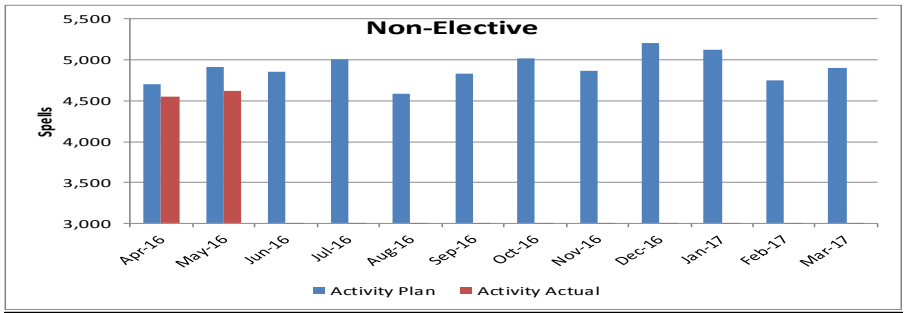
Activity Summary



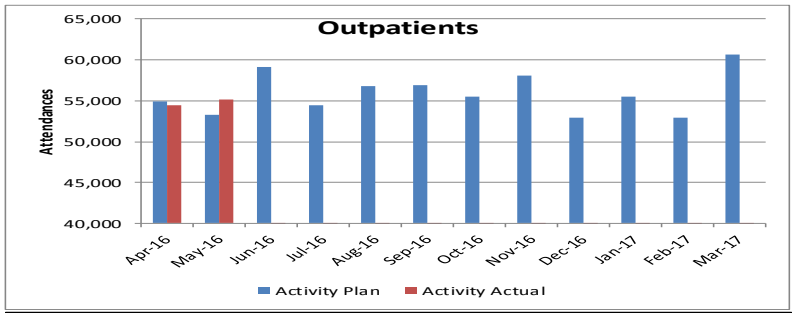
Our emergency departments have over performed in April and May by 5% overall with City and Sandwell sites both showing favourable variances of 5% and 7% respectively.



Elective care performance is currently 12% above plan year-to-date. Elective and outpatient care activity levels continue to be addressed through the demand and capacity work being led by the Chief Operating Officer.



Unplanned admissions in total under peformed in April and May against plan by 432 spells (4%) and 160 spells (2%) lower than April and May 2015.



Outpatient attendance performance is currently 1% above plan year-to-date to month 2. Elective and outpatient care activity levels continue to be addressed through the demand and capacity work being led by the Chief Operating Officer.

Activity and price variance based on average tariff at activity group level

Values presented are for the year-to-date period to month 2 (initial cut) and includes the four activity groups and Clinical Groups listed from the contracting dataset and does not include other income present in the ledger

Activity Group	Activity Plan	Activity Actual	Activity Diff	Price Plan Inc MFF	Price Actual Inc MFF	Price Diff Inc MFF	Activity Variance	Price Variance
Accident & Emergency	36,543	38,300	1,756	£3,566,082	£3,775,114	£209,032	£171,376	£37,656
Elective	7,062	7,900	838	£7,527,230	£7,064,793	-£462,437	£893,143	-£1,355,580
Non-Elective	9,580	9,105	-475	£14,935,585	£14,384,616	-£550,968	-£741,170	£190,202
Outpatients	95,150	96,778	1,628	£10,921,095	£10,780,237	-£140,858	£186,801	-£327,659
Grand Total	148,336	152,082	3,746	£36,949,991	£36,004,760	-£945,230	£510,151	-£1,455,381

Clinical Group	Activity Plan	Activity Actual	Activity Diff	Price Plan Inc MFF	Price Actual Inc MFF	Price Diff Inc MFF	Activity Variance	Price Variance
Medicine & Emergency Care	71,469	74,367	2,898	£17,045,465	£16,871,156	-£174,309	£691,128	-£865,437
Surgery A	21,720	21,526	-194	£9,014,580	£8,368,288	-£646,292	-£80,377	-£565,915
Surgery B	44,833	45,296	464	£5,940,079	£5,715,570	-£224,510	£61,425	-£285,935
Women's & Child Health	10,314	10,893	578	£4,949,867	£5,049,747	£99,880	£277,619	-£177,739
Grand Total	148,336	152,082	3,746	£36,949,991	£36,004,760	-£945,230	£949,796	-£1,895,026

Note:

- Reference to SLA Income 'initial cut 'only shown here not final SLA income - changes will result from later coding finaliisation

- The D&C workstream (under M McManus) focusses only on Elective, planned care - so there is no direct comparison to this overall

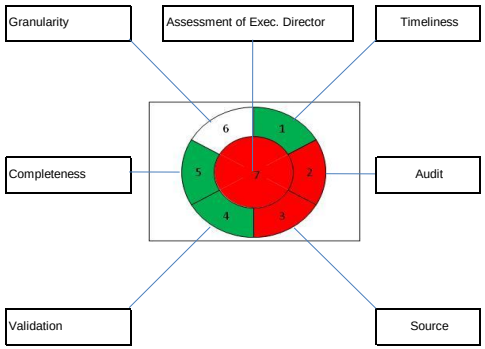
Legend

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
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		EC	AC	SC			
Patient Safety - Inf Control	C. Difficile	<= No	30	3																			May 2016	0	0	0	0	1	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			May 2016	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective (%)	=> %	80	80																			May 2016	85	74	43	69.0		
Patient Safety - Inf Control	MRSA Screening - Non Elective (%)	=> %	80	80																			May 2016	93	92	97	92.9		
Patient Safety - Harm Free Care	Falls	<= No	0	0	66	63	42	52	43	47	42	39	41	40	41	41	35	40	35	32	44	37	May 2016	14	16	7	37	81	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	1	0	1	1	0	1	5	0	1	1	2	0	0	1	1	0	0	May 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	7	10	1	1	8	3	6	2	0	6	2	3	4	4	6	4	4	3	May 2016	1	1	1	3	7	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			May 2016	95.7	90.5	99.2	96.6		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			May 2016	99.4	100.0	100.0	99.5		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			May 2016	98	0	100	98.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.0																			May 2016	97	0	100	97.5		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			May 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	May 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			May 2016	1	0	0	1	1	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98																	-	-	Mar 2016	55	67	50	59		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			9.6	10.7	10.0	10.5	11.7	10.5	10.3	11.5	10.7	9.7	9.6	8.6	9.3	9.2	9.4	9.6	9.7	-	Apr 2016				9.7		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			9.9	10.1	10.1	10.2	10.3	10.3	10.3	10.4	10.4	10.3	10.3	10.3	10.3	10.1	10.1	10.0	9.8	-	Apr 2016					9.8	

Medicine Group

Section	Indicator		Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate EC	AC	SC	Month	Year To Date	
Clinical Effect - Stroke & Card	Pts spending >90% stay on Acute Stroke Unit (%)	=> %	90.0	90.0																			May 2016		92.3		92.3	95.4	
Clinical Effect - Stroke & Card	Pts admitted to Acute Stroke Unit within 4 hrs (%)	=> %	90.0	90.0																			May 2016		74.4		74.4	73.6	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			May 2016		77.8		77.8	71.9	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.0																			May 2016		97.8		97.8	97.8	
Clinical Effect - Stroke & Card	Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			May 2016		0.0		0.0	40.0	
Clinical Effect - Stroke & Card	Stroke Admissions - Swallowing assessments (<24h) (%)	=> %	98.0	98.0																			May 2016		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=> %	70.0	70.0																			May 2016		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=> %	75.0	75.0																			May 2016		100.0		100.0	98.9	
Clinical Effect - Stroke & Card	Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=> %	80.0	80.0																			May 2016		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			May 2016		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			May 2016		100.0		100.0	100.0	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Apr 2016			94.4	94.4		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Apr 2016			100.0	100.0		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Apr 2016			85.1	85.1		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	0	1	4.5	4.5	2.5	1.5	0.5	6	3	3.5	-	Apr 2016	-	-	3.50	3.50	4	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	0	0	3	4	2	0	0	4.5	0	2	-	Apr 2016	-	-	2.00	2.00	2	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	62	97	228	165	138	104	98	154	98	175	-	Apr 2016	-	-	175	175		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Less than 1 Hour	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-			May 2016	-	-	38	38	38	
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	0	0	May 2016	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			31	30	36	38	41	35	41	53	36	29	43	42	32	34	47	39	49	36	May 2016	21	10	5	36	85	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			93	106	126	117	112	104	87	90	74	58	65	65	57	50	65	63	72	57	May 2016	28	14	15	57		

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		EC	AC	SC			
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																		May 2016	-	1.03	0.06	0.16		
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	May 2016	0.0	0.0	0.0	0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	1	0	0	9	8	1	2	4	7	0	0	1	0	2	1	1	0	3	May 2016	0.0	2.0	1.0	3	3	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	62	61	49	48	54	60	46	47	45	33	54	35	32	34	32	31	58	56	May 2016	0.0	0.0	56.0	56.0		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	1	2	5	0	0	1	1	0	0	0	0	0	0	0	May 2016	0.00	0.00	0.00	0.00	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95.0	95.0																			May 2016	90.3	94.0	Site S/C	92.2	91.4	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			1913	940	1242	1412	-	-	-	-	-	-	-	-	-	-	1560	1908	1246	1046	May 2016	1009	1	36	1046	2292	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0																			May 2016	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											-	-	-	-					May 2016	17.0	15.0	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											-	-	-	-					May 2016	50.0	46.0	Site S/C	48	48	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			May 2016	7.9	7.7	Site S/C	7.8	8.0	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			May 2016	3.1	4.5	Site S/C	3.8	3.7	
Emergency Care & Pt. Flow	WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	282	185	149	164	43	116	90	72	58	76	93	67	121	116	97	117	81	65	May 2016	25	40		65	146	
Emergency Care & Pt. Flow	WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	31	7	6	8	9	8	3	3	2	1	1	3	8	10	6	9	2	0	May 2016	0	0		0	2	
Emergency Care & Pt. Flow	WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			May 2016	0.00	0.00		0.00	0.02	
Emergency Care & Pt. Flow	WMAS - Emergency Conveyances (total)	No			4470	4001	3829	4182	3981	4214	114	4256	4241	4016	4260	4202	4573	4679	3961	4513	4115	4604	May 2016	2087	2517		4604	8719	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			May 2016	0.0	85.2	89.9	87.5		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			May 2016	0.0	84.0	79.3	80.8		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			May 2016	0.0	93.9	89.9	91.3		
RTT	RTT - Backlog	<= No	0	0	341	291	211	161	181	317	424	482	494	604	664	629	587	623	689	725	789	716	May 2016	0	183	533	716		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	1	1	0	0	0	0	1	0	0	1	1	1	3	4	0	0	May 2016	0	0	0	0		
RTT	Treatment Functions Underperforming	<= No	0	0	2	2	6	1	1	1	1	3	4	3	7	8	8	10	8	7	12	11	May 2016	0	4	7	11		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			May 2016	0	0.07	0	0.05		

Medicine Group

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		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	67,608	65,055	65,979	67,205	68,646	May 2016	12,484	17,418	38,744	68646		
Data Completeness	Open Referrals - Awaiting Management	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	27,219	May 2016	9,953	7,131	10,135	27219		
Workforce	WTE - Actual versus Plan	No			232	242	244	176	200	200	219	236	262	261	217	214	208	204	201	219	220	207	May 2016	106.6	55.55	39.42	207		
Workforce	PDRs - 12 month rolling (%)	=> %	95.0	95.0																			May 2016	91.59	90.46	89.14		88.6	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0					-														May 2016	77.27	93.1	87.18		87.3	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15																			May 2016	5.55	5.82	4.87	5.52	5.59	
Workforce	Sickness Absence - In month	<= No	3.15	3.15	-	-	-	-	-	-													May 2016	4.68	5.38	3.71	4.76	5.38	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-		-	-												-	Apr 2016	64.9	73.6	49.3		66.73	
Workforce	Mandatory Training (%)	=> %	95.0	95.0																			May 2016	81.93	81.77	82.26		82.1	
Workforce	New Investigations in Month	No			0	1	2	2	2	1	1	2	1	3	0	0	1	1	6	4	1	0	May 2016	0	0	0	0		
Workforce	Nurse Bank Fill Rate %	=> %	100	100	-	-	-	72	2528	3008	2311	3287	3019	4330	2700	1185	3654	3001	3002	4159	3992	-	Apr 2016				85		
Workforce	Nurse Bank Shifts Not Filled (number)	<= No	0	0	-	-	-	1031	1136	1055	771	1146	977	811	594	217	749	925	700	748	710	-	Apr 2016				710		
Workforce	Nurse Bank Use	<= No	34560	2880																		-	Apr 2016				2913	2913	
Workforce	Nurse Agency Use	<= No	0.00	0.00																		-	Apr 2016				1546	1546	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0.00	0.00																		-	Apr 2016				1102	1102	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0.00	0.00																		-	Apr 2016				83	83	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-	
Workforce	Your Voice - Response Rate (%)	No			-->	-->	6	-->	-->	-->	6	-->	-->	6	-->	-->	6	-->	-->	-->	-->	-->	Dec 2015	6.0	5.0	10.0	6.0		
Workforce	Your Voice - Overall Score	No			-->	-->	3.57	-->	-->	-->	3.49	-->	-->	3.45	-->	-->	3.37	-->	-->	-->	-->	-->	Dec 2015	3.44	3.56	3.10	3.37		

Surgery A Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate				Month	Year To Date	Trend
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		GS	SS	TH	An			
Patient Safety - Inf Control	C. Difficile	<= No	7	1																			May 2016	0	0	0	0	0	1	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			May 2016	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80	80																			May 2016	97.92	98.08	0	0	97.5		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80	80																			May 2016	94.13	96.62	0	100	94.9		
Patient Safety - Harm Free Care	Falls	<= No	0	0	6	0	4	4	5	9	5	4	2	4	2	6	11	13	6	11	7	8	May 2016	3	4	0	1	8	15	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	May 2016	0	0	0	0	0	1	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	4	0	0	2	0	0	1	1	1	2	1	1	1	2	0	1	2	2	May 2016	0	2	0	0	2	4	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			May 2016	95.57	90.05	0	98.65	94.1		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			May 2016	99.55	99.49	0	100	99.6		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			May 2016	100	100	100	0	100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.0																			May 2016	100	100	100	0	100.0		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0	0	0	May 2016	0	0	0	0	0	0	
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	0	May 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			May 2016	0	0	0	0	0	2	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98.0																	-	-	Mar 2016	83	50	0	100	76.5		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			6.4	7.3	7.0	6.4	7.7	8.2	7.9	7.3	7.8	7.8	7.3	7.4	8.7	7.6	7.2	7.9	7.4	-	Apr 2016					7.4		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.67	6.74	6.78	6.74	6.78	6.77	6.85	6.92	7.03	7.21	7.27	7.37	7.56	7.58	7.6	7.73	7.71	-	Apr 2016						7.7	

Surgery A Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate GS	SS	TH	An	Month	Year To Date
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2016	98.7		0.0		98.69	
Clinical Effect - Cancer	2 weeks (Breast Symptomatic)	=> %	93.0	93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2016	98.1				98.11	
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2016	98.4		0.0		98.44	
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2016	93.7		0.0		93.65	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	0	10	3	5	2	5	2	2	3	2	-	Apr 2016	-	-	-	-	2	2
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	4	6	1	2	0	4	0	0	1	0	-	Apr 2016	0	-	0	-	0	0
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			'	'	'	'	'	'	'	180	147	173	124	98	167	75	74	117	73	'	Apr 2016	73	-	0	-	73	
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Less than 1 Hour	<= No	100	100	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2016	8789	4246	0	1714	14749	29498
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	May 2016	0	0	0	0	0	0
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			7	15	9	16	16	8	16	16	15	15	18	18	11	16	14	19	24	15	May 2016	10	4	1	0	15	39
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			53	45	40	45	46	27	32	23	26	23	23	24	15	17	23	26	24	29	May 2016	15	11	3	0	29	
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	1.09	0.27	0	-	0.61	
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	May 2016	0	0	0	0	0	0
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	33	11	13	17	12	10	8	21	13	13	17	8	16	5	19	6	10	6	May 2016	5	1	0	0	6	16
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	70.8	77.6	78.7	75.1	78.5	77.8	78.7	80.2	78.2	77.9	78.4	78	72.2	74	75.8	76.8	76.2	76.2	May 2016	74.8	76.0	0.0	92.9	76.23	
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	2	0	0	0	7	2	8	0	0	0	0	0	0	0	May 2016	0	0	0	0	0	0
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			121	43	108	127	'	'	'	'	'	'	'	'	'	'	49	65	68	30	May 2016	15	13	0	2	30	98
Emergency Care & Pt. Flow	Hip Fractures BPT (Operation < 36 hours of admissions	=> %	85	85	-	-	-	-	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016		53.3			53.3	63.2

Surgery A Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		GS	SS	TH	An			
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			May 2016	78.5	56.6	0.0	0.0	67.5		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			May 2016	93.3	95.9	0.0	0.0	94.5		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			May 2016	92.5	88.7	0.0	0.0	90.8		
RTT	RTT - Backlog	<= No	0	0	421	493	475	492	488	423	373	486	562	651	768	785	725	698	617	662	676	636	May 2016	275	361	0	0	636		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	3	1	2	1	0	0	0	2	1	1	0	0	1	1	0	2	1	May 2016	0	1	0	0	1		
RTT	Treatment Functions Underperforming	<= No	0	0	4	5	8	4	2	3	2	2	4	8	10	9	11	9	9	7	10	8	May 2016	3	5	0	0	8		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			May 2016	0.0	0.0	2.1	0.0	0.99		
Data Completeness	Open Referrals	No			-	-	-	-	32,829	34,523	35,269	36,991	39,612	40,315	40,565	41,714	42,539	36,195	35,305	35,734	37,034	38,099	May 2016	21,655	12,905	0	3,539	38099		
Data Completeness	Open Referrals - Awaiting Management	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	14,749	May 2016	8,789	4,246	0	1,714	14749		
Workforce	WTE - Actual versus Plan	No			66	62	70	70.1	88.3	97.1	103	110	120	122	116	107	112	120	102	102	103	101	May 2016	32.26	23.7	19.68	22.69	100.98		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			May 2016	90.2	90.4	92.6	88.7		89.8	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0					-														May 2016	79.17	88.89	0	67.5		79.4	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15																			May 2016	5.8	3.6	6.4	4.9	5.3	5.3	
Workforce	Sickness Absence - In Month	<= No	3.15	3.15	-	-	-	-	-	-													May 2016	5.2	######	7.0	######	5.2	4.7	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-		-	-												-	Apr 2016	78.9	54.5	86.5	77.5	77.8	77.8	
Workforce	Mandatory Training	=> %	95.0	95.0																			May 2016	85.2	80.5	90.3	90.9		87.7	
Workforce	New Investigations in Month	No			0	1	1	2	3	3	1	2	1	0	3	0	0	1	1	1	0	0	May 2016	0	0	0	0	0		
Workforce	Nurse Bank Fill Rate	=> %	100.0	100.0	-	-	-	76	71	80	82.2	75.6	76.4	85.8	85.3	86.3	82.3	77.9	57.2	83.5	86.3	-	Apr 2016					86.34	86	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	335	313	247	197	347	303	272	220	117	232	269	202	223	226	-	Apr 2016					226	226	
Workforce	Nurse Bank Use	<= No	9908	826																		-	Apr 2016					1370	1370	
Workforce	Nurse Agency Use	<= No	0	0																		-	Apr 2016					431	431	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0																		-	Apr 2016					218	218	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0																		-	Apr 2016					56	56	

Surgery A Group

Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00					**-**	**-**	
Workforce	Your Voice - Response Rate	No			-->	-->	9	-->	-->	-->	10	-->	-->	10	-->	-->	8	-->	-->	-->	-->	-->	Dec 2015	-	-	-	9	**8**		
Workforce	Your Voice - Response Score	%			-->	-->	3.41	-->	-->	-->	3.56	-->	-->	3.37	-->	-->	3.31	-->	-->	-->	-->	-->	Dec 2015	-	-	-	3.49	**3.31**		

Surgery B Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate O	Directorate E	Month	Year To Date	Trend
Patient Safety - Inf Control	C. Difficile	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	0	0	0	0	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	87.5	91.8	90.7		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	93.9	82.1	86.0		
Patient Safety - Harm Free Care	Falls	<= No	0	0	1	1	0	0	0	0	2	1	0	0	1	2	1	1	1	1	1	1	May 2016	1	0	1	2	
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	May 2016	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	May 2016	0	0	0	0	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	97.6	98.4	97.9		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98	98	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	100	100	100		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	100	100	100		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	100	100	100		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	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	N/A	N/A	N/A	●	N/A	-	-	Mar 2016	0	0	0		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			5.0	2.9	4.5	5.5	5.7	4.4	3.4	5.7	3.6	5.3	5.0	4.4	6.1	3.1	5.8	4.9	2.8	-	Apr 2016			2.8		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			4.8	4.7	4.5	4.5	4.5	4.6	4.6	4.6	4.5	4.7	4.7	4.6	4.7	4.7	4.8	4.8	4.5	-	May 2016				4.5	

Surgery B Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate O	Directorate E	Month	Year To Date	
Clinical Effect - Cancer	2 weeks	=> %	93	93	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2016		94	94.0		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96	96	-	●	●	●	●	●	●	●	●	●	#DIV/0!	●	●	●	●	●	#DIV/0!	-	Apr 2016		0	0		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85	85	●	●	●	●	●	●	●	●	●	●	#DIV/0!	●	●	●	#DIV/0!	●	●	-	Apr 2016		100	100.0		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	0	0	0	0	1	0	0.5	0	0	0	-	Apr 2016	-	0	0	0	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	0	0	-	Apr 2016	-	0	0	0	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	62	51	62	0	104	54	84	0	59	0	-	Apr 2016	-	0	0		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Less than 1 Hour	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2016	-	0	0	0	
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	May 2016	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			14	14	12	16	14	9	6	15	15	16	18	18	17	9	14	19	21	14	May 2016	14	0	14	35	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			33	35	35	36	39	35	17	17	22	19	24	25	21	15	14	19	25	23	May 2016	21	2	23		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	1.58	0.53	1.19		
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	May 2016	0	0	0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	7	24	11	8	15	17	16	10	14	8	19	15	11	11	14	14	8	12	May 2016	10	2	12	20	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85	85	68	74.1	72	75.2	73.3	71.4	73.1	73.9	70.5	73.64	75	75.1	73.8	74.5	74.8	72.5	73.9	75	May 2016	77.4	68.6	74.99		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	0	0	1	0	0	0	0	0	0	0	0	0	0	0	May 2016	0	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	97.9		97.9	98.1	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			25	8	8	39	-	-	-	-	-	-	-	-	-	-	13	33	41	52	May 2016	45	7	52	93	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0	-	-	-	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	0		0	0	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15	●	●	●	●	●	●	●	●	●	●	-	-	-	-	●	●	●	●	May 2016	25		25	14	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60	●	●	●	●	●	●	●	●	●	●	-	-	-	-	●	●	●	●	May 2016	106		23	110	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5	5	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	4.05		4.05	3.95	

Surgery B Group

Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5	5																	May 2016	2.03		2.03	1.91	

Surgery B Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate O	Directorate E	Month	Year To Date	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90	90																			May 2016	79.1	87.0	82.0		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95	95																			May 2016	93.8	87.3	92.4		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92	92																			May 2016	93.1	95.4	93.9		
RTT	RTT - Backlog	<= No	0	0	551	669	540	559	574	547	549	582	630	678	693	561	579	578	626	646	560	595	May 2016	442	153	595		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	1	1	0	1	0	3	2	1	3	3	1	2	1	3	1	0	May 2016	0	0	0		
RTT	Treatment Functions Underperforming	<= No	0	0	1	2	7	1	1	2	1	1	1	1	5	3	3	7	5	6	6	5	May 2016	2	3	5		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1	1																			May 2016	0	0	0		
Data Completeness	Open Referrals	No			-	-	-	-	58,186	60,484	61,192	63,016	65,129	66,371	67,982	70,005	71,194	62,182	60,870	61,989	63,337	64,441	May 2016	52,967	11,474	64441		
Data Completeness	Open Referrals - Awaiting Management	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	19,626	May 2016	15,319	4,307	19626		
Workforce	WTE - Actual versus Plan	No			30	32	29	28.5	35.3	35.1	46.6	43.1	49.7	57.2	57.7	59.1	61.1	57.8	50.2	47	41.5	41.6	May 2016			41.6		
Workforce	PDRs - 12 month rolling	=> %	95	95																			May 2016	97.1	91.5		96.3	
Workforce	Medical Appraisal and Revalidation	=> %	95	95					-														May 2016	96.3	80	93.8	91.67	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			May 2016	3.53	2.64	3.27	3.21	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15	-	-	-	-	-	-													May 2016	3.85	4.4	3.89	3.24	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-		-	-												-	Apr 2016	72.7	77.2	77.33	77.33	
Workforce	Mandatory Training	=> %	95	95																			May 2016	85.8	93		87.54	
Workforce	New Investigations in Month	No			0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1	0	0	May 2016			0		
Workforce	Nurse Bank Fill Rate	=> %	100	100	-	-	-	100	99	99.6	98.4	98.2	96.9	96.02	97	97.6	93.5	97.3	95.9	97.1	96.4	-	Apr 2016			96.41	96.41	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	1	2	1	3	4	7	13	7	27	23	11	14	10	12	-	Apr 2016			12	12	
Workforce	Nurse Bank Use	<= No	2796	233																		-	Apr 2016			274	274	

Surgery B Group

Workforce	Nurse Agency Use	<= No	0	0																	-	Apr 2016			0	0	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0																	-	Apr 2016			144.0	144.0	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0																	-	Apr 2016			42.0	42.0	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	
Workforce	Your Voice - Response Rate	No			-->	-->	14	-->	-->	-->	12	-->	-->	15	-->	-->	14	-->	-->	-->	-->	-->	Dec 2015	7	31	14		
Workforce	Your Voice - Overall Score	No			-->	-->	3.54	-->	-->	-->	3.59	-->	-->	3.63	-->	-->	3.63	-->	-->	-->	-->	-->	Dec 2015	3.56	3.73	3.63		

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate				Month	Year To Date	Trend
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		G	M	P	C			
Patient Safety - Inf Control	C. Difficile	<= No	0	0																			May 2016	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			May 2016	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.00	80.00																			May 2016	98				98.0		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80.00	80.00																			May 2016	0	96.7			96.7		
Patient Safety - Harm Free Care	Falls	<= No	0	0	0	0	0	0	1	2	1	0	1	2	0	1	0	2	0	1	0	1	May 2016	1	0	0	0	1	1	
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	May 2016	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	2	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	May 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			May 2016	98.5	92.6			95.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			May 2016	100	100			100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			May 2016	100	100			100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.00																			May 2016	100	100			100.0		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			May 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			May 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			May 2016	0	0	0	0	0	0	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate G	M	P	C	Month	Year To Date
Patient Safety - Obstetrics	Caesarean Section Rate - Total	<= %	25.0	25.0																			May 2016		22.1			22.1	24.3
Patient Safety - Obstetrics	Caesarean Section Rate - Elective	%			11	8	6	9	8	7	8	11	9	9	10	9	9	8	8	8	10	7	May 2016		7.36			7.4	8.6
Patient Safety - Obstetrics	Caesarean Section Rate - Non Elective	%			16	15	17	16	15	18	15	18	17	18	15	16	14	17	15	18	17	15	May 2016		14.7			14.7	15.8
Patient Safety - Obstetrics	Maternal Deaths	<= No	0	0																			May 2016		0			0	0
Patient Safety - Obstetrics	Post Partum Haemorrhage (>2000ml)	<= No	48	4																			May 2016		2			2	4
Patient Safety - Obstetrics	Admissions to Neonatal Intensive Care	<= %	10.0	10.0																			May 2016		1.41			1.4	1.2
Patient Safety - Obstetrics	Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			May 2016		16.2			16.2	
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	90.0	90.0																			May 2016		80.3			80.3	
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0																			May 2016		138			137.7	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100.0	97.0		-				N/A			N/A	N/A			N/A		N/A		-	-	Mar 2016	50	0	0		50.0	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			7.2	6.6	7.4	6.9	7.4	6.9	7.1	7.1	4.4	4.5	6.4	5.9	4.8	4.7	6.7	5.5	4.9	-	Apr 2016					5.0	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.6	6.5	6.6	6.7	6.7	6.7	6.8	6.9	6.7	6.6	6.6	6.5	6.3	6.1	6.1	5.9	5.8	-	Apr 2016						5.8
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Apr 2016	91.8		0		91.8	
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Apr 2016	100				100.0	
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Apr 2016	75				75.0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	0	1.5	1.5	4	0.5	1.5	3	2	0	3	-	Apr 2016	3	-	0	-	3	3
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	1	1	0	2	0	0	0	0	0	1	-	Apr 2016	1	-	0	-	1	1
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	123	130	98	146	89	71	104	97	62	149	-	Apr 2016	149	-	0	-	149	
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Less than 1 Hour	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2016	0	-	0	-	0	0

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate G	M	P	C	Month	Year To Date	
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	May 2016	0				0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			7	11	9	11	7	9	14	14	12	10	9	10	15	17	4	13	5	10	May 2016	2	3	5	0	10	15	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			12	21	27	32	28	28	20	18	17	13	13	13	14	20	6	17	9	13	May 2016	0	0	0	0	13		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			May 2016	4.72		-		3.5		
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	May 2016	0				0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	7	1	5	7	6	4	2	2	4	7	6	9	13	6	7	13	4	10	May 2016	10				10	14	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	80	77	78	79	76	78	74	75	76	79	76	76	72	74	71	78	76	73	May 2016	73.5	-			73.5		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	8	3	0	0	0	0	0	0	0	0	0	0	0	0	May 2016	0	-	0	-	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			82	5	30	16	-	-	-	-	-	-	-	-	-	-	15	6	16	5	May 2016	3	0	2	0	5	21	
RTT	RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			May 2016	92				92.0		
RTT	RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			May 2016	95.2				95.2		
RTT	RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			May 2016	95.1				95.1		
RTT	RTT - Backlog	<= No	0	0	14	20	22	20	20	23	22	25	32	34	54	53	52	60	70	80	69	92	May 2016	92				92		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	May 2016	0				0		
RTT	Treatment Functions Underperforming	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	1	0	May 2016	0				0		
RTT	Acute Diagnostic Waits in Excess of 6-weeks	<= %	0.1	0.1																			May 2016	0				0.0		

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate G	M	P	C	Month	Year To Date	
Data Completeness	Open Referrals	No			-	-	-	-	19,676	20,814	21,841	23,178	25,152	26,342	27,705	29,256	30,745	23,372	23,021	22,929	23,294	24,026	May 2016	7,352	10,653	6,007	14	24026		
Data Completeness	Open Referrals - Awaiting Management	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	10,111	May 2016	3,710	4,875	1,525	1	10111		
Workforce	WTE - Actual versus Plan	No			66	67	68.6	66.9	67.9	70.8	87.2	95.8	111	96.6	85.7	82.5	98.9	96.9	94.7	91.8	87.3	101	May 2016	26.8	39.1	36.6	0	101.5		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			May 2016	93.2	91.2	93.6	0		92.5	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0					-														May 2016	94.7	100	76.9	0		93.2	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			May 2016	4.95	5.84	3.98	12.9	5.3	5.3	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	-	-	-	-	-	-													May 2016	3.16	4.78	1.67	0	3.9	4.1	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-		-	-											-		Apr 2016	83.2	72	78.1	50	75.04	75.04	
Workforce	Mandatory Training	=> %	95.0	95.0																			May 2016	90.1	85.7	86.6	0		86.5	
Workforce	New Investigations in Month	No			0	0	1	1	1	3	2	2	1	1	1	1	0	0	1	0	1	0	May 2016	0	0	0	0	0		
Workforce	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	93.5	90.8	92.9	91.4	-	Apr 2016					91.4	91.4	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	81	37	35	53	50	68	51	48	394	95	54	74	60	65	-	Apr 2016					65	91	
Workforce	Nurse Bank Use	<= No	6852	571																		-	Apr 2016					635	635	
Workforce	Nurse Agency Use	<= No	0	0																		-	Apr 2016					8	8	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0																		-	Apr 2016					98	98	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0																		-	Apr 2016					40	40	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	0	0																											
Workforce	Your Voice - Response Rate	No			-->	-->	9	-->	-->	-->	13	-->	-->	12	-->	-->	11	-->	-->	-->	-->	-->	Dec 2015	15	5	17	13	11		
Workforce	Your Voice - Overall Score	No			-->	-->	3.53	-->	-->	-->	3.66	-->	-->	3.64	-->	-->	3.63	-->	-->	-->	-->	-->	Dec 2015	3.69	3.67	3.62	3.45	3.6		

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate				Month	Year To Date	
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		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	159	167	207	193	159	-	-	Mar 2016				159	159	1434	
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	89.9	88.9	88.2	87.6	91.9	89	-	-	Mar 2016				89.1	89.05	88.72	
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	8.51	9.19	8.82	7.69	6.68	9.33	-	-	Mar 2016				9.33	9.33	8.73	
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	93.3	91.9	97.5	90.3	94.4	-	-	Mar 2016				94.4	94.39	87.39	
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	94.5	96.2	-	-	-	-	-	Dec 2015				96.2	96.24	88.65	
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	93	94.5	95.8	88.9	95.6	-	-	Mar 2016				95.6	95.61	91.41	
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	84.4	80.5	90.2	84.2	81.6	-	-	Mar 2016				81.6	81.55	80.08	
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	1	1	1	1	1	-	-	Mar 2016				1	1	12	
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	97.1	93.9	97.9	93.6	96	-	-	Mar 2016				96	95.98	92.37	
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	84.7	91.9	98.6	99.3	99.4	-	-	Mar 2016				99.4	99.44	86.83	
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	30.7	36.8	37.9	35.6	43.9	-	-	Mar 2016				43.9	43.87	34.5	
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	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2016				-	-	-	
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	360	358	353	335	391	341	-	-	Mar 2016				341	341	3215	
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	94.7	98.6	97.2	96.3	100	100	-	-	Mar 2016				100	100	95.18	
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	337	376	366	322	358	-	-	Mar 2016				358	358	3197	
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	94.1	91.8	98.2	99.7	98.8	100	-	-	Mar 2016				100	100	95.31	
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	257	316	352	294	339	-	-	Mar 2016				339	339	2809	
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	89.4	83.4	92.4	89.6	92.2	91.6	-	-	Mar 2016				91.6	91.62	88.7	

Women & Child Health Group

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	56	51	42	39	39	-	-	Mar 2016				39	39	411	
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 Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate HA	HI	B	M	I	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	0	0	0	0	0	0	0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	0	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	-	-	-		
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			2	3	1	5	0	2	3	0	2	0	1	2	0	2	4	2	3	4	May 2016	3	0	0	0	1	4	7	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			5	8	7	6	4	6	5	2	3	0	2	2	1	1	4	3	3	5	May 2016	3	0	0	0	2	5		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2016	-	-	-	-	-	-	-	
Data Completeness	Open Referrals	No			-	-	-	-	1,700	1,743	1,808	1,870	1,957	3,276	3,293	3,318	3,414	3,312	3,294	3,420	3,572	3,639	May 2016	1,464	1	1,673	0	501	3,639		
Data Completeness	Open Referrals - Awaiting Management	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,621	May 2016	719	0	726	0	176	1,621		
Workforce	WTE - Actual versus Plan	No			27	24	16	16	20.4	22.8	32.5	34	33.7	40.3	40.1	39.2	38.2	32.5	22.9	30.3	25.7	31.6	May 2016	10.7	5.12	11.7	4.14	0.32	32		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	90.6	100	92.4	98.3	100		94.65	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	-	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	0	100	100	100	100		91.43	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	5.86	1.46	4.45	3.3	3.89	4.12	4.11	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	-	-	-	-	-	-	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	2.0	1.1	7.3	2.0	0.1	3.88	3.72	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	●	-	-	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2016	81.1	97.4	75	91.9	100	80.7	80.7	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2016	93.1	98.8	93.8	93.9	95		94.2	
Workforce	New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	May 2016	0	0	0	0	0	0		
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2016						265	265	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2016						0	0	
Workforce	Your Voice - Response Rate	No			-->	-->	12	-->	-->	-->	21	-->	-->	24	-->	-->	19	-->	-->	-->	-->	-->	Dec 2015	15	28	12	26	57	19		
Workforce	Your Voice - Overall Score	No			-->	-->	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		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		DR	IR	NM	BS			
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			May 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			May 2016	0	0	0	0	0	0	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	<= No	0	0	3.0	1.0	1.0	-	-	2.0	2.0	2.0	1.0	1.0	1.0	-	-	1.0	2.0	-	2.0	-	Apr 2016					15.4		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	=> %	0	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	11.0	11.0	12.0	12.0	14.0	-	Apr 2016						5.17	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			May 2016			77.8		77.78	71.91	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.00																			May 2016			97.8		97.78	97.75	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	0	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	-	-		
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	May 2016	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			2	3	2	1	0	4	3	5	8	4	1	2	1	3	6	5	2	0	May 2016	0	0	0	0	0	2	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			8	9	7	5	0	5	5	7	11	7	3	2	0	3	6	5	2	1	May 2016	1	0	0	0	1		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2016	-	-	-	-	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			45	41	49	51	-	-	-	-	-	-	-	-	-	-	49	62	36	67	May 2016	67	0	0	0	67	103	
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			May 2016	0.03				0.03		
Data Completeness	Open Referrals	No			,	,	,	,	132	148	151	173	178	198	208	231	248	259	271	286	288	298	May 2016	298	0	0	0	298		
Data Completeness	Open Referrals - Awaiting Management	No			,	,	,	,	,	,	,	,	,	,	,	,	,	,	,	,	,	265	May 2016	265	0	0	0	265		
Workforce	WTE - Actual versus Plan	No			21	21	33	34	41	46	58	59	56	50	48	45	40	44	44	46	49	51	May 2016	24	1.2	6.8	6.5	51.0		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			May 2016	89.3	83.3	96	96.3		83.7	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0					.														May 2016	84	0	100	75		82.3	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			May 2016	3.1	6.9	1.8	5.5	4.65	4.63	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	.	.	.	.	.	.													May 2016	3.8	7.1	1.2	3.9	4.42	4.91	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	.	.	.		.	.												.	Apr 2016	60.7	92.9	77.6	22.9	57.4	57.4	
Workforce	Mandatory Training	=> %	95.0	95.0																			May 2016	84	92.6	91.1	89		87.4	
Workforce	New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	May 2016					0		
Workforce	Nurse Bank Use	<= No	288	24																		.	Apr 2016					170	170	
Workforce	Nurse Agency Use	<= No	0	0																		.	Apr 2016					241	241	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0																		.	Apr 2016					120	120	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0																		.	Apr 2016					0	0	
Workforce	Your Voice - Response Rate	No			-->	-->	18	-->	-->	-->	19	-->	-->	24	-->	-->	21	-->	-->	-->	-->	-->	Dec 2015	18	0	61	11	21		
Workforce	Your Voice - Overall Score	No			-->	-->	3.28	-->	-->	-->	3.41	-->	-->	3.11	-->	-->	3.40	-->	-->	-->	-->	-->	Dec 2015	3.3	0	3.8	3.9	3.4		
Imaging Group Only	Unreported Tests / Scans	No			.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.									
Imaging Group Only	Outsourced Reporting	No			.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.									
Imaging Group Only	IRMA Instances	No			.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.									

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		AT	IB	IC			
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.0	80.0																			May 2016	0	0	0	0		
Patient Safety - Harm Free Care	Falls	<= No	0	0	21	22	16	13	30	47	37	25	27	29	29	21	26	31	23	20	22	38	May 2016	0	31	7	38	60	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1	2	1	1	0	0	May 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	5	2	1	3	3	1	1	3	2	0	0	2	0	3	0	7	5	6	May 2016	0	4	2	6	11	
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			May 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			May 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			May 2016	0	0	0	0	0	
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	May 2016	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			1	2	1	1	0	1	2	1	3	5	4	4	2	3	6	7	3	5	May 2016	3	1	1	5	8	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			3	4	3	6	0	7	6	4	5	7	5	5	5	3	6	7	11	7	May 2016	3	0	4	7		

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		AT	IB	IC			
Workforce	WTE - Actual versus Plan	No			75	76	72.2	77.4	174	92.8	77.3	85.3	87.7	114	124	103	105	94.7	100	106	102	123	May 2016	17	56.5	49.8	123.3		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			May 2016	92.8	92.5	92.6		93.1	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			May 2016	3.18	5.09	4.66	4.53	4.62	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	-	-	-	-	-	-													May 2016	3.35	3.07	3.85	3.48	3.83	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-		-	-												-	Apr 2016	96.9	87.1	84.2	87.44	87.44	
Workforce	Mandatory Training	=> %	95.0	95.0																			May 2016	95.4	89.1	91.5		91.5	
Workforce	New Investigations in Month	No			0	0	0	0	1	3	0	0	0	0	0	4	0	0	2	0	0	0	May 2016				0		
Workforce	Nurse Bank Fill Rate	=> %	100	100	-	-	-	93	89.5	94.2	89.2	89	89.7	92.2	90.6	95.6	88	88.4	78.3	89.3	87.9	-	Apr 2016	-	-	-	87.87	87.87	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	36	41	31	46	72	62	56	48	19	78	90	78	86	87	-	Apr 2016	-	-	-	87	87	
Workforce	Nurse Bank Use	<= No	5408	451																		-	Apr 2016				485	485	
Workforce	Nurse Agency Use	<= No	0	0																		-	Apr 2016				282	282	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0																		-	Apr 2016				211	211	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0																		-	Apr 2016				0	0	
Workforce	Your Voice - Response Rate	No			-->	-->	28	-->	-->	-->	26	-->	-->	31	-->	-->	21	-->	-->	-->	-->	-->	Dec 2015	30	21	18	21		
Workforce	Your Voice - Overall Score	No			-->	-->	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	
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		AT	IB	IC			
Community & Therapies Group Only	DVT numbers	=> No	730	61	47	54	53	55	56	53	67	64	78	59	44	0	24	47	65	51	-	-	Mar 2016				51	608	
Community & Therapies Group Only	Adults Therapy DNA rate OP services	<= %	9	9	12	12.3	13.9	12.9	13.3	12	14.5	10.7	9.85	10.5	11.4	11	10.5	11.3	9	8.06	9.9	8.82	May 2016				8.8	9.4	
Community & Therapies Group Only	Therapy DNA rate Paediatric Therapy services	<= %	9	9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	10.5	May 2016				10.5	10.5	
Community & Therapies Group Only	Therapy DNA rate S1 based OP Therapy services	<= %	9	9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6.19	6.19	May 2016				6.2	6.2	
Community & Therapies Group Only	STEIS	<= No	0	0	1	0	0	-	-	-	0	0	0	0	1	0	1	2	1	1	0	0	May 2016				0	0	
Community & Therapies Group Only	Green Stream Community Rehab response time for treatment (days)	<= No	11.0	11.0	13.1	9.5	12.1	13.7	16	14	11	15	15	12	15	17	17	16	24	24	23	-	Apr 2016				23	23	
Community & Therapies Group Only	DNA/No Access Visits	%			1	1	1	-	-	-	-	6	1	1	-	1	1	1	1	0	1	1	May 2016				0.75		
Community & Therapies Group Only	Baseline Observations for DN	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	39.2	May 2016				39.17	39.17	
Community & Therapies Group Only	Falls Assessments - DN Intial Assessments only	%			45	62	54	65	47	55	50	46	44	43	42	41	46	52	55	54	61	161	May 2016				161.01		
Community & Therapies Group Only	Pressure Ulcer Assessment - DN Intial Assessments only	%			46	63	57	65	51	55	51	48	44	43	44	33	48	54	56	58	64	67	May 2016				67.09		
Community & Therapies Group Only	MUST Assessments - DN Intial Assessments only	%			10	19	18	-	22	22	24	21	23	23	23	23	26	28	32	32	37	35	May 2016				34.9		
Community & Therapies Group Only	Dementia Assessments - DN Intial Assessments only	%			51	61	62	-	46	56	40	48	45	50	43	50	29	28	31	21	40	37	May 2016				36.76		
Community & Therapies Group Only	48 hour inputting rate - DN Service Only	%			86	89	83	-	87	89	92	91	94	90	90	94	94	93	94	94	93	91	May 2016				90.88		
Community & Therapies Group Only	Making Every Contact (MECC) - DN Intial Assessments only	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	7	128	202	May 2016				28.77	25.1	
Community & Therapies Group Only	Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload acquired)	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	6	2	May 2016				2	8	
Community & Therapies Group Only	Avoidable Grade 2 Pressure Ulcers (DN caseload acquired)	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	3	2	May 2016				2	5	
Community & Therapies Group Only	Avoidable Grade 3 Pressure Ulcers (DN caseload acquired)	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0	May 2016				0	0	
Community & Therapies Group Only	Avoidable Grade 4 Pressure Ulcers (DN caseload acquired)	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0	May 2016				0	0	

Corporate Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate							Month	Year To Date	Trend
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		CEO	F	W	M	E	N	O			
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			6	15	5	6	5	7	8	6	15	11	13	8	5	4	5	8	8	10	May 2016	3	0	0	0	1	3	3	10	18	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			12	21	16	18	14	12	14	9	16	16	16	9	8	4	4	7	8	9	May 2016	4	0	0	0	1	1	3	9		
Workforce	WTE - Actual versus Plan	No			168	175	200	220	260	267	110	99.6	103	100	92.2	89.3	97.8	81.9	83.2	96.4	102	128	May 2016	10.7	1.52	-1	17	-1.61	58.4	42.9	127.95		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			May 2016	75	91	97	91	92	96	93		93.4	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0					-						#DIV/0!								May 2016			95					100.0	100	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			May 2016	2.68	2.96	3.58	3.10	3.71	5.33	4.52	4.46	4.50	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	-	-	-	-	-	-													May 2016	1.95	2.39	3.87	3.23	2.30	3.69	3.82	3.46	3.60	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-		-	-												-	Apr 2016	89.0	73.5	54.1	83.5	63.6	85.2	77.7	78.7	78.7	
Workforce	Mandatory Training	=> %	95.0	95.0																			May 2016	96	93	94	97	98	91	93	93.1	93	
Workforce	New Investigations in Month	No			0	1	0	0	1	0	1	2	1	1	5	0	1	2	2	2	4	4	May 2016	0	0	0	0	0	4	0	4		
Workforce	Nurse Bank Use	<= No	1088	91																		-	Apr 2016								156	156	
Workforce	Nurse Agency Use	<= No	0	0																		-	Apr 2016								18	18	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0																		-	Apr 2016	-	-	-	-	-	-	-	2492	2492	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0																		-	Apr 2016	-	-	-	-	-	-	-	113	113	
Workforce	Your Voice - Response Rate	No			-->	-->	15	-->	-->	-->	16	-->	-->	19	-->	-->	15	-->	-->	-->	-->	-->	Dec 2015	67	24	25	20	15	9	10	15		
Workforce	Your Voice - Overall Score	No			-->	-->	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:	**Financial performance – P02 May 2016**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Finance Director**
AUTHOR:	**Tim Reardon – Associate Director of Finance**
DATE OF MEETING:	**7 July 2016**

EXECUTIVE SUMMARY:

Key messages:

- Control total surplus £6.6m agreed with NHSI. Includes benefit of £11.3m STF funding.
- Financial plan profile consistent with exit run rate recurrent financial balance and reserves restored.
- Requires delivery of minimum £19.6m savings programme and income recovery above contract.
- Limited scope for contingency and balance sheet flexibility and which would further erode cash balances. Delivery must be tangible and sustainable.
- Year to date performance records significant deficit in each of first two months but indicates marginally ahead of plan.
- Significant step improvement in monthly run rate income recovery and expenditure reduction required in Q2 & Q3 to secure year exit run rate. Plan to deliver that remains to be fully confirmed in particular in respect of pay bill reduction.

Key actions:

- Confirmation and execution of step reduction in costs through focus on bed reduction, pay & workforce change & procurement cost savings. Underpinned by fit for purpose PMO.
- Delivery of now confirmed demand & capacity plan to secure increase in patient related income.
- Delivery of capital programme to time & budget consistent with enabling programme for MMH
- Delivery of working capital management consistent with achievement of EFL
- Development & delivery of liquidity / cash improvement plan.

Key numbers:

- Month deficit £957k being £722k favourable to plan; YTD deficit £2,613k being £544k favourable.
- Year plan surplus £6.6m in line with agreed control total and after benefit of £11.3m STF funding.
- Pay bill £25.3m (vs. £25.4m) in month; Agency spend £1.6m (vs. £1.8m).
- Savings delivery to date £1.5m being in line with plan but below expected scheme value.
- Total in year savings potential identified £19.9m – as plan required but subject to ongoing validation.
- Capex YTD £5.4m being £4.4m below plan. Variance relates to timing & accounting for MMH PDC.
- Cash at 31 May £20.9m being £4.4m below plan due to timing of drawdown of PDC funding.
- FSRR 2 to date being as plan; forecast is as plan at 3.
- Capital Resource Limit (CRL) forecast to be achieved.
- External Finance Limit (EFL) forecast to be achieved.

REPORT RECOMMENDATION:

The Committee is recommended to note the report. Also to REQUIRE those actions necessary to secure the required step change in underlying run rate 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		Legal & Policy	**x**	Patient Experience	
Clinical		Equality and Diversity		Workforce	**x**
Comments:					

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

Effective use of resources

PREVIOUS CONSIDERATION:

Performance Management Committee – June 2016

Finance Report

Period 02 2016/17
May 2016

Trust Board
7th July 2016

Contents

Page Title

Finance Report

Summary & Recommendations

Period 02 2016/17

Statutory Financial Duties	Value	Outlook	Note
I&E plan surplus	£6.6m	√	1
Live within Capital Resource Limit	£28.5m	√	2
Live within External Finance Limit	£46.6m	√	3

1. Control total agreed with NHSI and which benefits from expected receipt of STF funding. Underlying in year deficit £4.7m consistent with Board approved plan.
2. Capex control total reflects necessary estate & IT investment.
3. EFL reflects revised treatment of PDC re MMH. Plan includes gain of effective working capital management to realise cash.

Outlook

- £6.6m surplus plan agreed with NHSI.
- Sustainability and Transformation Funding (STF) agreed with NHSI. Receipt of £11m STF underpins delivery of surplus in FY 2016/17. Underlying £4.7m in year deficit.
- Revised surplus plan dependent on delivery of minimum £19.6m savings in year and recovery of SLA income above contract. Plausible plan identified and subject to validation.
- Profile of savings delivery planned to deliver recurrent balance exit run rate March 2017 with reserves restored.

Financial Performance for period to 31st May

- I&E deficit £2,613k being £544k favourable to April deficit plan;
- Capex £5,351k being £4,470k below plan; variance reflects contribution to MMH costs planned for April in original submission.
- Cash at the end of May is £20,861k being £4,387k less than plan; variance reflects timing of drawdown of PDC to underpin bullet payment contributions to MMH.

Opportunities & risks

Delivery of plan requires step change in planned care income recovery and step reduction in costs. This is being driven through the following key programmes:

- Demand & Capacity
- Bed reduction
- Pay & workforce change
- Procurement non-pay reduction

These programmes are subject to specific support through an enhanced PMO.

Recommendation

- Note reported P02 position and plan 2016/17 position including step change required in income & costs.
- Ensure plans underpin exit run-rate consistent with at minimum recurrent financial balance by March 2017

Finance Report

Financial Plan 2016.17 - overview

Period 02 2016/17

-£(7.0)m	**Original plan deficit as submitted April 2016 to NHSI**	**The trust submitted a £(7.0)m deficit financial plan to NHSI. This plan reflected the significant underlying deficit on exiting 2015.16, a realistic view of CIP achievability and made some modest allowance for the costs of change & restructuring. Planned care income was set to both recover the under-delivery experienced in 2015.16 and to over perform against expected contracts through the repatriation of activity. A revised plan deficit of £4.5m is plausible. This reflects the impact of final agreed contracts (+£0.9m) and non-recurrent application of double running cost funding for capital expenditure (+£1.6m). The trust has received and accepted a control total for 2016.17 with NHSI. The application of STF funding provides a route back to surplus. The control total surplus of £6.6m essentially requires the trust to deliver a maximum in year deficit of £(4.7)m before STF funding The challenge is to improve on that plan in 2016.17 and to remedy back to LTFM plan by the end of 2017.18. A supporting programme to re-float cash and liquidity is underpinned by prospective asset disposals. This means exiting 2016.17 in underlying financial balance and having restored the RCRH reserve which underpins the MMH unitary payment.**
-£(4.5)m	Revised plan deficit post conclusion of contracts	
+£ 4.3m	LTFM surplus consistent with medium term financial plan	
+£6.6m	Agreed control total surplus including £11.3m STF funding	

Finance Report

Performance to date – I&E and cash

Period 02 2016/17

I&E

The reported I&E deficit at month 2 of £2.613m represents the trading position of the trust and does not benefit from the use of balance sheet flexibility. However, of the actual CIP scheme achievement reported to date £77k are rated as non-recurrent. This would reduce the P02 reported position to a £2.690m deficit.

Savings

Progress reported through the Trust's savings management system TPRS indicates in line with plan to the end of May. The concern remains with regard to the delivery of full year plans. All schemes are subject to EIA & QIA challenge & confirmation.

Capital

Capital expenditure to date £5.4m vs £9.8m comparable plan. Variance reflects timing of payment & accounting for bullet payment contributions to MMH. Full year forecast currently as plan.

Continuity of Service Risk Rating

Rating of 2 in month compares with planned rating of 2. Although the updated forecast is inline with plan 3.

Cash

The cash position reflects timing in respect of both non-current asset and working capital management. Lower capital spend has improved cash but this has been offset by the fact that PDC to fund MMH payments has not yet been drawn down. Profile of drawdown in process of being finalised.

Prior year reliance on non-cash contingencies requires working capital mitigating action during 2016/17. Creditor stretch consistent with meeting obligations as they fall due and corporate social responsibility commitments.

Better Payments Practice Code

Performance has deteriorated for NHS bodies in month 2 relative to month 1. This was expected due to the resolution of historic, high value maternity pathway invoices with UHB and SLA invoicing with Birmingham and Solihull Mental Health Trust. The resulting payment of a number of old invoices had the effect of depressing this performance metric in the period they were paid.

The finance team continue to manage the Trust's cash positon, currently there is no expectation that the BPPC measure will be adversely impacted by this activity.

Finance Report

I&E Underlying Performance – P2+10

Period 02 2016/17

Summary SOCI: FY 2016/17

Period 2 YTD	Annual Plan £'000s	CP Plan £'000s	CP Actual £'000s	CP Variance £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s
Patient Related Income	406,769	32,629	33,589	960	66,498	66,916	418
Other Income	41,309	3,449	3,442	(7)	6,905	7,273	367
Income total	**448,078**	**36,078**	**37,031**	**952**	**73,404**	**74,189**	**785**
Pay	(297,847)	(25,193)	(25,293)	(100)	(50,055)	(50,683)	(628)
Non-Pay	(132,840)	(10,738)	(10,890)	(152)	(22,854)	(22,508)	346
Expenditure total	**(430,686)**	**(35,932)**	**(36,183)**	**(252)**	**(72,909)**	**(73,191)**	**(282)**
EBITDA	**17,392**	**147**	**848**	**701**	**495**	**998**	**503**
Non-Operating Expenditure	(22,162)	(1,847)	(1,829)	18	(3,694)	(3,659)	35
Technical Adjustments	248	21	24	3	41	48	7
DH Surplus/(Deficit)	**(4,522)**	**(1,679)**	**(957)**	**722**	**(3,158)**	**(2,613)**	**544**

Year to date modestly ahead of plan due to income recovery and non-pay moderation.
Deficit run rate emphasises requirement for step reduction in cost base Q2 through Q4.
There is very limited scope for contingency and balance sheet flexibility to mitigate any under delivery of savings requirement or significant additional costs of transformation and workforce restructuring.
Annual plan deficit of £4.5m reconciles to agreed control total surplus £6.6m by way of £11m STF funding.

Finance Report

Income Analysis

Period 02 2015/16

Year to Date Performance Against SLA by Patient Type

PERFORMANCE UP TO May 2016	Activity			Finance		
	Planned	Actual	Variance	Planned £000	Actual £000	Variance £000
Accident and Emergency Attendances	36,543	38,300	1,756	£3,566	£3,775	£209
Renal Dialysis	33	120	87	£4	£15	£11
Community Contacts	94,314	102,029	7,715	£5,648	£5,690	£42
Day Cases	6,205	7,194	989	£5,080	£4,945	-£135
Elective Inpatients	1,077	985	-93	£2,592	£2,301	-£291
Emergency Admissions	6,932	6,905	-28	£13,236	£13,041	-£195
Emergency Short Stay Admissions	2,680	2,275	-404	£1,795	£1,559	-£236
Maternity Pathways	3,311	3,252	-59	£3,164	£3,209	£45
Occupied Cot Days	2,377	1,997	-380	£1,217	£1,086	-£131
Other Contract lines	552,577	613,124	60,547	£15,496	£15,891	£395
Outpatients - First Attendance	28,886	29,283	397	£4,250	£4,270	£20
Outpatients - Procedures	9,973	10,517	544	£2,066	£2,082	£16
Outpatients - Review Attendance	67,387	67,521	134	£5,336	£5,124	-£212
Outpatients - Telephone Consultation	2,017	2,248	231	£46	£48	£2
Unbundled	11,421	11,546	125	£1,539	£1,546	£7
Excess Bed Days	2,152	2,899	747	£516	£692	£176
Non-Elective Admissions	0	0	0	£0	£0	£0
Total				**£65,553**	**£65,276**	**-£277**

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 not been offset by additional activity in other areas underlines the importance of the elective demand and capacity work to the recovery plan.

The variance on total Patient Related Income to date is £418k.
The difference compared to SLA income shown above is primarily related to pass through costs of drugs & devices and cancer drugs fund being above plan by more than £0.6m and which are offset by an equivalent variance on non-pay costs.

Finance Report

Pay bill & Workforce

Period 02 2015/16

Paybill & Workforce

- Total workforce of 6,861 WTE [being 59 WTE below plan] including 222 WTE of agency staff.
- Total pay costs (including agency workers) were £25.3m in May being £0.1m 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 May. Shifts procured outside of this are subject to COO approval and is driven by strict commitment to maintaining safe staffing.
- The Trust continues to exceed the national agency rate caps. 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	960	418
Other Income	(7)	367
Medical Pay	(170)	(386)
Nursing	393	439
Other Pay	(322)	(682)
Drugs & Consumables	(288)	(1,189)
Other Costs	136	1,536
Interest & Dividends	18	35
IFRIC etc adjustments	3	7
Total	722	544

Pay and Workforce	Current Period	Previous Period	Change in period Value	Change in period %
Pay - total spend	25,293	25,390	(97)	0%
Pay - substantive	21,588	21,576	12	0%
Pay - agency spend	1,651	1,844	(192)	-10%
Pay - bank (inc. locum) spend	2,054	1,970	84	4%
WTE - total	6,861	6,919	(58)	-1%
WTE - substantive	6,025	6,112	(87)	-1%
WTE - agency	222	250	(28)	-11%
WTE - bank (inc. locum)	615	557	58	10%

Finance Report

CIP achievement

Period 02 2016/17

Year to Date up to Period 2	16/17 In Year Target £'000s	Apr Actual £'000s	May Actual £'000s	In Year 16/17 F/Cast £'000s	In Year 16/17 Variance £'000s	Full Year Effect 16/17 Target £'000s	Full Year Effect 16/17 Schemes £'000s	Full Year Effect 16/17 Variance £'000s
Medicine and Emergency Care	4,494	48	134	4,552	57	7,617	7,159	(458)
Surgery A	3,256	0	48	1,214	(2,042)	5,519	2,976	(2,542)
Women and Child Health	1,976	60	32	1,886	(90)	3,349	2,680	(668)
Surgery B	1,568	7	5	498	(1,070)	2,658	1,010	(1,648)
Community and Therapies	787	0	0	1,911	1,124	1,334	2,756	1,422
Pathology	584	47	61	863	279	990	1,258	268
Imaging	875	29	100	927	53	1,482	796	(686)
Sub-Total Clinical Groups	**13,541**	**192**	**380**	**11,852**	**(1,689)**	**22,949**	**18,637**	**(4,312)**
Strategy and Governance	190	27	27	327	137	322	477	155
Finance	202	6	6	238	36	342	487	145
Medical Director	238	17	17	539	300	404	629	225
Operations	811	36	53	997	187	1,304	1,235	(69)
Workforce	230	20	24	451	220	390	646	256
Estates and NHP	419	80	39	846	426	710	1,388	678
Corporate Nursing and Facilities	1,154	59	59	1,745	591	1,886	2,564	678
Sub-Total Corporate	**3,244**	**244**	**224**	**5,142**	**1,899**	**5,358**	**7,426**	**2,068**
Central	2,816	246	246	2,957	141	3,800	2,957	(843)
DH Surplus/(Deficit)	**19,601**	**683**	**851**	**19,951**	**351**	**32,107**	**29,020**	**(3,087)**

This table shows the Trust's savings target by group.

The table also shows the total savings achieved in the current year to date.

CIP schemes with a part year effect of minimum £19.6m and full year effect £32.1m of savings are necessary to meet the requirements of the trust's plan.

Identified plans at May indicate that £19.9m of potential savings schemes could be delivered by the end of the 2016/17 financial year. This is £0.3m above the Trust target of £19.6m. These schemes are subject to ongoing validation, in particular in regard to pay & workforce related schemes.

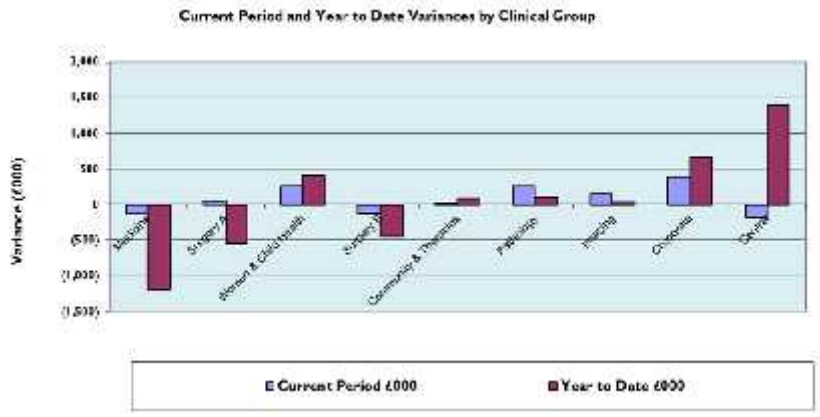
Actual savings delivered to date were £1,534k, being in line with plan but below the profiled value proposed by respective scheme managers.

Finance Report

Group Analysis – Month & YTD

Period 02 2015/16

Group Variances from Plan (Operating income and expenditure)	Current Period £000	Year to Date £000
Medicine	(126)	(1,184)
Surgery A	43	(544)
Women & Child Health	260	410
Surgery B	(119)	(447)
Community & Therapies	19	84
Pathology	258	106
Imaging	154	32
Corporate	389	658
Central	(177)	1,388



Performance of Clinical Groups

- **Medicine:** Slippage on TSP schemes including the ward run rate schemes, which combined with the ongoing use of unfunded capacity, are creating a pay cost pressure. Non-pay lines are also seeing cost pressures as a result of TSP slippage.
- **Surgery A:** Key risks are delivery of income to plan, both elective and trauma were down May YTD, and delivering CIP target. Demand and Capacity work is forecasting improvement against contract, not realised to date.
- **Women & Child Health:** Income over performance in Paediatrics and maternity together with vacancies for qualified nursing staff are the main drivers of the favourable variance.
- **Surgery B:** Intensive work around Demand and Capacity continues in FY 2016/17. Improvement is required but not seen yet with ENT and Ophthalmology (excluding drugs) both down. Significant gap in CIP identification and delivery remain a concern at the end of P02.
- **Community & Therapies**' key issue is the resolving the investment levels required in order to deliver the target income levels.
- **Pathology:** High levels of direct access activity and R&D income (previously receipted to charitable funds) is the main driver of the favourable variance. However, the group has also over delivered on vacancy management and this has provided a financial benefit to the position.
- **Imaging:** Additional direct access activity is underpinning the groups favourable variance despite being offset by under performance on nuclear medicine. Delivery of identified TSPs is the focus for this group.

Corporate Areas

- Pay underspends are offset combined with higher levels of income have contributed to the variance within corporate. Overachieved savings in workforce, estates and medical director have also benefited this group.

Central

- Central phasing adjustments to match internal budget to NSI reported plan account for the variance on central.

Finance Report

Capital

Period 02 2016/17

Programme	Year To Date TDA Plan £'000s	Actual £'000s	Gap £'000s	Full Year TDA Plan £'000s	Outlook £'000s	Variance £'000s
Estates	1,040	494	546	15,390	15,390	0
Information	823	18	805	8,134	8,134	0
Medical equipment / Imaging	30	7	23	1,950	1,950	0
Contingency	60	0	60	362	362	0
Sub-Total	**1,953**	**519**	**1,434**	**25,836**	**25,836**	**0**
Technical schemes	7,855	4,833	3,022	47,141	47,141	0
Donated assets	13	21	(8)	77	77	0
Total Programme	**9,821**	**5,373**	**4,448**	**73,054**	**73,054**	**0**

The above table shows the status of the capital programme, analysed by category, at the end of Period 02. At this stage of the year the view of out-turn is the plan level. The plan is consistent with the 2016/17 CRL and there is no risk cited currently in relation to achievement of plan expenditure.

The largest item of expenditure planned for the year reflects the trust's contribution to the construction costs of MMH. The value of certified work to end May was consistent with construction timetable and financial plan.

Finance Report

SOFP

Period 02 2016/17

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION 2016/17

	Balance as at 31st March 2016	Balance as at 31st May 2016	TDA Planned Balance as at 31st May 2016	Variance to plan as at 31st May 2016	TDA Plan as at 31st March 2017	Forecast 31st March 2017
	£000	£000	£000	£000	£000	£000
Non Current Assets						
Property, Plant and Equipment	196,384	199,350	196,354	2,996	210,333	210,333
Intangible Assets	386	359	386	(27)	386	386
Trade and Other Receivables	846	654	964	(310)	964	964
Current Assets						
Inventories	4,097	4,097	4,139	(42)	4,139	4,139
Trade and Other Receivables	16,310	18,034	21,323	(3,289)	57,608	57,608
Cash and Cash Equivalents	27,294	20,861	25,248	(4,387)	7,082	7,082
Current Liabilities						
Trade and Other Payables	(54,145)	(55,147)	(53,731)	(1,416)	(56,329)	(56,329)
Provisions	(1,469)	(1,405)	(373)	(1,032)	(370)	(370)
Borrowings	(1,306)	(1,306)	(1,017)	(289)	(1,017)	(1,017)
DH Capital Loan	0	0	0	0	0	0
Non Current Liabilities						
Provisions	(3,094)	(3,061)	(4,049)	988	(3,683)	(3,683)
Borrowings	(25,591)	(25,385)	(25,681)	296	(24,681)	(24,681)
DH Capital Loan	0	0	0	0	0	0
	159,712	**157,051**	**163,563**	**(6,512)**	**194,432**	**194,432**
Financed By						
Taxpayers Equity						
Public Dividend Capital	161,710	161,710	169,126	(7,416)	206,211	206,211
Retained Earnings reserve	(17,987)	(20,648)	(21,571)	923	(27,787)	(27,787)
Revaluation Reserve	6,931	6,931	6,950	(19)	6,950	6,950
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	159,712	**157,051**	**163,563**	**(6,512)**	**194,432**	**194,432**

The table opposite is a summarised SOFP for the Trust including the actual and planned positions at the end of May and the full year.

The plan figures are derived from the Trust's April plan submission and will require amendment following the revision to Trust control total for 2016/17.

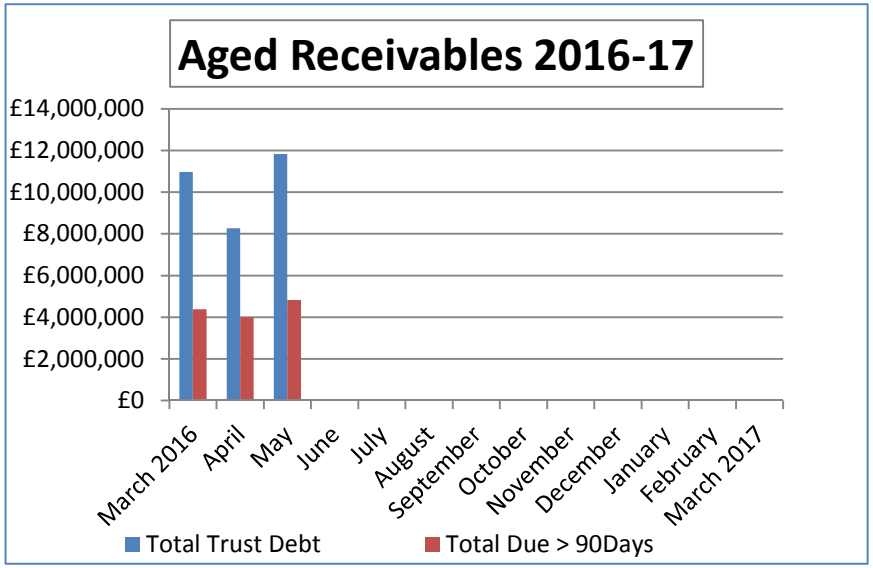
Graphs to represent the profile and overall performance of Receivables and Payables can be found on slide 8.

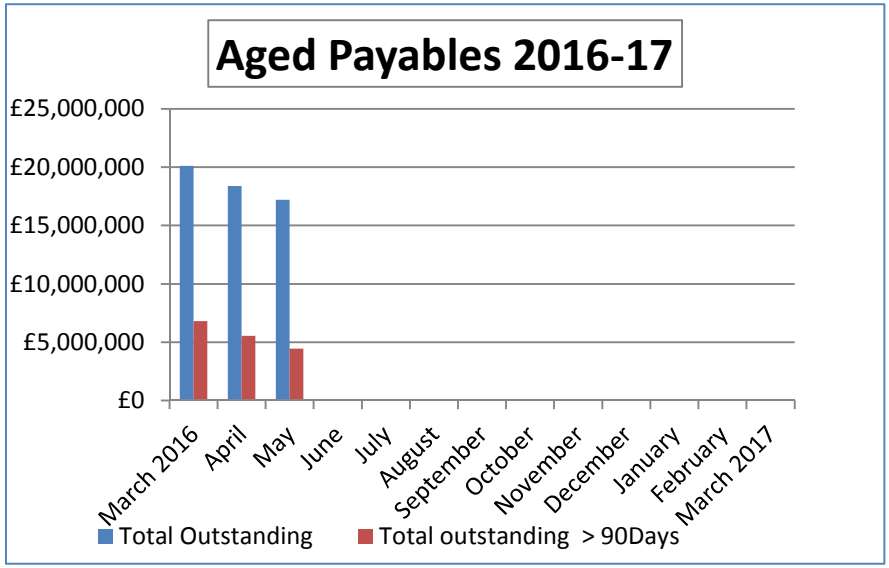
Variance from plan for PDC reflects that the Trust has not drawn down its planned additional PDC to fund the Capital MMH Scheme, currently funding the cash spend from the Trust's own resource. Discussions with NHSI will conclude shortly to ensure we can draw down the cash for MMH at a time to match the required bullet payments to the contractor.

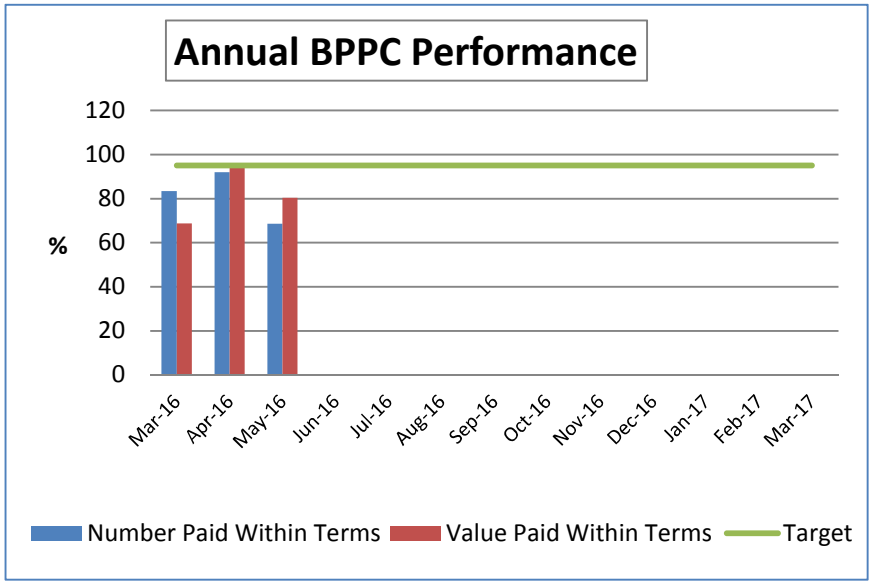
Finance Report

Aged Receivables, Aged Payables, BPPC and Cash Forecast

Period 2 2016/17







Note

- The May debt position increased predominantly due to Q1 invoices for Health Education England. Other Debt has reduced that reflects progress made debt management, however the remaining 90+ Day debt continues to be represented by NHS Debt that is under discussion at Executive Level for resolution in 2016-17.
- The Payables position has reduced during May as the Trust seeks to manage cash pressures and retain BPPC performance. The level of over 90 days liability has reduced as Maternity Pathway and other NHS invoices are settled.
- BPPC is below target of 95% by volume and value, this reflects improved performance over 15-16. The challenges in maintaining 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:	**Annual Report on the Implementation of Medical Appraisal**
SPONSOR (EXECUTIVE DIRECTOR):	**Dr Roger Stedman, Medical Director**
AUTHOR:	**Dr Roger Stedman, Medical Director**
DATE OF MEETING:	**7th July 2016**

EXECUTIVE SUMMARY:

Medical Revalidation has been in place since December 2012 and is well established within the Trust. Approximately 400 doctors have now been through the revalidation process. The Medical Director acting as the Responsible Officer (RO) has a statutory duty to ensure that the requirements of revalidation are met. To be revalidated a doctor has to demonstrate that they have been participating in annual appraisal (assessed against the requirements of the GMC's Good Medical Practice) and have undertaken at least one patient and colleague multisource feedback exercise prior to their revalidation date.

This report provides a summary of the medical appraisal and revalidation activity within the Trust in the period 1st April 2015 to 31 March 2016. It includes information on the number of doctors that the RO is responsible for (430), the number of appraisals undertaken (319) and the number of revalidation recommendations made (134).

The report sets out the governance arrangements around revalidation, provides details on how the performance of doctors is monitored and how concerns with doctors are responded to.

The report seeks to assure the Board that the Trust is compliant with the requirements of medical revalidation.

REPORT RECOMMENDATION:

That the Board:

- accept this report and to note that it will be shared (along with the annual audit) with the higher level RO.
- approve the `statement of compliance' confirming that the Trust, as a designated body, is in compliance with the regulations (see Appendix 6).
- agree that a report on medical revalidation continue to be presented to the Trust on an annual basis

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

Annual Report on the Implementation of Medical Appraisal

Report to Trust Board on 7th July 2016

BACKGROUND

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Previous Board Reports on Medical Revalidation were presented to the Trust Board in May 2012 November 2012, July 2014 and July 2015.

Trusts have a statutory duty to support their Responsible Officers (RO) in discharging their duties under the Responsible Officer Regulations(`The Medical Profession (Responsible Officers) Regulations 2010 as amended in 2013' and `The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012') and it is expected that Trust Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

GOVERNANCE ARRANGEMENTS

A Medical Revalidation Implementation Group (MRIG), chaired by the RO, was established in 2012 and was the main forum for ensuring the various components of medical appraisal and revalidation were being adhered to and that the Trust kept up to date with new requirements and developments. MRIG is no longer meeting as revalidation has been fully implemented. The main group is now the Appraiser Forum led by the Trust Appraisal Lead (Dr Santhana Kannan).

The medical appraisal and revalidation process is clearly set out in the Trust Appraisal Policy for Career Grade Medical Staff which was implemented in 2012 and further revised in October 2013.

An IT system, PReP, was acquired in 2012 that fully documents the appraisal process. The doctor completes their appraisal input form on PReP with the necessary supporting information uploaded for each domain under the GMC's Good Medical Practice document.

The appraiser then has access to the input form on PReP and can reject the form in advance of the appraisal meeting if it is felt that that the input form does not meet the necessary requirements. The PDP and Output form is completed as part of and after the appraisal meeting and signed off on PReP by both appraiser and appraisee. The PReP system provides the RO with access to all the appraisal input and output information for all the doctors he has responsibility for. There is also an RO dashboard and a suite of reports available on the system.

The operational management of the PReP system and the revalidation process is now undertaken by the Business Manager to the Medical Director who has weekly meetings with the Head of Medical Staffing to report progress and/or concerns.

The process for ensuring the Trust maintains an accurate of list of prescribed connections is undertaken by the Business Manager to the Medical Director and Head of Medical Staffing. New Consultants and SAS Doctors are trained on the PReP system and we obtain confirmation of their current appraisal and revalidation status when they commence.

The ROs have established a regional network to share concerns about doctors who work in their Trust. The SWBH RO has also set up meetings with the main private healthcare providers to ensure that any concerns that might have been flagged in private practice are feedback to the Trust.

The RO has to provide regular self assessments for the Revalidation Support Team of NHS England. This has been in the form of quarterly Organisational Readiness Self Assessments (ORSAs) which have now been replaced by Annual Organisational Audits (AOAs).

3.8 In January 2016 we had an external inspection and assurance visit from NHS England. A summary of their findings is attached at Appendix 1. Baker Tilly, internal auditors undertook a report in October 2015 and their findings are attached at Appendix 2.

MEDICAL APPRAISAL

Appraisal and Revalidation Performance data

As at 31st March 2016 the Trust had a prescribed connection with 430 doctors (291 Consultants, 68 SAS Doctors, 69 Temporary or short term contract holders and 2 other doctor with a prescribed connection to this designated body)

In the period 1 April 2015 to 31st March 2016 the number of completed appraisals was 319 (238 Consultants, 45 SAS Doctors, 35 Temporary or short term contract holders and 1 other doctor with a prescribed connection to this designated body). A summary of the reasons for missed or incomplete appraisals is contained in Appendix 3 (`Other doctor reasons' account for the majority of missed appraisals and the vast majority of those would best be described as `underestimation of preparation and workload involved in appraisal process leading to delay in appraisal').

In the period 1 April 2015 to 31st March 2016 there were 2 doctors in remediation and/or disciplinary processes. In addition there was one GMC referral that the Trust made during this period. The Trust referral was a capability concerns raised about a locum Foundation year 1 doctor.

As part of the appraisal and revalidation process all doctors that have a prescribed connection to the Trust will undertake a colleague and patient multisource feedback (360 degree feedback) every three years. The doctor is required to evidence reflection on the results of this feedback with their appraiser in advance of their revalidation date.

Appraisers

As at 31st March 2016 there are 84 medical appraisers within the Trust, all of whom have undertaken Strengthened Appraisal Training. This is a reduction on the 31st March 2015 figure as both NHS England and Baker Tilly reports recommended that there should be fewer appraisers. In the period 1st April 2015 to 31st March 2016 83 of those trained appraisers undertook at least one appraisal. This training is a one day training session that the Trust has commissioned (the objectives of the training include: Be familiar with SWBH appraisal policy for medical staff; Understand the purpose of the medical appraisal and how it relates to other management and regulatory processes; Be aware of the General Medical Council (GMC), British Medical Association (BMA) and Department of Health's guidance on appraisals in line with Good Medical Practice; Understand the role of the appraisal in the revalidation process, based on the most current information from the Revalidation Support Team (RST) and the Trust; Understand what preparatory work needs to be done by the appraiser and appraisee before the appraisal interview and the timescales; Have examined the appraisal process and what supporting information should be included under each section in terms of evidence; Have explored the role of the appraiser and the skills required to conduct an effective appraisal interview; Know how to complete the summary of appraisal form and PDP sections with the appraisee, using SMART objectives; Be able to handle difficult appraisals which may include: performance or capability issues; inadequate evidence; reluctance to agree the need for further development; health and probity issues and who to communicate concerns to within the Trust; Have practised the skills required to carry out appraisals by appraising a colleague(s) during the workshop.)

An Appraiser Forum has been established and is chaired by Dr Santhana Kannan (Medical Appraisal Lead). Items that have been discussed include the following: improvements required on PReP system (both from an appraiser and appraisee perspective), reflection, discussions re appraiser feedback, educational and clinical supervisor GMC accreditation, PDP and SMART Objectives,

We would like to improve attendance at the Appraiser Forum by having a development programme that is valued by the group. There are issues of discussion that should make attendance of at least a proportion of the forum meetings mandatory.

A regional appraiser network has been established in parallel to the Responsible Officers network so that good practice and experience can be shared.

Quality Assurance

The Quality Assurance Process has three strands to it – the appraisal portfolio, the individual appraiser and the organisation.

For the appraisal portfolio an audit of 40 anonymised input forms and output forms has been undertaken by the Medical Appraisal Lead . This audit reviewed electronic appraisal folders to provide assurance that the appraisal inputs (pre- appraisal declarations and supporting information) provided is available and appropriate; that the appraisal outputs (Personal Development Plan (PDP), summary and signoffs) are complete and to an appropriate standard and any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs.

The summary of the audit is contained in Appendix 4.

The Medical Appraisal process is all captured on the PReP IT system and before the appraisee is able to countersign the output form on PReP they have to complete the feedback questionnaire which includes ratings on how the appraisal was undertaken and the skills of the appraiser. It has been agreed that this feedback will be shared at the Appraisers Forum but will only be done so once there have been a sufficient number of appraisals undertaken to provide robust data and to minimise issues of confidentiality.

Access, security and confidentiality

The PReP system limits access of appraisal information to only those who need such access. The appraisee has access to their own appraisal inputs and outputs; an appraiser has access to their appraisees appraisal inputs and outputs. The RO has access to all the doctors appraisal input and outputs. The only others with access are the administrators of the PReP system (Head of Medical Staffing and Business Manager to the Medical Director). The system is web based and has a high level of data security. All users of PReP have to sign an undertaking that the information is used and stored in accordance with Data Protection legislation and must not contain any patient identifiable data.

Clinical Governance

There is an expectation that individual Consultants, SAS Doctors and other doctors should already be aware of the complaints and Serious Untoward Incidents (SUIs) that they have been involved in and that reflection on these should not be left until appraisal. It is recognised however that complaints and incident information is not always available to every Consultant and SAS Doctor so every quarter the Business Manager to the Medical Director provides the Risk Department with a list of doctors whose appraisal is due in the quarter so an individual summary containing the complaint and SUI information can be sent to those people being appraised (the appraiser is copied into this report too).

There have been occasions where the RO has chaired a Table Top Review (TTR) and as part of the outcomes of the TTR process a doctor has been required to ensure that their learning and reflections on the event have been captured on PReP. There is a specific section on PReP which asks the individual doctor to confirm whether or not they have been required by the RO to ensure that information is discussed at appraisal. This has to be completed and a failure to complete correctly would be seen as a potential disciplinary issue.

REVALIDATION RECOMMENDATIONS

During the period 1st April 2015 to 31st March 2016 there were 134 revalidation recommendations made to the GMC by the Trust. All of the recommendations were made on time. There were 109 positive recommendations, 25 deferral requests and 0 non engagement notifications.

The revalidation recommendations are usually made no later the third week of the preceding month and there is a robust process managed by the Business Manager to the Medical Director to ensure timescales are always kept to. The Head of Medical Staffing and the Business Manager to the Medical Director work together to action the recommendations jointly on behalf of the Medical Director. The Head of Medical Staffing and/or the Business Manager to the Medical Director escalate any concerns to the Medical Director.

RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

All staff employed by SWBH undergo the necessary pre-employment checks in accordance with NHS Employers and Trust policy.

All locums engaged via locum agencies are procured via either the Health Trust Europe (HTE) or Crown framework agreements which have a stringent requirement on pre-employment checks and are independently audited to ensure compliance. Every locum booked via an agency would have been first screened by a Consultant in the specialty to ensure that the qualifications and experience are suitable for the post. Agency locum recruitment is now managed by the Trust Bank

MONITORING PERFORMANCE

The RO and Head of Medical Staffing meet regularly and as part of that meeting issues relating to doctors performance are routinely discussed. There is also a monthly Medical Director Decision Making Group (MDDMG) which is attended by the RO, Associate Medical Directors, Deputy Director of Workforce, Deputy Director of Governance, Head of Medical Staffing and Business Manager to the Medical Director where a summary of current concerns is presented. There is a detailed discussion of the approach being taken in each case and challenge is encouraged to ensure the RO is managing the issues appropriately. New concerns or issues are also raised at this meeting. The Deputy Director of Governance has the opportunity to bring to the group's attention any issues with complaints data, SUI data, trends etc that might indicate poor practice or learning and development needs of

individual doctors and/or teams. The Business Manager to the Medical Director presents a summary of those doctors with revalidation dates in the next period and confirms whether they are revalidation ready or not, getting the RO and other members of the MDDMG to input their views.

The RO and Head of Medical Staffing meet the GMC Employer Liaison Adviser every quarter and the current GMC issues with our doctors are discussed. This meeting also provides the RO with the opportunity to discuss any other matters that have not yet been notified to the GMC or are low level concerns.

The RO regularly discusses clinical outcome data with Group Directors and Clinical Directors and areas of concern or further investigation are identified.

RESPONDING TO CONCERNS AND REMEDIATION

Where there are concerns raised then the Trust Disciplinary Policy for Medical Staff is used (this incorporates the national framework Maintaining Higher Professional Standards in the NHS (MHPS) document). The policy covers the process for dealing with issues relating to doctors conduct, capability and health. This policy also outlines the process for exclusion of a doctor.

An important component of responding to concerns is effective investigation. A need has been identified for more people to be trained in case investigation within the Trust. The aim is for all the Group Directors to be trained along with the HR Business Partners. A number have now been trained and Case Investigators will now have more specialised support from the Case Investigation Unit.

The processes within the disciplinary policy are well established however more work is required to develop remediation, re-skilling and rehabilitation options within the Trust. Work has started within the Black Country Alliance (BCA) to look at remediation and related policies for medical staff.

The RO and Head of Medical Staffing have established good links with the National Clinical Assessment Service (NCAS), GMC (via the aforementioned Employers Liaison service) and Capsticks, the Trust's solicitors to obtain specialist advice when concerns are raised.

DEVELOPMENTS REQUIRED/ NEXT STEPS

The medical appraisal and revalidation systems within the Trust have worked effectively since revalidation was introduced in 2012. The main areas to be developed now are:

- Further Appraiser development and improvement: through ongoing training, reflection, feedback and performance review. The Appraisal Forum needs to be integral to this improvement process and attendance at the forum must become a mandatory requirement for ongoing status as a medical appraiser.
- Develop processes for remediation, re-skilling and rehabilitation of doctors within the Trust;

- Explore the possibility of greater patient involvement in the medical appraisal process over and above the patient feedback exercises.
- Raise awareness amongst SAS Doctors and other non-consultant grades regarding appraisal and revalidation

Most of these required developments were included in the 2015 Trust Board Report and need to be taken forward this year. The recruitment of a new Deputy Medical Director who has revalidation processes as part of their portfolio of responsibilities should help to take these developments forward. The recently appointed Director of Medical Education will also have an important role to play.

13 RECOMMENDATIONS

13.1 To accept this report and to note that it will be shared (along with the annual audit) with the higher level RO.

13.2 To approve the `statement of compliance' confirming that the Trust, as a designated body, is in compliance with the regulations (see Appendix 6).

13.3 To agree that a report on medical revalidation continue to be presented to the Trust on an annual basis

[Dr Roger Stedman, Executive Lead]
[Medical Director/Responsible Officer]
[22 June 2016]

APPENDICES:

Appendix 1 – NHS England report (received 17 June 2016)

Appendix 2 – Baker Tilly Report October 2015

Appendix 3 – Summary of Missed or Incomplete appraisals 2015-16

Appendix 4 – Quality assurance audit of appraisal inputs and outputs 2015-16

Appendix 5 – Audit of revalidation recommendations 2015-16

NHS England

Midlands and East

REPORT ON REVALIDATION ASSURANCE VISIT

Sandwell & West Birmingham Hospitals NHS Trust

Purpose of Visit

The visit took place on 7th January 2016 and was undertaken following assessment of the organisation's Annual Organizational Audit (AOA) report. The visiting team was interested to learn why, in comparison to other trusts of a similar size in the same sector, the Trust had higher than average appraisal rate for unapproved or missed appraisals 21% compared to 8.5% and a slightly lower approved appraisal rate 79% compared to 81.3%.

NHS England was provided with the following documents prior to the visit:

- Annual Report 2015
- Summary of missed or incomplete appraisals 2014-15
- Quality assurance audit of appraisal input and outputs 2014-15
- Audit of revalidation recommendations 2014-15
- Appraisal policy for career grade medical staff
- Whistleblowing policy
- Disciplinary policy

A review of these documents identified key areas for discussion during the day. This included their appraisal policy and processes.

Attendees

Sandwell & West Birmingham Hospital NHS Trust

- Dr Roger Stedman, Medical Director and Responsible Officer
- Dr Santhana Kannan, Appraisal Lead
- Dr Philip Andrew, Head of Medical Staffing
- Jacquie Whitaker, Business Manager (Revalidation Lead)

NHS England, Midlands and East

- Chris Parsons, Programme Manager – Revalidation
- Dr Ian Gell, Clinical Lead, Appraisal
- Soulla Stylianou, Revalidation Project Support Officer

Summary of Findings

Sandwell & West Birmingham Hospitals NHS Trust is a non-foundation trust serving the north-west of Birmingham and all towns within Sandwell across a number of sites. Planning permission was received in September 2015 to build a new state of the art "Midland Metropolitan Hospital" which is set to open in 2018/19.

The Medical Director and Responsible Officer, Dr. Roger Stedman, warmly welcomed the visit seeing it as an opportunity to discuss existing appraisal and revalidation systems and to collect examples of best practice.

We were content that Sandwell & West Birmingham Hospitals NHS Trust's existing policies, processes and procedures for appraisal and revalidation were adequate and met requirements of the current processes.

Responsible Officer
Prescribed connections: 404
Time spent in role: The time split is not readily identifiable.
Support/Resources: The Medical Director has an executive secretary. The primary support to the Responsible Officer is the Head of Medical Staffing and the Business Manager (revalidation lead).

The Responsible Officer attends network events and has chaired the local Medical Director Forum for several years. The Trust also has a good working relationship with their GMC representative.

Management Arrangements
The Responsible Officer has a good team in place. The Trust currently has a challenging workforce to manage, with approximately 100 SAS doctors, including long established and middle grade doctors.

There are seven clinical groups which have group directors and a team of associate medical directors who have no managerial responsibility. The format of this supporting structure was due to be reviewed.

The potential for splitting the role of the Medical Director and Responsible Officer was discussed with the outcome that the role would remain combined.

Governance
The Responsible Officer is a member of the board and presents an annual report prepared by the Head of Medical Staffing which also includes their Statement of Compliance for approval.
AOA, Statement of Compliance, Quarterly Returns: The Trust complies with its obligations for the completion and timely submission of quarterly reports to NHS England along with the Annual Organisational Audit and Statement of Compliance.
Policy Review Process: The visiting team noted that some policy documents, including the medical appraisal policy, were due for review. The visiting team suggested the review would be an opportunity to strengthen policy documents in terms of process and consequences and to remove ambiguity and old terminology. The policy review process will also consider the requirements for the completion of the post-meeting appraisal documentation. The visiting team asked that the revised documents be provided once ratified.

Appraisal

Policy: We were content that in general the policy met requirements but needed some tightening up and refreshing to align with current processes. The opportunity to review related policies was identified in order to ensure alignment between the various documents.

Appraisal System: The Trust uses Premier IT's PReP web-based medical appraisal and revalidation system and Edgecumbe's 360º tool for doctor and patient feedback. The Business Manager keeps an excel spreadsheet backup of what reminder emails/letters have been sent and sends reminders in addition to the electronic system. The Business Manager and Head of Medical Staffing have a good working relationship and meet weekly. There are some minor issues with the appraisal system which require manual adjustments. It was suggested that a PReP user group be sought out.

The Trust's appraisal year is 1st April to 31st March, although this is not documented in the medical appraisal policy. Doctors are appraised mainly within speciality, the appraiser is allocated and there is a system for change if required. The Responsible Officer confirmed that the appraisal due date is fixed for each doctor, does not change from year to year and appraisals are not linked to pay progression.

The system generates reminders automatically and there is an escalation process in place for missed appraisals. However these processes, and the consequences of a missed appraisal, are not clearly documented in the medical appraisal policy and the visiting team suggested including this information and clarifying the processes around lack of engagement, including the potential use of the GMC REV6 form. It was also suggested that the timing of reminders was reviewed.

It was noted that group directors have a joint medical and managerial appraisal. Any medical appraisal should follow the normal format and be separate from the managerial content. The Responsible Officer should not take part in any medical appraisals. A scope of access statement was advised to ensure there is clarity around who may have access to appraisal documentation.

During the visit it transpired that there was some confusion with regards to the classifications and definitions in reporting appraisal figures in the AOA. As a result some appraisals had been incorrectly classified. The visiting team highlighted the process diagrams and definitions in the AOA questionnaire.

Appraisal Format: Medical Appraisal Guide via the PreP system.

Appraiser Numbers: NHS England's policy currently advocates that an appraiser should conduct a minimum of at least five appraisals per year. The visiting team highlighted that currently the Trust has far too many appraisers than it actually needs, with approximately 152 appraisers for 404 connected doctors. The Responsible Officer and Head of Medical Staffing agreed that a review of numbers was required along with the distribution across specialties, and this will take into account the number carried out; quality; training and attendance at forum meetings. There will be a mandatory minimum number of appraisals. Appraisers carry out their duties within their 1.5 SPA allocation. The Trust does have some appraisers in SAS grades and there is also an SAS lead.

Appraiser Training: There is an appraisal forum that is managed by the Appraisal Lead. The forum meets quarterly and the Responsible Officer intends to make it mandatory for appraisers to attend at least one meeting a year to receive anonymised feedback and training. Appraisers are not added onto the electronic appraisal system until they have been trained. Any appraisers who have not attended forums or conduct too few appraisals may be removed or offered further training.

Appraiser Support: Appraisers link to the Business Manager or Head of Medical Staffing for support.

Appraiser Feedback: Anonymised feedback is given via the forum structure where the Appraisal Lead will discuss anonymised appraisals, points of excellence and areas requiring improvement. However no individual personalised feedback is provided. The Appraisal Lead attends appraiser network meetings.

Quality Assurance Process: The board report references the quality assurance process, with a random sample of 10% being undertaken which are reviewed utilising a template tool. The initial focus was ensuring that everyone was comfortable using the appraisal system

and now the onus is to improve the quality of the content. The Responsible Officer expects more anonymised appraisals to be checked against criteria via the appraiser forum.

Revalidation: A decision making forum is in place, chaired by the Responsible Officer. This group meets monthly to consider both doctors in difficulty and revalidation. Recommendations are proposed following review by the Business Manager and the Head of Medical Planning, with input from the Responsible Officer. There is no lay involvement within this group, nor any move toward its inclusion.

A scheme of delegation should be put in place to make it clear who has delegated responsibility to process recommendations on GMC Connect on behalf of the Responsible Officer.

All decisions are reviewed one month in advance of revalidation. Deferral rates have recently increased reflecting the fact they are now considering a more difficult group of less engaged doctors comprised largely of SAS doctors who are a diverse group and not tightly managed. The SAS group have an annual conference and the Responsible Officer has used this to discuss and raise the profile of appraisals and the revalidation process.

Automatic deferral occurs where information is lacking, particularly in respect of doctors coming from abroad or following the completion of training schemes.

The Business Manager requests information from the case investigation unit, within the Governance department, regarding complaints and incidents, three months ahead of appraisal and sends it to the appraisee. Doctors can also contact the case investigation unit to ascertain if there are named in any complaints.

Responding to Concerns and Remediation Policy: The Trusts' remediation policy, which also covers concerns, is still in draft form and needs reviewing against the interacting suite of other policy documents. The Trust policies follow NCAS guidance.

The Trust currently has no cases at present. The decision making forum use NCAS framework to manage behaviours and the process before concerns become formal cases.

The Responsible Officer has received NCAS training in the past and is a case manager. All the clinical leads and Associate Medical Directors have been trained as investigators. Human Resources also have a case investigations team to support case investigators and managers.

Complaints, Compliments and Incidents information: Is readily available and discussed at monthly the monthly DMG. The case investigation unit provides information and support.

Sharing Information

MPIT Use: The Trust currently does use the MPIT form to request information although they find it cumbersome and difficult to complete. The need to use a secure process if sending any such information to a non-NHS email address was emphasised. The specific issue of exchanging information with local private independent providers was discussed and the need for regular communication was noted. This process is to be explored by the Head of Medical Staffing. The Trust responds to requests for information from other Trusts.

Pre-employment checks: The necessary pre-employment checks are carried out in accordance with good practice. There is a central Trust-wide database that is used by anyone who recruits to check details. This includes accessing HPANs to check any alerts and checking credentials on GMC.

The Trust is currently considering including stronger wording in their offer letters regarding the doctor's responsibilities with regards to appraisals, proof, documents etc. The Trust issues a pro-forma to new doctors once they have accepted a position. The new employees receive the form before they start work, or during their induction. The Business Manager meets new employees in the first week of employment to set them up on the appraisal system and provide some initial instruction.

The Trust uses a mix of bank and agency locums. Long- term direct locums will be put onto the appraisal system whilst short-term locums would be expected to utilise a MAG form. Agency supplied locums are expected to be appraised by their agencies. Concerns would immediately be passed to an agency's Responsible Officer, although there have been issues ascertaining who that may be and in some instances the GMC have been involved. The Office of the Higher Level Responsible Officer may be able to assist in identifying Responsible Officers.

Auditing of locum suppliers was discussed and it was noted that they did not currently take place.

Appraiser/Doctor Interviews

The visiting team interviewed two appraisers and two doctors. Both appraisers had received training – one from the onset of appraisal, and both had received support during their first few appraisals. They knew where to seek help and were positive in the support received from the Business Manager.

The appraisers confirmed that appraisees feedback at the end of the appraisal and they receive anonymised feedback that they use for their own appraisals. It seemed that neither appraiser had received any personal specific feedback on their performance from the Trust. One appraiser, who had been to appraiser forums, was aware of the Appraisal Lead and their ongoing work to improve the quality of appraisals and revalidation whilst the other was not aware of any QA processes and had not attended any appraiser forums.

The appraisal discussion lasted between one and two hours with further time beforehand and afterwards for completing the output documents.

The doctors knew their appraisal months and had been appraised. The doctors valued the automatic reminders and recognised the effort by appraisers to read the supporting evidence. Doctors were asked about their whole scope of practice. Both doctors acknowledged the support of the Business Manager.

Actions

- Responsible Officer to send copy of the revised medical appraisal policy and related documents when in approved status. To include a:
    - scope of access statement into the appraisal policy;
    - scheme of delegation policy to document who has delegated responsibility to process recommendations on GMC Connect on behalf of the Responsible Officer.

  Please provide an update by 31 August 2016
- Responsible Officer to send copy revised copies of the remediation (including concerns) policy once ratified.
- **Please provide an update by 31 August 2016**
- Complete the reassessment of remaining relevant policies to ensure they are up to date and cross referenced.

- **Please provide an update by 31 August 2016**
- Review the appraiser pool and ensure an appropriate mix and number are available to provide the required outcome.
- **Please provide an update by 31 August 2016**

Recommendations

- Medical appraisal policy
    - Document appraisal process, escalation procedures and consequences of non-engagement including breach of contract
    - Include information on the responsibilities of both the appraiser and the appraiser.
    - Confirm the minimum number of appraisals per appraiser per annum is five.
- Revalidation and appraisals
    - Consider sending appraisers reminders as well as appraisees
- Locums
    - Consider auditing the framework supplier of locums to ensure appropriate processes are being followed.

NHS England Revalidation Team
Midlands and East

Sandwell and West Birmingham Hospitals

Doctor Appraisal & Revalidation

Report Version (FINAL)
Internal Audit Report (8.15/16)

9 October 2015

Contents

Debrief Date	26 June 2015	**Auditors**	Mike Gennard, Head of Internal Audit Asam Hussain, Senior Manager Wesley France, Client Manager Keith Wing, Assistant Manager Kelly Beckett, Consultant
Draft report issued	17 August 2015		
Draft report re-issued	5 October 2015		
Responses received	7 October 2015		
Final report issued	9 October 2015	**Client sponsor**	Roger Stedman, Medical Director
		Distribution	Roger Stedman - Medical Director Philip Andrew – Head of Medical Staffing Jacquie Whittaker – Business Manager to the Medical Director

1 Executive summary

1.1 Background

As part the approved internal audit periodic plan for 2014/15, a review of the Doctor Revalidation process in place within the Trust has been undertaken.

The General Medical Council (GMC) sets out in its revalidations guidelines on their website that:

"Revalidation is the process by which all licensed Doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care. This means that holding a licence to practise is becoming an indicator that the Doctor continues to meet the professional standards set by the GMC and the specialists' standard set by the medical Royal Colleges and Faculties."

Revalidation was introduced to help the GMC strengthen the way in which Doctors who practise in the UK are regulated. This is completed by working with employers to ensure that appraisal systems are utilised to regularly check their Doctors are up to date and fit to practise.

The Trust has adopted the principle that all qualified medical staff will undertake an annual appraisal to enable their revalidation with the GMC every five years. The Trust uses the PReP system, to keep a track of its 404 Doctors with respect to their continuing professional development, as well as the Edgecumbe 360 service to record patient and colleague feedback on their performance, both of which are essential elements of proceeding through the revalidation process.

A meeting was held with the Lead for Medical Appraisals, who has operational responsibility for the Doctor Revalidation process, to gain an up to date position on developments as to how the Appraisal and Revalidation of Doctors is completed and recorded for the Trust. As part of our audit we have reviewed relevant papers and systems which included:

- The Appraisal Policy;
- Appraisal Guidance;
- The PReP System;
- Appraisal Documentation;
- GMC Guidance;

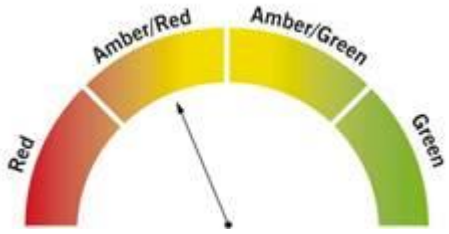
1.2 Conclusion

We have provided an Amber / Red opinion based on the Trust having a fairly robust Revalidation process in place. We have however noted some weaknesses within our review which do require attention to further strengthen the Trust's processes. Most notably is the weaknesses relating to the Responsible Officer (RO) not reviewing all recommendations for revalidation of Trust doctors or indeed performing random sample checks on evidence supporting on those recommendations which are made by the Head of Medical Staffing on behalf of the RO.

Internal Audit Opinion:

Taking account of the issues identified, the Board can take partial assurance that the controls to manage this risk are suitably designed and consistently applied.

Action is needed to strengthen the control framework to manage the identified risk(s).



1.3 Key findings

The key findings from this review are as follows:

- The Trust has an Appraisal Policy for Career Grade Medical Staff which was approved by the Trust Board in October 2013 and schedule for review in November 2016. This provides a comprehensive guide to the revalidation process followed within the Trust.

- Job descriptions for the Medical Director and the Business Manager to the Medical Director contain reference to the role and responsibilities they have in relation to the appraisal and revalidation processes operating within the Trust.

- The Medical Director is the 'Responsible Officer' within the Trust for recommending the revalidation of Medical staff. In turn the Medical Director has delegated respective administration responsibilities to the Head of Medical Staffing and the Business Manager to the Medical Director. The Head of Medical Staffing and the Business Manager to the Medical Director review the evidence required for revalidation including but not limited to the following having been completed; appraisals completed by both the appraise and appraiser, personal development plans, patient feedback and colleague feedback. Once this evidence is in place each Doctor is revalidated through the GMC website by the Head of Medical Staffing. Only exceptions are discussed at the Medical Directors Decision Group chaired by the Medical Director. This group is not minuted as often discussions are sensitive.

- Whilst it is acceptable within current GMC guidance to have administrative support in the process of revalidating doctors, the guidance is also clear that the Responsible Officer remains responsible for all recommendations made to the GMC. Therefore it would be prudent for the Medical Director to undertake sample checking of revalidation cases each year to gain assurance over the accuracy/ robustness of the processes as ultimately responsibility for this cannot be diluted away from the RO.

- Monitoring of the appraisal process and Doctors due or overdue an appraisal is undertaken by the Business Manager to the Medical Director, who reviews the appraisal log and contacts any individuals who are overdue a review. An escalation process is in place for Doctors who are overdue an appraisal with a reminder being sent to the individual in the first instance, a second reminder being sent with the appraiser copied in if still no appraisal has been completed or booked in and finally a written letter being sent to the individual from the Medical Director should the first two reminders not result in an appraisal taking place. At the time of this review we identified that there were 6 Doctors who had overdue appraisals, all were being chased by the Business Manager to the Medical Director.

- Whilst an annual quality audit of appraisals is undertaken there is no evidence of any feedback being given to appraisers or appraises where issues have been identified. Where issues have been identified these should be formally documented and feedback to individuals concerned provided, to ensure that lessons are learnt and the same issues do not continue to arise.

- Reporting of Doctor Revalidation and appraisals is produced as part of the Integrated Quality and Performance Report which is presented to the Trust Board on a monthly basis.

  The report details the Trust's current position in relation to appraisals and revalidation and whether this is an improvement on the previous month's results. The report provides a breakdown by Directorates allow the Trust Board to identify whether there are any areas that are consistently underperforming in comparison to the rest of the Trust.

- Whilst the Trust policy states that all appraisers will receive regular training we have noted that of the 152 appraisers in the Trust only 19 have accepted and confirmed attendance for training provided. A further 3 training days have been made available for appraisers to attend however currently no records are held by the Trust to confirm who has or has not attended these training sessions.

1.4 Additional information to support our conclusion

Risk	Agreed actions		
	High	Medium	Low
The Trust has developed processes for managing Doctors' appraisal and revalidation including the implementation of the PReP appraisal system. The Trust is required to assure the Board and professional regulators that this system and the processes around it are sufficiently robust to make safe recommendations for the revalidation of Doctors.	1	3	3
Total	**1**	**3**	**3**

2 Action Plan

The table below sets out the actions agreed by management to address the findings

Ref	Findings summary	Priority	Agreed Management action	Implementation date	Owner responsible
Area: The Trust has developed processes for managing Doctors' appraisal and revalidation including the implementation of the PReP appraisal system. The Trust is required to assure the Board and professional regulators that this system and the processes around it are sufficiently robust to make safe recommendations for the revalidation of Doctors.					
1.1A	The Trust does not maintain training records for Appraisers; therefore we cannot confirm that any of the Appraisers have received the recent refresher training provided.	Low	The Trust should maintain records of Appraisers who have attended the refresher training. This will allow any individuals who have not received refresher training to be clearly identified and actions put in place to ensure that they receive this training.	31 March 2016	Business Manager to the Medical Director
1.1B	The Trust has 152 appraisers in comparison to 404 medical staff requiring appraisals.	Low	Currently the Trust have 152 appraisers and 404 Doctors, this is a large amount of appraisers in comparison to staff being appraised. The Trust should review the level of appraisers to confirm that this is appropriate.	31 March 2016	Business Manager to the Medical Director

Ref	Findings summary	Priority	Agreed Management action	Implementation date	Owner responsible
1.2	There is an escalation process in place for chasing individuals who have not completed their appraisal within the given timescale however this is not formally documented.	Low	The Appraisal Policy for Career Grade Medical Staff should be amended to include a formalised escalation process including timescales for pursuing individuals who have not completed their appraisal by their given target date. Additionally the Trust should ensure that all appraisals are completed in 12 month cycles following the anniversary of the Doctors first appraisal, rather than the anniversary of the previous appraisal.	31 March 2016	Business Manager to the Medical Director
1.3	There were six instances where staff appraisals had not been completed within the 12 month period we were reviewing. These ranged between one and three months overdue.	Medium	Staff should be reminded on the importance of completing appraisals on an annual basis in order to fulfil GMC revalidation requirements. The Trust policy should be amended to ensure it states 'In order for a Consultant to be successfully revalidated an annual appraisal must have occurred and be available for review by the responsible officer for each year since the Consultants previous validation.	Completed	N/a

Ref	Findings summary	Priority	Agreed Management action	Implementation date	Owner responsible
1.4	In order to meet the requirements of revalidation, multisource feedback should be received; we identified five cases out of 20 examined where either patient feedback or colleague feedback was not in place. Whilst we understand that there are instances where a doctor does not come in to regular contact with patients (i.e. pathology) this should be recorded within the revalidation documentation.	Medium	Patient and colleague feedback should be obtained by Medical Staff in order to meet requirements for Doctor revalidation. Where doctors do not come into regular contact with patients, feedback is limited to colleagues only.	Completed	N/a
1.5	The Head of Medical Staffing advised that the Medical Director has delegated responsibility for revalidating doctors and therefore, although he remains responsible the vast majority of recommendations for revalidation the Medical Director has not personally reviewed.	High	This is now included on the Agenda for the Medical Directors 'decision making group' monthly meeting. All doctors due to be revalidated in the following month will be considered by the Group which includes the Medical Director.	Completed	N/a

Ref	Findings summary	Priority	Agreed Management action	Implementation date	Owner responsible
1.6	Quality issues of completed appraisal forms identified through the Quality audit process are discussed with the concerned staff however these discussions or remedial actions are not documented.	Medium	Where quality review has identified issues with the information contained within the Appraisal forms, feedback should be provided to both the appraiser and appraisee. This feedback should be formally documented and should be signed by both parties to confirm any remedial actions identified have been agreed.	31 March 2016	Appraisal Leads

3 Detailed findings

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all audit testing undertaken.

Ref	Control	Adequate control design (yes/no)	Controls complied with (yes/no)	Audit findings and implications	Priority	Agreed Management action
Area : The Trust has developed processes for managing Doctors' appraisal and revalidation including the implementation of the PreP appraisal system. The Trust is required to assure the Board and professional regulators that this system and the processes around it are sufficiently robust to make safe recommendations for the revalidation of Doctors.						
1.1	All staff involved in completing appraisals for medical staff have received the appropriate training required to complete this role. Trust policy states that all Appraisers will receive regular training which will include the following as a minimum: • Core skills of appraisal. • Giving Constructive feedback • Confidentiality • Assessing satisfactory participation by	Yes	Yes	Appraiser training is provided externally and all Appraisers are invited to attend however no records of who has attended the training are maintained within the Trust. Currently the Trust has 152 Appraisers for Medical staff all of whom have been invited to attend refresher training on 3rd July 2015. Of the 152 people invited only 19 have accepted the invitation. There are a further 3 refresher sessions throughout the year so it is hoped that the remaining Appraisers will attending these although there is no method of monitoring whether all Appraisers have attended, therefore the Trust cannot be sure that all appraisers are appropriately trained to complete appraisals.	Low Low	The Trust should maintain records of Appraisers who have attended the refresher training. This will allow any individuals who have not received refresher training to be clearly identified and actions put in place to ensure that they receive this training. Currently the Trust have 152 appraisers and 404 Doctors, this is a large amount of appraisers in comparison to staff being appraised. The Trust should review the level of appraisers to confirm that this is appropriate.

Ref	Control	Adequate control design (yes/no)	Controls complied with (yes/no)	Audit findings and implications	Priority	Agreed Management action
	the appraisee in the appraisal discussion • When and how to halt the appraisal discussion					
1.2	A log of dates for appraisals and revalidation is maintained and monitored by the Business Manager for the Medical Director to ensure key dates are not missed.	Yes	Yes	The Business Manager for the Medical Director and the Clinical Lead for Appraisals maintain a log of Doctor appraisals within an Excel spreadsheet. This details the individual, assigned appraiser, last appraisal date, revalidation date, 360 degree feedback attached to revalidation. The Clinical Lead for Appraisal monitors the appraisals and discusses any outstanding appraisal with the individuals concerned. The Head of Medical Staffing and Business Manager for the Medical Director keep a log of all appraisal due and doctors due for revalidation. Three months prior to revalidation they begin chasing the Doctors to ensure that all the required evidence is in place prior to the revalidation. Appraisals take place on an annual basis on the anniversary of the previous year's appraisal, as part of the revalidation process the Head of Medical Staffing and the Business Manager for the Medical Director confirm that there are 5 appraisals in place. However, in the circumstances of continued delayed appraisals of a doctor, ahead of the Revalidation, there may not be sufficient	Low	The Appraisal Policy for Career Grade Medical Staff should be amended to include a formalised escalation process including timescales for pursuing individuals who have not completed their appraisal by their given target date Additionally the Trust should ensure that all appraisals are completed in 12 month cycles following the anniversary of the Doctors first appraisal, rather than the anniversary of the previous appraisal.

Ref	Control	Adequate control design (yes/no)	Controls complied with (yes/no)	Audit findings and implications	Priority	Agreed Management action
				appraisals covering the 5 year period and that is why we have recommended that appraisals are undertaken in 12 month cycles following the anniversary of the doctor's first appraisal as opposed to the anniversary of the previous appraisal. All appraisals are required to be completed prior to revalidation, only in exceptional circumstances such as long term sick leave or maternity leave will the revalidation period be extended. On a monthly basis the Business Manager for the Medical Director chases individuals whose appraisal is overdue, In the first instance an email is sent the appraisee, if the appraisal is still not completed then another email is sent with the appraiser copied in, then if a meeting is still not booked and the appraisal does not take place a formal letter is sent to the individuals home address from the Medical Director. Although we were able to confirm the process is working in practice the escalation process is not currently formally documented.		
1.3	In order for Doctors to receive revalidation an appraisal is required which includes a personal development plan. In order for a Consultant to be successfully revalidated	Yes	Yes	In order to fulfil the requirements of Doctor revalidation medical staff need to be able to evidence that appraisals have taken place. Trust Policy dictates that appraisals are required on an annual basis. For staff employed by the Trust for a period of 6 months or more the PReP system is used to complete the appraisals. Staff members will be linked with the system and will be provided	Medium	Staff should be reminded on the importance of completing appraisals on an annual basis in order to fulfil GMC revalidation requirements. The Trust policy should be amended to ensure is states 'In order for a Consultant to be successfully revalidated an annual appraisal must have occurred and be available for review by the responsible officer for each year since the Consultants previous validation.

Ref	Control	Adequate control design (yes/no)	Controls complied with (yes/no)	Audit findings and implications	Priority	Agreed Management action
	an annual appraisal must have occurred and be available for review by the responsible officer for each year since the Consultant's previous revalidation which occurs every five years			with dates for appraisals to take place. The individual staff member is then responsible for ensuring that meetings with their Appraiser are booked and that they complete the relevant sections of the appraisal form including scope of work, continuing professional development and compliments or complaints. The system produces automatic reminder emails for the staff members to advise them that their appraisal date is approaching, these are sent out at 8 weeks, 4 weeks and 2 weeks before the individual is due to have their appraisal. This is meant to prompt staff members to complete the forms and book in meetings. The appraisal forms on the PReP system are based on the Good Medical Practice Framework for Appraisal and Revalidation and contain the following 4 key domains: - Knowledge, Skills and Performance; - Safety and Quality; - Communication, Partnership and Teamwork; and - Maintaining Trust. For staff who are at the Trust for 6 month or less, appraisals are completed using the Model Appraisal Guide form produced by the National NHS Revalidation Support team to complete their appraisals. Where they have received an appraisal by another Trust within the previous 12 months a copy of the Personal Development Plan is requested from		

Ref	Control	Adequate control design (yes/no)	Controls complied with (yes/no)	Audit findings and implications	Priority	Agreed Management action
				the individual directly. All Doctors who begin working at the Trust are checked against the GMC website to confirm that they have the relevant validation and to ascertain when they are due for revalidation. Where revalidation falls within the period of their work in the Trust they would be expected to follow the same revalidation process and permanent staff members. A review of the 20 appraisals sampled identified that 6 appraisals were out of date with the last appraisals being completed over 12 months ago at the time of review. Of the 6 that were out of date 3 were completed in March 2014, 2 in May 2014 and 1 in June 2014. We have confirmed that in all cases above the individuals have been contacted to advise their appraisal is overdue. We confirmed with the Business Manager for the Medical Director that of the 6 overdue appraisals detailed above, 2 of the March 2014 appraisals are still outstanding and have been chased via email, the remaining appraisal for March was completed in April but the appraisal log had not been updated. One of the overdue appraisals for May 2014 has been completed but was not recorded on the appraisal log either, the remaining case for May has not been chased at the time of review and the appraisal outstanding for June 2014 has been booked in to be completed in August 2015. All 20 appraisals had an input form completed reflecting the appraisees thoughts on their		

Ref	Control	Adequate control design (yes/no)	Controls complied with (yes/no)	Audit findings and implications	Priority	Agreed Management action
				performance and all had a personal development plan included within the input form, however 6 of these related to appraisals that were completed in 2014. Of the 20 appraisal forms reviewed 14 were fully completed; 1 was completed however did not include details of any compliments or PDP reflections; 3 forms did not include any details of compliments and 2 forms did not include colleague and patient feedback or compliments; however feedback reports for colleagues and patients were received. If appraisals are not completed fully or multisource feedback is not received there is a risk that the Doctors are revalidated without achieving the required standard or having the relevant documentation in place.		
1.4	As part of the appraisal process for Revalidation 360 degree feedback is to be obtained from 6 peers/colleagues and 17 patients prior to revalidation taking place	Yes	Yes	As part of the revalidation process Medical Staff have to have multisource/360 degree feedback, Within the Trust a practice has been implemented whereby each member of medical staff requiring revalidation needs to obtain feedback from the following sources: - 6 peers/ colleagues; and - 17 patients. The Trust currently uses the Edgecumbe 360 system to record and collate feedback. There are 2 aspects of the Edgecumbe system one is for colleagues and the other is	Medium	Patient and colleague feedback should be obtained by Medical Staff in order to meet requirement for Doctor revalidation. Where doctors do not come into regular contact with patients, feedback is limited to colleagues only.

Ref	Control	Adequate control design (yes/no)	Controls complied with (yes/no)	Audit findings and implications	Priority	Agreed Management action
				for patients. For the colleague feedback, the Doctor requiring feedback nominates staff members on the Edgecumbe system requesting feedback, an email is sent to these individuals advising them they have been nominated to provide feedback. Once the individuals have completed the feedback this is collated by the Edgecumbe system and a report is produced which feeds into the PReP appraisal system. For patient feedback the staff member identifies 30 patients to receive a GMC patient questionnaire, an independent member of staff within the Trust is nominated to collect/receive the questionnaires from patients. This staff member will then send the completed questionnaires to Edgecumbe. The Patient Questionnaire, asks patients to score the Doctor from poor to very good in a variety of areas. Once the completed questionnaires are received by Edgecumbe these are collated and an average score based on the feedback received from patients is provided. Once the scores have been collated a report is produced by Edgecumbe and this is sent to the staff member being reviewed and attached to their appraisal. In respect of our sample of 20 appraisals, 18/20 cases colleague feedback reports had been received, in the remaining 2 cases, one individual had been revalidated prior to joining the Trust so the Trust had no evidence of this and for the other individual no colleague		

Ref	Control	Adequate control design (yes/no)	Controls complied with (yes/no)	Audit findings and implications	Priority	Agreed Management action
				feedback was received. 17/20 appraisals had patient feedback attached therefore meeting revalidation requirements. Of the remaining 3 cases, 1 individual was revalidated prior to joining the Trust, 1 staff member is not patient facing so would not require this feedback and for the remaining case less than 17 patient forms were returned so a report was not produced. It is not clear what the process is where Doctors receive insufficient amounts or even no feedback from colleagues and/or patients, however it is clear that this is a requirement of the revalidation process therefore this feedback is required in order to revalidate the Doctor. Also where doctors do not have regular patient contact (i.e. pathology) the Trust should consider recording this as the reason for not obtaining patient feedback within the revalidation documentation.		
1.5	Prior to revalidation the Medical Director will make a recommendation to the GMC for the Doctor in question to be revalidated.	Yes	Yes	Through discussion with the Head of Medical Staffing it was identified that the Responsible Officer, the Medical Director, has delegated the administrative responsibility for collating the evidence to support the revalidating recommendation for the doctors to the Head of Medical Staffing and the Business Manager to the Medical Director. These post holders go onto make the recommendation for revalidation on the GMC website and in cases where there are no exceptions, the Medical Director who is the responsible officer for making the recommendation does not review	High	This is now included on the Agenda for the Medical Directors 'decision making group' monthly meeting. All doctors due to be revalidated in the following month will be considered by the Group which includes the Medical Director.

Ref	Control	Adequate control design (yes/no)	Controls complied with (yes/no)	Audit findings and implications	Priority	Agreed Management action
				any supporting evidence held or indeed perform any random sample checks to gain assurance over the robustness of the delegated tasks. Only exceptional cases are discussed at the Medical Directors Decision Group. Whilst it is acceptable within the guidance, to have administration support, the Responsible Officer remains responsible for all recommendations for revalidations for the Trust doctors. Therefore it would be prudent for the Medical Director to at least check a sample of revalidation processes each year to gain assurance over the process for which he is responsible and accountable for.		
1.6	On an annual basis a quality review of appraisals undertaken to ensure that appraisals have been completed to the correct standard and include all necessary documentation.	Yes	Yes	On an annual basis the Clinical Lead for Appraisals completes a quality review of the appraisals completed during the year. A sample of 40 (10%) are chosen to be reviewed by the Clinical Lead for Appraisals. The review consists of the following questions being answered: Input forms - Full scope of practise described: - CPD compliant with GMC requirement? - Quality Improvement Activity compliant with GMC requirement?	Medium	Where quality review has identified issues with the information contained within the Appraisal forms, feedback should be provided to both the appraiser and appraisee. This feedback should be formally documented and should be signed by both parties to confirm any remedial actions identified have been agreed.

Ref	Control	Adequate control design (yes/no)	Controls complied with (yes/no)	Audit findings and implications	Priority	Agreed Management action
				- Patient feedback included? - Colleague feedback included? - Complaints recorded (including zero?) - Significant events/clinical incidents/SUIs recorded (incl. none)? - Supporting information includes all the doctor's roles and places of work? - Has any patient identifiable evidence been - submitted? - Is the portfolio sufficiently completed for the stage of the revalidation cycle year [year 1 to year 4] Output forms - Evidence is summarised with a description of what it demonstrates? - Objective statements about the quality of the evidence are documented? - 3 – 6 PDP targets set? - PDP targets meet SMART objectives? For 2014/15 the Clinical Lead for Appraisals has recently completed the quality audit, 39 appraisals were sampled with the following results: - All 39 appraisals detail the scope of practice, contained patient and colleague feedback, detailed any complaints or significant events and held sufficient supporting information for		

Ref	Control	Adequate control design (yes/no)	Controls complied with (yes/no)	Audit findings and implications	Priority	Agreed Management action
				doctors role and work in order to meet revalidation requirements. However some areas of concern were highlighted. - There was 1 case where the CPD was not deemed to be compliant with GMC requirements; - In 2 cases the Quality improvement activity were not compliant with GMC requirements; - 5 appraisals did not have the evidence summarised with a description of what it demonstrates; - 9 output forms did not have objective statement from the appraiser about the quality of evidence; - 5 forms did not include 3-6 PDP targets; and - in 11 cases the PDP targets did not meet SMART objectives. We have discussed the above findings with the Clinical Lead for Appraisals who has advised that he will be discussing these with the individual's appraisers/appraisees to ensure that there are aware of what is required for the future. The results of the above review are to be presented to the Trust Board in the July meeting as part of the annual appraisal and revalidation report.		

Appendix A: Scope

Scope of the review
To evaluate the adequacy of risk management and control within the system and the extent to which controls have been applied, with a view to providing an opinion.

When planning the audit, the following areas for consideration and limitations were agreed:

Areas for consideration:
We have reviewed the Trust's appraisal process and check to ensure that it is geared to support the revalidation process including checks to:

- Appropriate Roles and Responsibilities for all those involved in the revalidation process have been identified.
- Guidance and procedures on the Revalidation process has been put in place and made available to all Doctors, Responsible Officers and Appraisers.
- Training has been provided to the Appraisers.
- 360 degree feedback mechanisms have been implemented to obtain the necessary feedback to inform the GMC's revalidation process; and.
- Feedback reports / release of information to support the appraisal of non-connected Doctors has been formally documented and being adhered to.
- Appraisals have been undertaken with relevant Trust documentation completed.

Limitations to the scope of the audit assignment:

This audit has focused on the information presented to us at the time of the review and will not identify if additional relevant information exists in the Trust.

- The scope of the work was limited to those areas examined and reported upon in the areas for consideration in the context of the objectives set out in for this review. It should not, therefore, be considered as a comprehensive review of all aspects of non-compliance that may exist now or in the future.
- This review will focus on the appraisal process for Consultants which assist in the Consultant revalidation process.
- The review has not assessed the quality of the Doctor appraisal process to establish if appraisals are undertaken in a consistent and high quality manner to enable the Trust to take assurance that they are in line with national guidance from the GMC and NHS England.
- We have not established or tested whether appraisals are being completed for other Trust staff.

In addition we did not confirm that:

- Appraisal objectives were the most suitable.
- Appraisal objectives are likely to be delivered.
- All staff underwent an appraisal although sample testing will be completed.
- Any testing undertaken as part of this audit was on a sample basis only.

In addition, our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud.

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Appendix 3 Summary of missed or incomplete appraisals 2015-16

Audit of all missed or incomplete appraisal in period 1 April 2015 -31 March 2016

Doctor factors [total]	**Number**
Maternity leave during the majority of the 'appraisal due window'	1
Sickness absence during the majority of the 'appraisal due window'	2
Prolonged leave during the majority of the 'appraisal due window'	2
Suspension during the majority of the 'appraisal due window'	0
New starter within the 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	1
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by the doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	18
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	1
Lack of time of appraiser	0
Other appraiser factors [describe]	0
[describe]	0
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors [describe]	0
Total	**25**

Appendix 4

Quality assurance audit of appraisals inputs and outputs 2016

	Number sampled appraisal deemed to be acceptable
Appraisal inputs (out of 40)	
Scope of work: has a full scope of practice been described.	39
Continuing Professional Development [CPD]: Is **CPD** compliant with GMC requirement?	40
Quality improvement activity: Is quality improvement activity compliant with GMC requirement?	34
Patient feedback exercise: Has a patient feedback exercise been completed?	35
Colleague feedback exercise: Has a colleague feedback exercise been completed?	37
Review of **complaints**: Have all complaints been included?	40
Review of **significant events**/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	39
Is there sufficient supporting information from all the doctor's role and places of work?	38
No patient identifiable evidence been submitted	40
Is the **portfolio sufficiently completed** for the stage of the revalidation cycle year [year 1 to year 4]	39
Appraisal Outputs (out of 40)	
Descriptive Summary present	**33**
Objective **statements** about quality of statements	**29**
PDP (3- 6 targets set)	**33**
PDP contains **SMART** objectives	**39**