Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION AGENDA

Venue: Anne Gibson Board Room, City Hospital **Date:** 7th September 2017, 09:30h – 1245h

Members:

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
Ms M Perry	(MP)	Non-Executive Director
Cllr W Zaffar	(WZ)	Non-Executive Director
Mr T Lewis	(TL)	Chief Executive
Dr R Stedman	(RST)	Medical Director
Ms E Newell	(EN)	Chief Nurse
Ms R Barlow	(RB)	Chief Operating Officer
Mr T Waite	(TW)	Director of Finance
Miss K Dhami	(KD)	Director of Governance
Mrs R Goodby	(RG)	Director of OD

In attendance:

Mrs C Rickards	(CR)	Trust Convenor
Mrs R Wilkin	(RW)	Director of Communications
Ms R Carter	(RC)	Director of Midwifery
Mrs Fiona Shorney	(FS)	Group Director of PCCT

Board support

Ms R Fuller	(RF)

Time	Item	Title	Reference Number	Lead
0930h	1.	**Welcome, apologies and declarations of interest** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting.* **Apologies:** Kate Thomas	Verbal	**Chair**
	2.	**Patient Story**	Presentation	**EN**
0940h	3.	**Questions from members of the public**	Verbal	**Chair**
0945h	4.	**Chair's opening comments**	Verbal	**Chair**
		UPDATES FROM THE BOARD COMMITTEES		
0950h	5a	To: (a) receive the update of the **Major Projects Authority** meeting held on 18th August 2017 (b) receive the minutes of the **Major Projects Authority** meeting held on 23rd June 2017	SWBTB (09/17) 002 SWBTB (09/17) 003	**RS**
0955h	5b	To: (c) receive the update of the **Quality and Safety Committee** meeting held on 25th August 2017 (d) receive the minutes of the **Quality and Safety Committee** meeting held on 28th July 2017	Tabled SWBTB (09/17) 004	**OD**

Time	Item	Title	Reference Number	Lead
1000h	**5c**	To: (a) receive the update of the **Finance & Investment Committee** meeting held on 25th August 2017 (b) receive the minutes of the **Finance & Investment** meeting held on 28th July 2017	SWBTB (09/17) 005 SWBTB (09/17) 006	**MP**
	MATTERS FOR APPROVAL OR DISCUSSION			
1005h	**6.**	**Black Country Local Maternity System**	SWBTB (09/17) 007	**EN**
1020h	**7.**	**Integrated Performance Report**	SWBTB (09/17) 008	**TW**
	7.1	**Persistent reds**	SWBTB (09/17) 009	**TW**
	7.2	**Cancelled operations in Ophthalmology**	SWBTB (09/17) 010	**RB**
1035h	**8.**	**Financial performance: Period 04 July 2017**	SWBTB (09/17) 011	**TW**
1040h	**9.**	**Chief Executive's Report**	SWBTB (09/17) 012	**TL**
1100h	**10.**	**2017/18 Board Assurance Framework**	SWBTB (09/17) 013 To Follow	**KD**
1115h	**11.**	**Trust Risk Register**	SWBTB (09/17) 014	**KD**
1130h	**12.**	**Safety Plan outcomes data**	SWBTB (09/17) 015	**EN**
1140h	**13.**	**NHSE Emergency Preparedness Response and Recovery (EPRR)**	SWBTB (09/17) 016	**RB**
1150h	**14.**	**Learning from deaths**	SWBTB (09/17) 017	**RSt**
1205h	**15.**	**Public Health Plan**	SWBTB (09/17) 018	**TL**
1220h	**16.**	**Reference Costs 2016/17**	SWBTB (09/17) 020	**TW**
1225h	**17.**	**Never Event: Dermatology**	SWBTB (09/17) 021	**KD**
	UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS			
1240h	**18.**	**Minutes of the previous meeting and action log** (a) To approve the minutes of the meeting held on 3rd August 2017 as a true and accurate records of discussions (b) Update on actions from previous meetings (action log	SWBTB (08/17) 022 SWBTB (08/17) 023	**Chair**
	MATTERS FOR INFORMATION			
	19.	**Any other business**	Verbal	**All**
	20.	**Details of next meeting** The next public Trust Board meeting will be held on **5th October 2017 starting at 09:30am** in an off-site venue tbc		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MAJOR PROJECTS AUTHORITY SUMMRY	
	18th August 2017
Attendees	Mr Samuda, Mr Hoare, Mr Tony Waite, Mr Kenny, Dr Stedman and Mr Reynolds, Ms Barlow and Ms Downing.
Apologies	Apologies were received from Mr Lewis and Mrs Goodby
Key points of discussion relevant to the Board	<u>Taper Relief</u> Mr Waite drew the Committee's attention to the very limited flexibility in the assessed costs consequent on necessary use of taper relief income to support the capital programme and having regard to £3.5m on extant cost mitigations. Cost assessment to be kept in view. <u>Distribution strategy specification</u> The Committee challenged and was assured that the review covered the totality of the trust's services and properties. A full report shall be considered by the Executive team in September and a final report and recommendation is intended for the October Committee. <u>Accredited manager programme: timescale</u> The roll-out of the SWBH Accredited Manager will be brought forward from Q4 and will launch in October 2017 and the initial roll out will deliver through October 17 to January 18 to deliver the 5 essential modules. Actions – Final two module dates to be brought forward. Process map to be devised to show timescale of all training commencing <u>Digital Plan – scorecard</u> Two areas are showing as red – infrastructure and EPR. Once plans have been implemented the work streams will be showing as green. Actions - Detailed delivery plan/mapping process to be devised Non-exec tour to commenced around the IT departments <u>BTC draft design</u> Mr Kenny described the current proposed design and service allocation for the BTC and Sheldon block. He drew the Committee's attention to those residual matters requiring resolution. <u>Producing a GPO-able estate programme</u> Development has commenced with creating a GPO for estates. A PMO board has been devised to include all the key areas.
Positive highlights of note	
Matters of concern or key risks to escalate to the Board	• Case note scanning (post-implementation review findings & learning) • EPR (process for finalisation of implementation plan)
Matters presented for information or noting	
Decisions made	

Richard Saumda
CHAIR OF THE MAJOR PROJECTS AUTHORITY MEETING
For the meeting of the Trust Board scheduled for 7th September 2017

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Major Projects Authority Committee Minutes

Venue Anne Gibson Committee Room, City Hospital Date 23rd June 2017 0930 - 1100

Members Present:		In attendance:	
Mr Mike Hoare	Non-Executive Director (Chair)	Miss Claire Wilson	Executive Assistant
Mr Toby Lewis	Chief Executive		
Mr Alan Kenny	Director of Estates and New Hospital		
Dr Roger Stedman	Medical Director		
Mrs Raffaela Goodby	Director of OD		
Mark Reynolds	Chief Informatics Officer		

1. Welcome, apologies and declarations of interest	Verbal
Mr Hoare welcomed the members to the meeting. Apologies had been received from Mr Samuda and Mr Waite and Ms Barlow. The members present did not have any interests to declare.	
2. Minutes of the previous meeting	SWBMPA (06/17) 002
The mintues of the previous meeting held on 28th April 2017 were agreed as a true record.	
3. Matters arising (action log)	SWBMPA (06/17) 003
All actions are to be reviewed through the agenda.	
3.1 Taper Relief revised plan	SWBMPA (06/17) 004
Mr Kenny stated the trust has secured £22.3million of taper relief to be received over a 4 year period (2016-2020), and that we were successful in recovering the £3.0m income profiled to 2016/17. This funding is the only revenue source earmarked to cover, decommissioning costs, dual running costs, moving costs, MMH commissioning and Logistics / Inventory Management. The finance team are working with NHSi colleagues and potentially NHSE to secure an appropriate taper relief for 17/18. Mr Lewis asked for the taper relief costs to be split by irreducible items and decision items to be able to make choices about the balances of available funds. Information to be provided at the next meeting. Dr Stedman asked about increased costs due to the MMH opening delay and if there is a case to reoccur costs and if this could be done nationally or through the original source.	

Mr Lewis stated this was doubtful but he has been working with the teams and has asked them to review what the costs are to see where expenditure can be decreased due to the MMH delay.

Mr Hoare asked if we are aware of what the implications would be if NHSI do not provide the full £7million and if we have a backup plan. Mr Lewis stated work is commencing to review this.

Action:
Taper relief costs to be split by irreducible/decision items – Mr Kenny / Mr Waite

3.2 Distribution strategy specification	SWBMPA (06/17) 005

Mr Lewis noted we have received the DHL proposition and we have identified none recurrent money to complete this piece of work. He will confirm the scope with Mr Waite to ensure that the process has been thought through fully to ensure the delivery process continues up to ward level (not stop at the hub).
Mr Hoare asked if DHL have the experience of moving inventory around a complex hospital environment. Mr Lewis believed they do, as they have done this work elsewhere and have won national awards.
Committee was asked to review the proposition and if they have any concerns hiring DHL to let Mr Lewis know.

<u>Tracking of theatre equipment</u>
Mr Lewis also mentioned the need to look at the timing of the introducing the implantation of the tracking of instrumentation and other devises.
Mr Reynolds gave a brief overview of what needed to be done and that the tracking system would need to link in with all our procurement suppliers.
Mr Lewis stated the executive team need to look at the scope and how this will be lead/managed.

Action:
Committee was asked to review the proposition and if they have any concerns hiring DHL to let Mr Lewis know.

Executive team to look at devising the scope for introducing tracking of theatre instrumentation and how this will be lead/managed.

3.3 Revised Charter Manager Timescale	Verbal

Mrs Goodby explained there were concerns raised at the last meeting about the timeframe on the charter management programme as it was originally on a 3 year roll out.
Work has commenced and revised timescales have been done which means all managers will be up to level 1 standard in 5 key models by Q4 (before the roll out of the new PDR process in April).

Mr Lewis asked about future training for new managers. Mrs Goodby explained there will be a rolling programme and new managers will be booked on the relevant training as part of their induction. Work is also to commence to look at ways of identifying who new line managers are and to ensure they are booked on their relevant training within the first few months.

Mr Hoare asked if we have received any feedback on the training and use of the new tool. Mrs Goodby explained the PDR training feedback has been positive and the criticism received has been about the process

not the training. Where people have struggled is trying to identify what the service needs to deliver and how that translates into the organisation, which will take time to complete.
Detailed feedback will be shared through workforce/OD committee and Trust Board.

Digital plan 4.1 Scorecard on programme	SWBMPA (04/17) 006

Mr Reynolds gave an update on the various digital work streams.

<u>Education Centre / Room arrangements</u>
Discussion commenced about the booking system and the new education centre. Mr Lewis stated he had wrote a paper which had been signed off but as of yet not implemented. Mrs Goodby stated changes have been made since, in relation to splitting the booking and training systems (as there were issues on how they linked together). Mr Lewis stated he is keen for discussion to commence to see what we will have in place in the new education centre prior to its opening in October.

4.2 E-Docs go live decision update	Verbal

Dr Stedman explained the project went live on 20th June and they are running the first week as a major incident to ensure business continuity plans are in place. Feedback from users has been good and there have only been a few incidents where neither paper or scanned notes were available.
Dr Stedman stated the rollout has highlighted some process issues in areas that were not fully identified previously which will need to be looked into and the main issue that has arisen relates to the two external providers (Iron Mountain/Synapps) interlinking with each other.

Mr Lewis explained that supplier risk should have been identified and Miss Dhami will be providing a review of the arrangements of the project.

Action: Project to review casenote scanning to take place under leadership of Kam Dhami.

4.3 Future gateway report	SWBMPA (06/17) 007 MR

Mr Reynolds explained the report is from the external gateway review and most actions have been completed.

Mr Lewis asked for:
19 - To be reopened - The Trust needs to consider the implications of failure to meet the planned EPR Go-Live date of 23 October 2017, and how this may impact on the MMH programme
22 - To be brought up at future MPA meeting - The Executive should articulate its ambition for post go-live optimisation, post MMH optimisation, in addition to business-as-usual capabilities

Action: Go live optimisation to discussed at a future meeting

4.4 Digital Committee Governance – programme board	Verbal

Mr Lewis asked for a paper on the overall governance in place for the digital committee to ensure there are formal ways of addressing issues.

Action: Digital committee governance paper to be written to ensure there are formal ways of addressing issues.

5. People Plan 5.1 scorecard programme	Verbal

Mrs Goodby explained that since the last meeting work has commenced on the KPI's and she is requesting sign off from the committee.

Mr Hoare asked if feedback had been received from the executives/committee. Mrs Goodby explained work has commenced and that she has asked colleagues if they thought the KPI's were achievable.

6 Capital plans for the estate	Verbal

<u>Homeless</u>

Mr Kenny explained as of June 2017 there are 1450 members of staff in the homeless list who have not been allocated desk space as of yet. However there are 70 desk that are available for allocation and as majority of staff will be agile working there should be efficient capacity to home them. Mr Kenny explained a detailed paper has been written which will be presented at a corporate level.

Mrs Goodby stated as part of the MMH reallocation there will be work streams to look at changing staffs contracts due to their site reallocation. She also explained they will be looking at flexible/agile working, which means staff can work at home which will free up some of the agile spaces. Mr Reynolds stated work will need to commence within the IT team to ensure all staff can log onto every PC in an agile way. Mr Hoare asked about the process for informing staff of their reallocation. Mr Kenny stated all staff will be written to and he anticipates this will be done by the summer.

6.1 BTC Draft Design	SWBMPA (06/17) 008

Mr Kenny explained the planning and design work to being undertaken to enable the City Hospital site to accommodate those clinical and corporate services which need to remain on, or be relocated onto the future retained estate on the City Hospital site.

- Clinical services which will need to be accommodated in the BTC include:
- Trauma & Orthopaedic Clinic (Fracture Clinic).
- Antenatal, Diabetes, and Rheumatology Clinics
- Research and Development
- Audiology
- New MRI and CT scanners

Clinical services which will be accommodated in the Sheldon unit include:

- Therapies
- Oral Surgery Clinic
- Dermatology

Meeting effectiveness	Verbal

The members were of the view the meeting had facilitated useful discussions.

Matters to raise to Board	Verbal

- Taper Relief
- Distribution strategy

• CDA – EPR status • Summary of homeless project • Congratulations for health & wellbeing award	
Any Other Business	Verbal
Congratulations were given to Mrs Goodby and her team for winning a national award for work on health and wellbeing.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS

NHS Trust

QUALITY AND SAFETY COMMITTEE MINUTES

Venue Anne Gibson Committee Room, City Hospital **Date** 28 July 2017, 10.30 – 12.00 hours

Members attending:		**In attendance:**	
Ms. O. Dutton	Chair and Non-Executive Director	Mrs. S. Cattermole	Executive Assistant
Ms. R. Barlow	Chief Operating Officer		
Miss K. Dhami	Director of Governance		
Ms. E. Newell	Chief Nurse		
Dr. R. Stedman	Medical Director		
Mr. T. Waite	Director of Finance		
Ms. C. Parker	SWBH CCG		

Minutes	**Paper Reference**
1. Welcome, apologies for absence and declarations of interest	**Verbal**
Apologies were received from Mr. Samuda and Ms. Perry. The members present did not have any interests to declare.	
2. Minutes of the previous meeting	**SWBQS (07/17) 002**
The minutes of the previous meeting were approved as a correct record.	
3. Matters and actions arising from previous meetings	**SWBQS (07/17) 003**
a) Minute 7 (31.03.17): Mortality reviews for vulnerable patients – Ms. Parker confirmed that the item has been raised at the CCG Q&S meeting. Discussions have been taking place about linking in with the Learning Disabilities programme. A Black Country meeting is being arranged to take this forward. Dr. Stedman suggested that the view of a medical examiner may be beneficial. Ms. Parker said that she would contact Samar Mukherjee to look at the matter. **A report will be brought back at September Q&S meeting.** b) Minute 7 (24.02.17): IPR – clinic cancellation – **August Q&S meeting.** c) Minute 7 (24.02.17): IPR – SOPs for new indicators – Mr. Waite confirmed that work has been done in the Audit Committee meeting and auditable indicators are being worked on - **CLOSED** d) Minute 4 (30.06.17) : Statistics on male and female interpreters – Ms. Newell informed the members that there are currently 17 male interpreters and 84 female interpreters. There is a lack of interpreters out of hours and on some occasions the language required is not available. Ms. Parker confirmed that General Practitioners currently use the interpreter services from Language Line - **CLOSED** e) Minute 8 (30.06.17) : MBRRACE0UK Perinatal Mortality Surveillance Report – **August Q&S meeting.**	
4. Patient story for the August Trust Board	***Verbal***
The patient story for the August Trust Board meeting is about a gentleman receiving palliative care within the community and the issues with crossing regional borders. A member of the Primary Care and Community and Therapies team will be presenting the story on his behalf.	
5. DNACPR Progress Report	***SWBQS (07/17) 004***
Dr. Stedman informed the Committee members that a weekly audit programme of DNACPR forms and recording of information on eBMS has commenced for a selection of wards at City and Sandwell Hospitals. The outcome of the audit	

was tabled and discussed. The Committee were asked to note the actions taken in response to concerns raised regarding the accuracy of DNACPR information, in particular the recording of a patient's DNACPR status in eBMS.
There has been lots of communication around DNACPR including the CEO's Friday message, a video on staff comms and team communications around the Trust. After discussion, Ms. Newell confirmed that she has agreed to include DNACPR as part of the Safety Plan checklist as this is being managed and measured routinely as part of the safety plan to ensure that improvements are made. Dr. Stedman explained that when a DNACPR is in place the flag must be set on eBMS immediately. This indicates to the ward team and others that the DNACPR order is in place.

Following a query from Miss Dhami as to why the flag is not being set on eBMS, Dr. Stedman explained that it is being missed due to it being a separate process - the doctor has to log onto a separate system to set the flag after they have spoken to the patient. Although it is a team responsibility to ensure that the flag is set, it was agreed that there needs more clarify on who should be setting the flag (Junior Doctor, Nurse or Admin Clerk). Improvements should be made once EPR is implemented because when the DNACPR form is completed in EPR, the flag will automatically be set but unfortunately it is currently a separate process.

Ms. Dutton queried what the appropriate disciplinary consequences would consist of and was informed that staff who do not comply would go through extra coaching, be subjected to warnings and receive a similar escalation process to VTE and safety plan.

6. DOLS Progress Report	***SWBQS (07/17) 005***

The Committee was asked to note the actions taken in response to further concerns raised regarding the lack of progress in undertaking appropriate and timely DoLS assessment and referrals. In order to achieve the agreed improvement trajectory, a further 5 assessments per day are required over a 9 week period.

Ms. Newell confirmed that there have been 27 active DoLS in July, (20 new, 7 rolled over). After assessing compliance in Q1 statistics show an average of 87% compliance, with 95% being achieved in July, wards are progressing but improvements still need to be made. Although the Trust submits more DoLS than other organisations in the area, the local authority is returning them back as not appropriate. Ms. Parker advised that this should be picked up with Michelle Caralan from the Sandwell authority to find out why this is happening. A query was raised regarding the DOLS understanding in a hospital setting being the same as local authority. Ms. Newell confirmed that the details were worked on with the local authority so both should be working from same guidelines as the company Capsticks provide the staff training to both NHS and local authority. Discussions took place around the figures and getting a benchmark figure in place. There are currently 50/60 dementia cases per month. Dr. Stedman asked if there was a dementia flag that is used on eBMS and was informed that when a memory assessment is carried out by the nurse but it does not mean that the patient has dementia and lacks capacity. Gemma Diss attended a recent Q&S meeting and gave a talk on Dementia patients. Work is being carried out on improvements to this indicator in the IPR.

7. Learning from Deaths : Outline Plan	***SWBQS (07/17) 006***

The actions in progress for the 'Learning from Deaths' Programme for SWBHT were presented to the committee by Dr. Stedman. A full update will be presented to the August Committee on local progress made in taking forward the actions.

The current cremation fees were explained to the Committee members. Form 1 is completed by a junior doctor (pace makers etc. removed); Form 2 is completed by a consultant to identify patient etc. There is currently a contract set up between the doctors and the undertaker and a fee of £60/70 per form is paid to the doctors totalling approximately £200k per year. As the activity is carried out during work time why are the doctors being paid separately. The money made will fund the in-house medical examiner sessions.

Dr. Stedman explained that the new medical examiner role will at time of death certification : screen the care of the deceased patient; communicate with relative and carers about care, review process and quality improvement work; support death certification by medical staff; identify cases for review ; clarify coding for the deceased patient; liaise with the coroner and the governance processes where appropriate.

The Mortality and Quality Alerts Committee will also be reformed and look into cases that may need to be treated separately. A three stage process will be followed. Of the 100% deaths reviewed by the medical examiner, 40% of them will require a structured judgemental review and the other 60% will require a full investigation. End of Life and Safeguarding will warrant a separate review. The CDOP material mortality reviews are already established, there will be no change but checks will be followed.

Ms. Dutton queried if the complaints figures will be affected; Miss Dhami confirmed that statistics should improve when deaths have been reviewed.

8. CQC outlier alert relating to puerperal sepsis	***SWBQS (07/17) 007***

The Committee were asked to note the CQC outlier alert relating to an increase in reported cases of puerperal sepsis within 42 days of delivery between July and November 2016. The Trust is required to provide a response to the CQC no later than 10th August 2017. The letter was circulated and provided information on the requirements of the report which is currently being prepared by the Senior Maternity team. It is proposed that the final report detailing relevant findings is submitted to the August Q & S committee. Dr. Stedman confirmed that he would look over it before it is returned.

The regional sepsis tool for maternity was explained by Ms. Newell. The indicators measure any puerperal sepsis recorded either during the delivery episode or at any admission to hospital within 42 days from the start of the delivery episode. Dr. Stedman explained that there is sometimes a misunderstanding of the differences with sepsis. However detecting and treating puerperal sepsis early is really important.

9. Integrated Performance Report	***SWBQS (07/17) 008***

Mr. Waite summarised the IPR and the items discussed included the NHSI formal Q1 review – ED performance – good performance recognised for Carer and RTT regulators. Cancelled operations – there has been a 13 month consistence. Dr. Stedman confirmed that an in-depth review of mortality has taken place and this will be brought back to the August Q&S meeting. Cancellations – Ms. Barlow has sent a letter to the surgeons. Tina Robinson, Group Director of Surgical Services is now the single point of contact and looking at hot spots (T&O, Urology and Gynae). There have been significant reductions in cancellations. The team are working to get back into the target range. Leadership coaching for staff has been identified as a development requirement for staff. Items being looked at include availability of notes at pre-assessment. Use of resources was briefly discussed.

9.1 Persistent Reds	***SWBQS (07/17) 009***

Executive colleagues were contacted and asked to provide information on their assigned standards as to whether a plan existed or not to address the continued non-compliance of the set target. An indication of when compliant performance will be achieved was requested. The final list was tabled and briefly discussed. It was agreed that the item should be kept on the agenda and the trigger for persistent reds needs to be clarified ie do we have the right indicators set in place. A full report will be given at the Trust Board meeting.

10. Q1 Complaints Report	***SWBQS (07/17) 010***

Miss Dhami called out that in this quarter, it is reported that the complaints activity has decreased, to 227 from 235, and also shows that 73% of complaints have been managed within their target date with 98% of complaints received since April 2017 being managed within their target date. There have only been 2 breaches and these were responded to within a few days. The quality of the responses has improved.

A number of complaints have been received from patients attending the Birmingham and Midland Eye Centre (BMEC) about being referred to the Urgent Care Clinic as opposed to A&E (having had the eye issue assessed as being non sight threatening). New posters and patients leaflets have been produced and since these have been displayed, and the process embedded, the Trust has received no further complaints of this nature.

A review has taken place as to positioning of the nurses call cords in bathrooms in Sandwell General Hospital. Ceiling mounted cords have been replaced by wall mounted boxes but in a recent incident, it was identified that the wall mounted boxes could not be accessed from the shower area. A health and safety review confirmed that the ceiling mounted pull cords are more appropriate and this recommendation was forwarded to the Estates Department for consideration.

Over many reports, it has been recognised that there is a need to acknowledge and better understand why certain ethnic groups make disproportionate numbers of complaints, compared to their patient numbers. The data will be presented at the next BME group meeting so that ideas can be shared from BME staff and a strategy developed to start to address the issue of disproportionality.

Purple phone project update – ward patients will be able to get an immediate response to address their 'live' concerns. The project is planned to be in place by the end of October.

11. Monthly Serious Incident Report	***SWBQS (07/17) 011***

Miss Dhami confirmed that the Risk Management Team is working with departments to strengthen responses to SIs and Never Events.

12. Meeting effectiveness	***Verbal***

The meeting discussions were felt to be useful and constructive.

13. Matters to raise to the Trust Board	***Verbal***

The Committee wished to bring the following matters to Trust Board's attention:

- Work on DNACPR
- Work on DOLS
- Persistent Reds
- Work on Complaints
- Learning from Deaths - information being brought back in August

14. Any other business	***Verbal***

Ms. Parker confirmed that the Safeguarding Training will be extended to September 2017 and available throughout the summer.

Next meeting: 25 August 2017 at 10.30h in the Anne Gibson Committee Room at City Hospital.

Signed ……
Print ……
Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FINANCE & INVESTMENT COMMITTEE UPDATE	
Date of meeting	25th August 2017, 0830h – 1000h
Attendees	Mr Mike Hoare (Chair), Mr Richard Samuda, Mr Harjinder Kang, Ms Marie Perry, Mr Toby Lewis, Mr Tony Waite, Ms Rachel Barlow, Mrs Raffaela Goodby, Mr Tim Reardon and Mrs Elaine Quinn.
Apologies	None.
Key points of discussion relevant to the Board	<u>Financial Performance and outlook, P04 July 2017</u>: • The Committee noted that the position at the end of P04 shows performance before STF as being in line with plan. This is after £2.1m of unplanned contingencies and flexibilities. Headline performance after STF is reported as £341k adverse to plan, which reflects Q1 failure of the A&E waiting times performance element of STF. • The Committee challenged the significant under-delivery on planned care production plan and sought to understand the recoverability of income over the remainder of the year. Ms Barlow explained the causes of underperformance as being issues with both planning & delivery. A remedial plan was in development and an update shall be provided to the Board. This will specifically include the expectations for August & September delivery. • The Committee's attention was drawn to the income recovery risk relating to outstanding resolution of data & activity challenges. The Committee noted a significant risk to the forecast based on P01 residual £0.5m remaining in dispute (equivalent of £6m for the year). The timetable to close out this matter was noted as 8th September. • Mr Waite was asked to routinely provide additional information regarding the totality of income and outlining any key variances. • The Committee noted that the reported year end position indicates plan delivery pre-STF and under-recovery of £549k after STF. Its attention was drawn to the risk to that delivery and plausible route to delivery which was subject to review and validation. • The Committee challenged the exit run rate as being inconsistent with financial plan for recurrent balance going into 2018/19 noting that any remediation plan required accelerated [pay] cost reduction. The scale of that reduction and route to delivery required to be resolved urgently. • The Committee noted that the capex programme continued to be pursued as per financial plan and that CRL remains to be confirmed by NHSI. The Committee was assured that NHSi were aware of this approach. • The Committee noted the update on cash remediation and welcomed the land disposal proceeds noting the consequent deferral of any revenue borrowing requirement to January 2018. <u>Finance Plan – CIP 2018-20</u> • The Committee is moving to being focussed on the medium term outlook, specifically on the period to 2020 and a post-MMH go live situation. • The Committee noted the aggregate CIP challenge for the period 2017-20 and that current plans and FIP2 review identified opportunities for savings fall materially short of meeting that challenge.

	• The Committee sought to understand the potential consequent on the outcome of the GE Finnamore review of the SWB health economy. Mr Lewis made clear that any potential from that review would need to come on the back of significantly improved delivery by the trust.
Positive highlights of note	• Agency spend reduction to £1.4m [from £2.4m at December 2016]; • Completion of land sale.
Matters to escalate to the Board	The Committee wished to highlight the following matters: (a) Income recovery (production plan & CCG data challenges). (b) Pay bill (exit run rate determination and delivery) (c) 2018-20 savings plan (incomplete)
Matters presented for information or noting	None.
Decisions made	None.
Actions agreed	No specific additional actions beyond those being progressed by management.

Mike Hoare
CHAIR OF THE FINANCE AND INVESTMENT COMMITTEE
For the meeting of the Trust Board scheduled for 7th September 2017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FINANCE & INVESTMENT COMMITTEE MINUTES

Venue: Anne Gibson Committee Room, City Hospital **Date**: 28 July 2017, 0830h – 0930h

Members present:		**In attendance:**	
Mr Mike Hoare	Chairman	Mr Toby Lewis	Chief Executive
Mr Richard Samuda	Non-Executive Director	Mr Tim Reardon	Associate Director of Finance
Mr Tony Waite	Director of Finance	Mrs Elaine Quinn	Executive Assistant
Mrs Raffaela Goodby	Director of OD		
Ms Rachel Barlow	Chief Operating Officer		

Minutes	**Paper Reference**
1. Welcome, apologies and declarations of interest	**Verbal**
The Chair welcomed all to the meeting. Apologies had been received from Mrs Perry and Mr Kang. The members present did not have any interests to declare.	
2. Minutes of the previous meeting held on 30 June 2017	**SWBFI (07/17) 002**
The minutes were agreed as a true record.	
2.1. Matters arising and update on actions from the previous meetings	SWBFI (07/17) 002(a)
The Committee noted that there were no on-going actions.	
3. Financial Performance & Outlook– P03 June 2017	**SWBFI (07/17) 003**
Mr Waite reported that the position at the end of Quarter 1 shows performance before STF as being in line with plan. This was noted to be after £1.9m of unplanned contingencies and flexibilities. Headline performance after STF was reported as £235k adverse to plan, which reflects Quarter 1 failure of the A&E waiting times performance element of STF. The Committee noted that P03 had traded to plan without the use of unplanned contingencies and flexibilities. This reflected income recognition being a step up from P02 in line with the [revised] production plan. The Committee challenged and was advised that the Trust remains in dialogue with commissioners in respect of data and other challenges to the income position. The scale of that issue has been moderated but remains a significant matter and consequent risk to the financial position. The contract timetable provides for escalation to CEOs on 16 August and formal mediation from 31 August if Finance Directors cannot resolve. The Trust is working to that timetable and will routinely report to the Committee on this matter.	

The Committee noted that the work to assure that the workforce plan is aligned with the Trust's financial plan needed top end alignment. Mr Lewis was confident that this would be achieved in time for the next Board meeting on 3rd August. Mrs Goodby reported that the Board were sighted on the reduction plan for agency staff. Nursing agency reduction was going in the right direction. The recruitment plan was noted to be on track to fill all HCA vacancies. Medical agency staff in excess of £100 per hour would require sign off by Mr Lewis. The Trust would look to benchmark against other local Trusts in this respect. The difficulties being experienced nationally would also need to be a consideration. The Trust would need to risk assess the position in terms of being able to run certain services if it was not to pay £100 plus per hour. The CIP delivery to date was reported as being £0.3m ahead of NHSI plan, but notably £0.8m being the internal plan on TPRS. Detailed forecasts are to be worked up for review at P04. The £13m unidentified CIP risk for P12 plan may be covered by the prospect of a profit on disposal of surplus assets. Ms Barlow reported that controls in place to progress schemes are settling in, with the pace of CIP development being very positive compared with recent months. Expenditure on capital was noted as being £3.8m below plan to date, associated with the revised profile of expenditure for the EPR and estates schemes related to MMH, the Sandwell Treatment Centre and the Medical Education Centre. CRL remains to be approved by NHSI. A formal submission has been made to NHSI and which reflects the extant capital programme. Dialogue is on-going and progress shall be routinely reported to the Committee. The Committee noted the update on cash remediation. The key items that remain live were detailed in the cash remediation plan presented to FIC meeting on 31st May 2017. The Committee noted that the Trust planned to take a revenue loan in January. This was subject to the land sale being finalised in early August (this is subject to NHSI final approval due to the scale of receipt being above the delegated limit). Mr Reardon confirmed that should the receipt be delayed then mitigations were in place for the Trust to meet its obligations as they fall due in August and to secure any requirement for a revenue loan in September.	
4. Financial Improvement Programme – next steps	**SWBFI (07/17) 004**
Mr Waite informed the Committee that this report followed on from the paper that had been challenged and supported at the July Trust Board meeting. Ms Barlow went on to report the implementation of a new level of scrutiny to the delivery of financial controls totals, supported by a tiered structure of scrutiny and support at Directorate, Group and Executive level. This would look at procurement, non-pay, minimising diagnostic delay, theatres, bed base, community properties and staffing volumes and skill mix. With the exception of the specialist knowledge required for the work in relation to Community Properties, the Trust is prioritising its own resources to deliver these programmes of work.	
5. Matters to highlight to the Trust Board and Audit & Risk Management Committee	**Verbal**
The Committee wished to highlight the following matters: • The data challenge risk is to be tracked.	
6. Meeting Effectiveness Feedback	**Verbal**
The Committee felt the matters on the agenda were the key matters that it needed to focus its attention on.	
7. Any Other Business	**Verbal**
There were no other items of business.	

Details of the next meeting	**Verbal**
The next Finance and Investment Committee meeting will be held on 25th August 2017 at 0830h – 1000h in the Anne Gibson Committee Room, City Hospital.	

Signed ……..

Print ……..

Date ……..

TRUST BOARD

DOCUMENT TITLE:	Black Country Local Maternity System
SPONSOR (EXECUTIVE DIRECTOR):	Elaine Newell – Chief Nurse
AUTHOR:	Rachel Carter – Director of Midwifery
DATE OF MEETING:	7th Sept 2017

EXECUTIVE SUMMARY:

Purpose:
To provide the Trust with an update on developing the Black Country Maternity System and progress in the delivery of the Black Country Transformation Plan 2017-2020

Background:
In February 2016 *Better Births* set out the *Five Year Forward View* for NHS maternity services in England. *Better Births* recognised that delivering such a vision could only be delivered through locally led transformation. The purpose of a Local Maternity System is to provide place-based planning and leadership for transformation. Its first task is to put in place the governance, structure and membership required to discharge this purpose effectively. Subsequently, it has two objectives to fulfil:
a. To develop and implement a local plan to transform services as part of the local STP.
b. To establish and operate shared clinical and operational governance, to enable cross-organisational working and ensure that women and their babies can access seamlessly the right care, in the right place, at the right time.

Key messages:
1) Key Stakeholders across Walsall, Dudley, Wolverhampton, Sandwell and West Birmingham have been meeting monthly since late 2016.
2) The Black Country Maternity Transformation Plan 2017 – 2020 will be circulated late August 2017 for comment.
3) The Black Country Maternity Transformation Plan 2017 – 2020 will come to the Trust Board meeting for approval in October 2017.

Key Actions:
1) The Black Country Maternity Transformation Plan 2017 – 2020 to be added to the October Trust Board meeting

REPORT RECOMMENDATION:

The Board are requested to not the information contained within the report and schedule the BC maternity Transformation plan for discussion and approval in October 2017

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		Patient Experience	x
Clinical	**x**	Equality and Diversity	x	Workforce	x

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

PREVIOUS CONSIDERATION:

Better Births: Summary

The report sets out the following vision for maternity care in England:

"Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.

And for all staff to be supported to deliver care which is woman centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries."

The vision is underpinned by seven themes, which form the basis for the recommendations set out in the body of the report:
1. Personalised care.
2. Continuity of carer.
3. Safer care.
4. Better postnatal and perinatal mental health care.
5. Multi-professional working.
6. Working across boundaries.
7. A fairer payment system.

Background:
Development for the Black Country Local Maternity System started towards the end of 2016; commitment for maternity transformation and improvement is a priority within the Black Country Sustainability and Transformation Plan 2016-2021 (as detailed in section 1.3). A number of events with key stakeholders have taken place across the Black Country to define our vision, ambitions and commitment to work together to fundamentally transform and improve our Black Country Maternity Services.

Late 2016 the Black Country Sustainability and Transformation Plan 2016 – 2021 was published detailing a strategic vision to transform health and care in the Black Country and West Birmingham. We need to bridge three critical gaps:

- **Our populations suffer significant deprivation, resulting in poor health and wellbeing;**
- **The quality of the care we offer varies unnecessarily from place to place, so not everyone has the best experience of care or the best possible outcome; and**
- **We risk not being able to afford all the services our populations need unless we take early action to avoid future costs, creating a sustainable health and care system that helps Black Country and West Birmingham lives to thrive.**

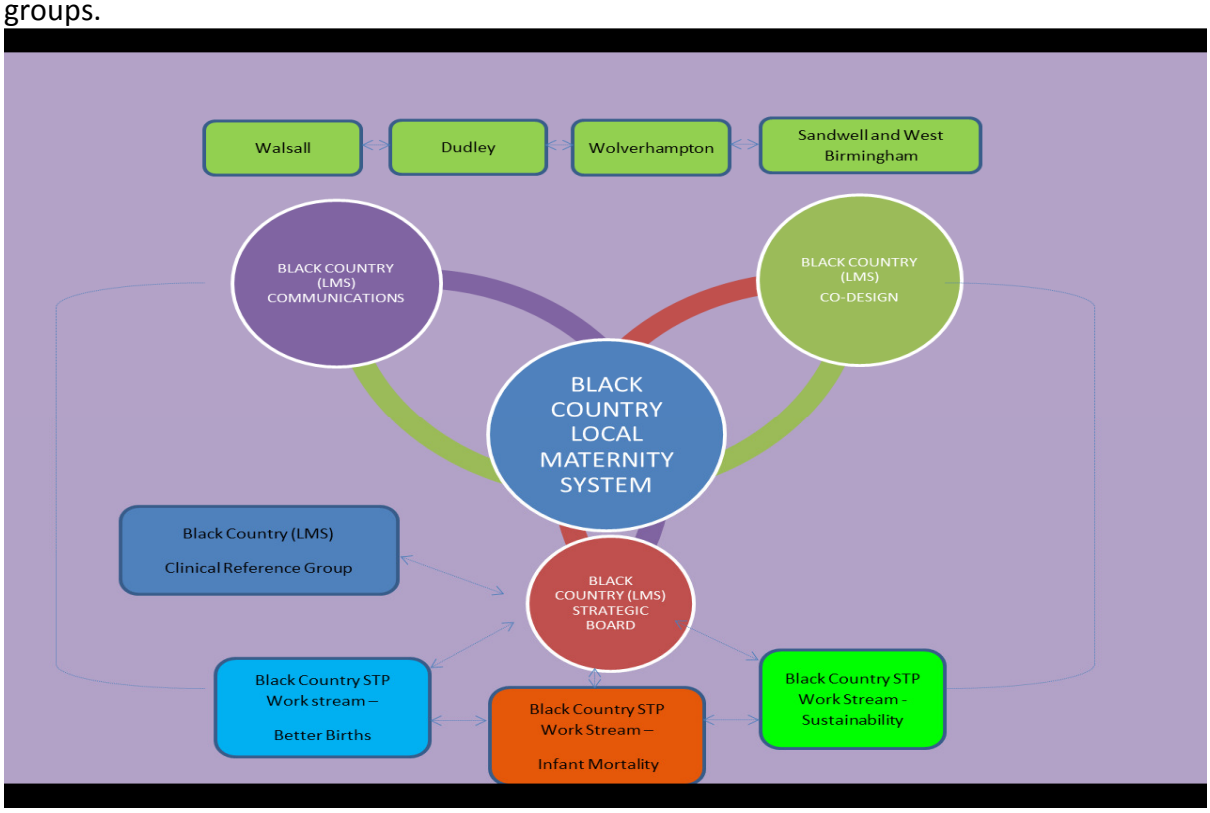
At the heart of our plan is a focus on standardising service delivery and outcomes, reducing variation through place-based models of care provided closer to home and through extended collaboration between hospitals and other organisations.

Development of Local Maternity Systems:

Local Maternity Transformation Plans need to state how the Local Maternity System will deliver the following by the end of 2020/21:

- Improving choice and personalisation of maternity services so that:
  - All pregnant women have a personalised care plan.
  - All women are able to make choices about their maternity care during pregnancy, birth and postnatally.
  - Most women receive continuity of the person caring for them during pregnancy, birth and postnatally.
  - More women are able to give birth in midwifery settings (at home and in midwifery units).
- Improving the safety of maternity care so that by 2020/21 all services have:
  - Reduced rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2030.
  - Are investigating and learning from incidents and sharing this learning through their Local Maternity System and with others.
  - Fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Health Safety Collaborative.

The Black Country has developed the following *Operating Model* which consists of seven groups.



The BCLMS will be driven by the BCLMS Strategic Board responsible for:

- Developing a local vision for improved maternity services and outcomes based on the principles contained within Better Births; which ensure that there is access to services for women and their babies, regardless of where they live;

- Progressing the Black Country Maternity Sustainability and Transformation Plan. Ensuring the plan focuses on how providers will work together so that the needs and preferences of women and families is paramount.
- Including all providers involved in the delivery of maternity and neonatal care, as well as relevant senior clinicians, commissioners, operational managers, and primary care.
- Ensuring that they co-design services with service users and local communities.
- Putting in place the infrastructure that is needed to support services to work together effectively, including interfacing with other services that have a role to play in supporting woman and families before, during and after birth, such as health visitors, GPs and other primary care services.
- Driving the development of a learning culture. It will maintain a focus on experience and outcomes, and enable healthcare professionals who work together to train together across professional and organisational boundaries.
- To establish and operate shared clinical governance to enable cross-organisational working and ensure women and their babies can access seamlessly the right care, in the right place, at the right time

Work Streams and Priorities:

Better Births Work Stream responsible for:

- Be reflective of National Agenda for maternity services, specifically 'Better Births'.
- Work to standardise pathways to support women to make informed choices regarding maternity services.
- To agree consistent pathways and consistent data sets to ensure continuity of maternity services across the Black Country.
- Ensure best practice arrangements for birth agenda, improving maternity safety outcomes across the Black Country.
- Develop maternity pathways in co-design with mothers and families, reflective of best practice guidance.
- Share principles and outcomes of the Birmingham United Maternity Programme, reflecting the Black Country perspective of this work.
- Strategic leadership to embed the 'normalisation' agenda; increasing the number of births within midwifery led care
- To determine workforce needs and workforce baselines to support understanding future workforce needs

Progress

Better Births gap analysis is now complete with a RAG assessment against the 28 recommendations. Clear gaps and areas for improvement for all areas include:

- Perinatal Mortality
- Perinatal Mental Health
- IT Systems
- Personal Budgets
- Community Hubs.

Each Trust has identified their key challenges as follows:

UNIT	Key Challenges
DGH	Intervention rates; caesarean section and induction of labour. Estates; limited scope for expansion. IT-maternity specific EPR. **Focus:** Patient safety: improving outcomes for women and babies (NSC2*)
SWBH	Transient population, 52% of population served are 'most deprived' (MBRRACE 2015) Language/ communication issues, engagement (25% late bookers). **Focus:** Patient Safety: Reducing perinatal mortality & Improving engagement (NSC*1)
Walsall	Ranked 33rd out of 326 local authorities for deprivation rates, 24% Black and Ethnic minority, Capping of birth numbers, Birth : Midwife ratio **Focus:** (NSC3*) Normality Strategy, reducing unnecessary intervention rates, responding to CQC inspection, increasing capacity – theatre and NNU
RWH	Activity – increased birth (transfers in from Staffordshire & Walsall); staffing impacted despite proactive recruitment. IT challenge – no 'fit for purpose' EPR. **Focus:** Patient safety: Reducing perinatal mortality (NSC1*)

***NSC: National maternity and Neonatal Safety Collaborative wave 1,2 or 3

Perinatal and Infant Mortality Work Stream responsible for:

- Be reflective of National Agenda for Perinatal and Infant mortality, specifically 'Better Births'.
- Develop and define a BC system wide reporting data set for infant mortality
- To determine highest social risk factors for Black Country in order to target provisions and determine priorities
- Share best practice examples of local work with regards infant mortality work streams already in place.
- Review the outcomes of the regional neonatal review and implement the recommendations for the Black Country.
- Co-ordinate and develop an integrated approach to a Black Country Healthy Pregnancy Strategy.
- Develop pregnancy pathways in co-design with mothers and families, reflective of best practice guidance.
- Work with Better Births work stream to ensure effective pre-conceptive care.
- Share principles and outcomes of the Birmingham United Maternity Programme, reflecting the Black Country perspective of this work.
- Standardise the Black Country process for CDOP ensuring learning themes are widely shared and disseminated
- To produce a communication strategy that can support all CCG's to give out key messages to reduce perinatal and infant mortality

Progress

New Perinatal and Infant Mortality Dashboard developed and out for consultation.

Agreement from all areas to share learning from Serious Incidents.

Sustainability Work Stream responsibilities:

- Identify opportunities across the Black Country to improve –
    - Clinical Sustainability (workforce)
    - Financial Sustainability (budget)
    - Quality Sustainability (safety)
- Strategic leadership to embed the 'normalisation' agenda; increasing the number of births outside hospital settings
- Work with the Perinatal and Infant Mortality work steam and the Better Births work stream to ensure effective system planning
- Develop and define a BC system wide reporting data set for sustainability

Progress

Capacity and demand modelling sessions are now complete. The final report is due in September 2017 to inform future planning.

Black Country Maternity Transformation Plan 2017- 2020

The BCLMS Strategic Board is leading the first draft of the plan. The plan will be circulated for comment week commencing the 21st August 2017.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Performance Report – P04 July 2017
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Finance & Performance Director
AUTHOR:	Yasmina Gainer, Head Performance Management & Costing
DATE OF MEETING:	7 September 2017

EXECUTIVE SUMMARY:

IPR – Key indicators summary – P04 July 2017

- × **ED 4 hour** performance for July was 86.0% (83.47%) 2,686 breaches in the month; August 87.6% with target 90.0% compliance for September in line with required Q3 STF trajectory;
- ✓ **RTT** July delivery 93.59% compliant with the national standard of 92%. Waiting list at 33,053, patient backlog of patients at 2,151 in July [2122). The Trust continues to perform well in comparison to peer trusts.
- ✓ **Acute Diagnostic waiting times** within 6 weeks compliant as at July 99.59% with 34 breaches.
- ✓ **62 day cancer** compliant at 85.6% at June vs. target of 85%; all other cancer targets continue to deliver. Q1 delivery of the full cancer target has therefore been achieved. July delivery is confirmed. August 2WW and 62 Day delivery is not on track at this stage and likely to fail standards across 2WW and 62 Days.
- × **52 week incomplete breaches** x8 in July. A significant increase in reported breaches mainly due to Dermatology biopsies being incorrectly coded for RTT status.
- × **Neutropenic sepsis** remains below 100% standard [10/39 (26%) patients did not receive treatment within the required 1hr timeframe.
- ✓ **VTE** delivers full year to national standard at 96.9% in July with 244 patients missing the assessment.
- ✓ **MRSA** – no cases year to date
- ✓ **CDiff** – x7 cases year to date against a target of 10.
- × **Falls** reported in July at 85, 1 fall resulting in serious harm. Falls with harm remain very low & favourable to peer comparison.
- × **Elective Operations Cancellations** consistently under-delivering and at 1.2% against 0.8% target in July; cancellations are the high still at 50 on day cancellations of which 20 were validated as avoidable;
- × **28 Day Guarantee** x2 urgent cancellations during July in Dermatology plastics patients.
- × **Theatre utilisation** at 70% being below 85% standard impacted by cancellations and DNA rates.
- × **Hip fractures** best practice tariff performance has unfortunately worsened again in month to 71% compared to last month performance of 84%. Hence remains below 85% standard;
- × **Sickness rates** in the month of July at 4.56%; cumulatively at 4.53%. Short-term sickness increased in July to 612 cases [444], long term sickness slightly increasing to 225 [218] month on month.
- ✓ **Mortality rate** indicators remain within confidence limits. MDO review of emergent divergence between weekday and weekend rates.
- ✓ **MSA Breaches** none were incurred in July.
- ✓ **Readmissions** at 7.1% in June (7.1%).

Requiring attention – action for improvement :

Cancelled operations

- We continue to see high levels of cancellations which impact patient experience as well as contractual obligations; a high level of avoidable cancellations persists (c50% of all cancellations)
- High levels of 'on day' cancellations causing attention with regulators, coupled with late starts and low theatre utilisation warranting a refreshed cancellations process.
- Remedial action plan agreed with CCG to be overseen through Theatres Management Board
- Theatre Improvement Project established on 14th June to drive out 'theatre value chain' improvements as recently recommended also by EY review.
- Over the last week a further planned care focus group and approach has been put in place which should drive reductions in cancellations as part of improved throughput focus

Neutropenic Sepsis

- Shows improvement but stubborn to further reduction to secure 100% local 'always event' compliance standard. MD to action improvement. 10 patients missed it in July (31 year to date this year).

Sepsis [CQUIN]

- Q1 performance only 42k below possible achievement, Q2 delivery stepping up so increased focus required
- To address performance in respect of patients identified for screening who are screened and for those patients who are confirmed with sepsis to receive IV antibiotic within 1 hour.
- Reviews of AB to be carried out within 72 hours

Recovery Action Plans (RAPs)

Require oversight at PMC / OMC to ensure ongoing engagement across the services and EG

The Trust now has the following RAPs ongoing for action:

1. Community Gynae referral to 1st OP within 4 weeks: delivering to trajectory
2. Safeguarding training:
    a. Children level 3 – delivering to trajectory
    b. Children level 2 – delivering to trajectory
    c. Adult Advanced training – delivering to trajectory
3. Dementia and Falls Assessments (Community); Data quality review ongoing for these indicators involving the GDN.
4. Cancelled on day operations: progress not yet established – Theatre Improvement Project overseeing
5. Two Maternity indicators which are have failed to deliver improvement trajectory for BMI and CO. The Director of Midwifery is aware and progressing improvement as well as data quality input and reporting is being reviewed as part of this.
6. A&E being managed separately, but also under RAP.

CQUINs 2017/18 – Q1 Position

- Q1 reporting completed with 42k funding missed to secure – this is against the Sepsis scheme.
- Risks within specialised commissioning schemes exists against the Long Term Conditions scheme (HIV) – this has not delivered last year and is questionable whether the trust can deliver currently (£200k full year impact)

REPORT RECOMMENDATION:

The 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 in the IPR report

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

Accept	Approve the recommendation	Discuss
		X

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

Financial	**x**	Environmental		Communications & Media	**X**
Business and market share		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, Q&S

Sandwell and West Birmingham Hospitals NHS Trust

SWBTB (09/17) 008a

Integrated Quality & Performance Report

Month Reported: July 2017

Reported as at: 31/08/2017

TRUST BOARD

Contents

July 2017

Infection Control

Cdiff - compliant
• 1x C. Diff cases reported during the month of July;
• x7 cases year to date against a target of 10.
• An annual trajectory of 30 has been agreed with the CCG for 17/18.
On track.

MRSA - compliant
• Nil cases of MRSA Bacteraemia were reported in July; zero cases on a year to date basis.
•Annual target set at zero.

MRSA Screening - compliant
June month:
• Non-elective patients screening 92%
• Elective patients screening 91.7%
both indicators are compliant with 80% target in-month and year to date

Elective screening is compliant with standard at a whole trust & group level.
Directorate level compliance with exception of Medicine Scheduled Care [75%].

MSSA - compliant
MSSA Bacteraemia (expressed per 100,000 bed days) for the month of June at 0.0 against a tolerance rate of 9.42.
Year to date rate at 9.1 compared to target of 9.42. 7/12 months elevated levels.
Escalated to CNO and Infection Control clinical lead for review & assurance

Harm Free Care

Safety thermometer - not compliant
93.9% reported for July against NHS Safety Thermometer against the target 95%; a worsening to the last two months when targets were met.

x85 [x87] falls reported in July with x1 [x1] fall resulting in serious injury.
x311 falls reported year to date
In month, 36 falls within community and 49 in acute setting.
Falls remain subject to ongoing CNO scrutiny.

x7 [x6] avoidable, hospital acquired pressure sores reported in July of which 5x at grade 2 and 2x at grade3
x8 separate cases reported within the DN caseload.

x1 [x3] serious incidents reported in July;
routine collective review in place and reported to the Q&S Cttee.

• Nil never event were reported in July ;
• WHO Safer Surgery as at July at 99.8% vs the 100% target
Clinician specific, list specific follow up by MD to secure 100% compliance

There were no medication error causing serious harm in July continuing a trend of no occurrences.

x27 (x6) DOLS have been raised in July of which 6 were 7-day urgents;

Venous Thromboembolism (VTE) Assessments in July at 96.9% compliant with 95% standard across all Groups and improving yet again month on month.

Residual number of assessments missed (244 in July) - being addressed through Safety Plan roll out to secure 100% compliance.

Obstetrics

C-section rate - not compliant
The overall Caesarean Section rate for July is 25.9% and hence slightly above the 25% standard.
25.2% year to date against the 25% target.
Elective and non-elective rates are 7.5% and 18.4% respectively.
9/12 months elevated levels.
Matter considered at Q&S & Board and to be kept in view.

Adjusted perinatal mortality rate (per 1000 births) for July is 9.67 [4.12] above threshold levels of 8; elevated this month.
The indicator represents an in-month position and which, together with the small numbers involved provides for sometimes large variations.
The year to date position is within the tolerance at 6.4 and meeting the target of 8.
Nationally, this indictor is monitored using a 3 year cumulative trend, based on which the Trust is within normal confidence limits.

• Post Partum Haemorrhage (>2000ml) back to routine levels of 1 against a threshold of 4
• Puerperal Sepsis within normalised range; ongoing review by Group Director & MD for assurance.

• Early Booking Assessment (<12 + 6 weeks) - SWBH specific definition target of 90% has consistently not been met and for July the delivery is 77.6%;

Breastfeeding initiation performance reports quarterly, and as at June quarter is at 73.1% slightly below the target of 74.0%. The data capture has changed within the service and the indicator count will pick this up from next month which will show improved performance more in line with service expectations.

Mortality & Readmissions

Mortality - compliant
The Trust overall RAMI for most recent 12-mth cumulative period is 99 (available data is as at April)
RAMI for weekday and weekend each at 96 and 109 respectively. MDO review of recent divergence to Septembr Q&S.

SHMI measure which includes deaths 30-days after hospital discharge is at 103 for the month of February (latest available data).

• Deaths in Low Risk Diagnosis Groups (RAMI) - month of April is 62. This indicator measures in-month expected versus actual deaths so subject to larger month on month variations.
• Crude in-month mortality rate for June is 1.3 [1.3] lower than 16-mths avg of 1.4 but increased month on month;
• The rolling crude year to date mortality rate remains consistent at 1.3 and consistent with last year same period at this stage and stable to long term average.
• There were x129 [x113] deaths in our hospitals in the month of June; slightly higher than last year same period which was at 119.

Mortality review rate in May at 48% worsening again to a low last month; an exception report has been requested from the MD office to identify causes
Remains subject to MDO attention for remedy.

Readmissions (in-hospital) reported at 7.1% in June; fairly static to previous months.

7.1% rolling 12 mths. The equivalent, latest available peer group rate is at 7.8% .

Stroke Care & Cardiology

Stay - compliant
Stroke data for July indicates that 92.6% [86%] of patients are spending >90% of their time on a stroke ward - compliant with the 90% operational threshold

Admission - not compliant
July admittance to an acute stroke unit within 4 hours is at 71.9% [90.27%] above the local target of 90% and the national target of 80%.
The national target of 80% is generally met, but recently this has been slipping - a review of data and performance is to take place.

Scan - compliant
• Pts receiving CT Scan within 1 hour of presentation is at 70.2% [78] in July being consistently compliant with 50% standard;
• Pts receiving CT Scan within 24 hrs of presentation delivery in month at 93% [97.6%] failing the 95% standard in month

Thrombolysis - not compliant
1x Breach out of 4 patients for the month of July due to a delay in CT scan which is being investigated.

For July , Primary Angioplasty Door to balloon time (<90 minutes) was at 100% and Call to balloon time (<150 minutes) at 90.9% hence both indicators delivering consistently against 80% targets

RACP performance for July is at 100% [100%] exceeding the 98% target for over 16 consecutive mths

• TIA (High Risk) Treatment <24 Hours from receipt of referral delivery as at July is at 80.8% [100%] against the target of 70%.
• TIA (Low Risk) Treatment <7 days from receipt of referral delivery at July is 89.7% [96.9%] against a target of 75%.

Cancer Care

Cancer standards - compliant
• June performance delivery across all cancer targets including 62 Days at 86.2%
• July performance confirmed as delivered,
• August pressures are being managed against 2WW and 62 Day targets with particular challenges against the 62 day target in Gynae.

June validated position is that :
• x9.5 [x9.5] patients waited longer than the 62 days.
• x1 [x2] patients waited more than 104 days at the end of June
• The longest waiting patient as at the end of June was at 106 days [139 days]

Neutropenic sepsis - not compliant
• (10/39 patients) - 26% of neutropenic sepsis July cases failed to receive treatment within prescribed period (less than 1hr). Number of missed delivery is reducing, but the aim is to achieve 100% target consistently.
• 0% of Tertiary referrals were met within 38 days by the Trust for the month of June - the consistent failure to meet this target requires attention and escalated to GDO for review & assurance. Cancer team track breaches and provide RCAs for each.

Patient Experience - MSA & Complaints

MSA - compliant
There were no MSA breaches in July.

Friends & Family reporting requires a review to understand the consistent under-delivery across several areas.

The number of complaints received for the month of July is 78 with 2.6 formal complaints per 1000 bed days.
100% have been acknowledged within target timeframes (3 days).
23% mnth (24% YTD)of responses have been reported beyond agreed target time; escalated to DG for remedy.

Patient Experience - Cancelled Operations

Cancelled Ops - not compliant
- 50 [58] sitrep declared late (on day) cancelations were reported in July of which avoidable were high.
- Of the 51 patients who were cancelled, 21 [20] were validated as avoidable in July;
- Elective operations cancelled at the last minute for non-clinical reasons, as a proportion of elective admissions, was 1.2% for July (rising since Jun16 when at 0.7%) failing the tolerance of 0.8% consistently.
13 months consistent under-delivery to standard

- There were 2x breaches of the 28 days guarantee in July - both in Dermatology
- No urgent cancellations took place during the month of July

Theatre utilisation is consistently below the target of 85% at a Trust average of 70.1% in July (77.3% in June) - a significant worsening to last months and to prior months which reflects in the level of income achieved. The utilisation indicator alone does not measure productivity and hence this is subject to the Theatre Improvement Project overseen by the Theatres Board which should focus on productivity improvement. Intensive planned care focus aims to improve booking rates and hence utilisation will improve as a result - this should be already visible in September's performance.

Emergency Care

ED 4hr standard - not compliant
• The Trust's performance against the 4-hour ED wait target in July was 86.00% (83.47%) against the 90% STF & 95% national target
• 2,686 breaches were incurred in July

ED quarterly performance trend for 17/18: Q1 at 83.3%

• WMAS fineable 30 - 60 minutes delayed handovers at 111 [242] in July. A significant reduction in month.
• x1 [x6] cases were > 60 minutes delayed handovers in July
• Handovers >60mins (against all conveyances) 0.02% in July meeting the target of 0.02% therefore in month; 0.11% on a year to date basis. - This performance is against total conveyances of 4,429 (the highest level over 18 months) demonstrating therefore a good process

Fractured NOF - not compliant
Fractured Neck of Femur Best Practice Tariff delivery for July is at 71% [84%] showing worsening to previous month.
Consistently below target.

DTOCs accounted for 635 [483] bed days in July; of which 370 [312] beds were fineable to BCC.
Sustained elevated levels of DTOCs with no obvious system plan for resolution.

Referral To Treatment

RTT - compliant
• RTT incomplete pathway for July is at 93.59% [93.3%]; continuing to perform to trajectory in aggregate.

• Specialities which continue to under-perform against 92% standard are: T&O, Oral surgery, Plastic Surgery and Dermatology but have clear improvement plans to achieve

• The RTT backlog for June has 2,115 [2,188] patients waiting over 18+ ; this is largely made up of Inpatients, followed by OP follow ups

• The total waiting list has remained fairly static for the last three months stabilising at 32,000-33,028 patients

• August performance is expected to deliver the national standard of 92% and the Trust is tracking this performance against internal expectations of 93.87%

There were 8x 52 week breaches in July on the incomplete pathway. Most are due to due to inappropriate application of the RTT status in Dermatology, which has only recently been identified as inaccurate by service management.

• Diagnostics performance has delivered at 99.59% in July with 34 breaches.

Data Completeness

• The Trust's internal assessment of the completion of valid NHS Number Field within inpatient data sets remains below the 99.0% operational threshold (May 98.3%). OP and A&E datasets deliver to target.
• ED required to improve 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.
• Ethnicity coding is performing for Inpatients at 91% against 90% target, but under-delivering for Outpatients. This is attributed to the capture of data in the Kiosks and revision to capture fields is being considered.

Open Referrals, non RTT pathways/ without future waiting list activity, stand at 123,000 as at July showing a steadily increasing trend again as administration/IT processes persistently do not close down referrals/pathways as appropriate. A project to re-visit this has been kicked off and new PTL meetings will focus on working these through. Low patient risk rated (green risk) amount to c15,000 (which are part of the 123,000 total), are subject to auto-closures since Jan2016.

Staff

PDR - not compliant
PDR overall compliance as at the end of July is at 88% against the 95% target.
Medical Appraisal at 85.4%.

Sickness - not compliant
In-month sickness for July is at 4.56% (4.36%) decreasing slightly to last month ; the cumulative sickness rate is 4.53% [4.52%]. The number of short term sickness 612 [444] cases showing a large increase to last month; long term 225 [218] cases remain fairly consistent with the last few months.

The Trust annualised turnover rate is at 11.8% [11.6%] in July.
Specifically, nursing turnover in July is at 12.6%; the trust aspiration for this staff group is 10.7% by Mar18.

MT - not compliant
Mandatory Training at the end of July is at 87.2% overall against target of 95%;
Health & Safety related training is above the 95% target at 95.4% in July.
Safeguarding training recovery plans (Level 2 Child & Adults) are hitting improvement trajectory for July and set to fully recover to 85% for Sept17 across all 5 safeguarding modules, which results partly in changes of the training delivery.

CQUINs & Local Quality Requirements 2017/18

CQUIN - Q1 £42k cost of not compliant
• The Trust has been funded to support 9x national CQUINs and 3x Specialised Commissioning schemes and several Public Health schemes. The funding value in 2017/18 is £8.8m.
Quarter 1 reporting completed at the end of July and feedback from commissioners has been received:
• National schemes delivered 1.04m against a 1.08m possible (42k loss Sepsis).
• Specialised schemes delivered 15k out of 15k possible.
• Whilst this is overall a good result, Sepsis remains an area of risk and needs increased level of awareness and focus.

Local Quality Requirements 2017/18 are monitored by CCG and the Trust is fineable for any breaches in accordance to guidance. The Trust has got a number of formally agreed RAPs (recovery action plans) in place at this stage which continued into 17/18:
• Safeguarding training for which the performance notice action plan has been accepted and the July performance is hitting the trajectory.
• Community falls & dementia delivery is being addressed, but reporting issues remain
• Maternity indicators are being actively monitored for MBI and CO Monitoring
• On the Day Cancellations are subject to Theatre Improvement Project (TIP) focus
• Gynae 4 week community clinics are delivering in line with improvement trajectory
• A&E including morning discharges and other A&E indicators are subject to an overall plan.
• The specific IPR page has been added to highlight and monitor areas of non-compliance (Local Quality Requirements page).

STF Criteria & NHSI Single Oversight Framework

STF - £551k cost of Q1/Q2 not compliant

'30% [c£3.1m] performance related STF to be assessed against achievement of ED 4hr improvement trajectory. Of which 15% is for A&E 4 hour breaches and 15% is around GP streaming.

Q1 ED funding component [£236k] not secured due to non-compliance with 90% standard.
Q2 ED funding component [£315k] not secured due to non-compliance with 90% standard.

Balance of STF [c£7.4m] related to achievement of financial plan.
Q1 financial performance reported as being on plan but supported by c£2.0m of non-recurrent measures.

Summary Scorecard - July (In-Month)

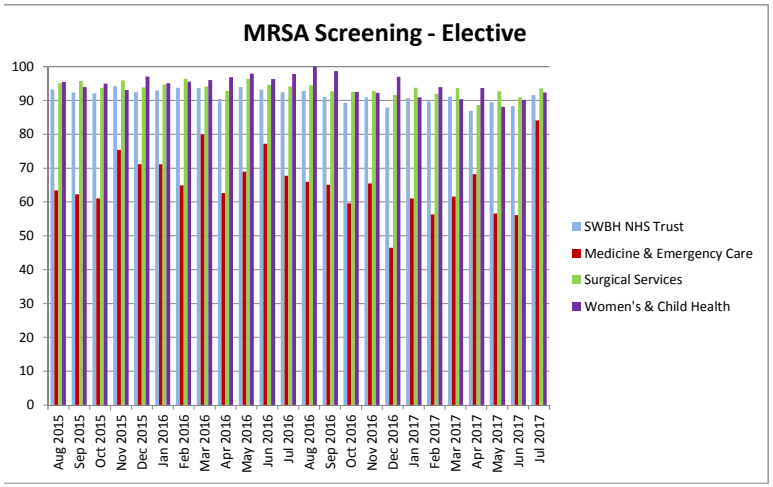
Summary Scorecard

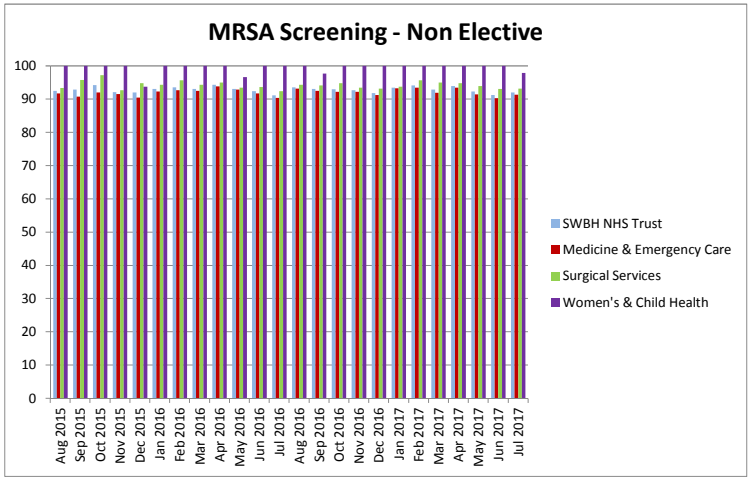
Section	Red Rated	Green Rated	None	Total
Infection Control	0	6	0	6
Harm Free Care	10	3	9	22
Obstetrics	3	4	6	13
Mortality and Readmissions	1	1	11	13
Stroke and Cardiology	3	8	0	11
Cancer	0	10	5	15
FFT, MSA, Complaints	14	2	5	21
Cancellations	6	2	0	8
Emergency Care & Patient Flow	10	4	4	18
RTT	6	2	6	14
Data Completeness	2	8	9	19
Workforce	5	1	13	19
Temporary Workforce	0	0	28	28
SQPR	12	0	6	18
Total	**72**	**51**	**102**	**225**

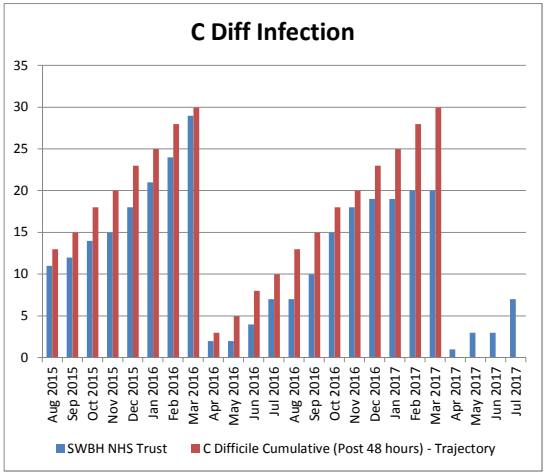
Persistently red-rated performance indicators are subject to ongoing monitoring and detailed improvement trajectories will be set to recover performance to agreed thresholds.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Feb 2016) F M A M J J A S O N D J F M A M J J	Data Period	Group M	Group SS	Group W	Group P	Group I	Group C	Group CO	Month	Year To Date	Trend
4		d	C. Difficile	<= No	30	2.5		Jul 2017	0	1	0					1	7	
4		d	MRSA Bacteraemia	<= No	0	0		Jul 2017	0	0	0					0	0	
4			MSSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9.42		Jul 2017								0.0	9.1	
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	94.9	94.9		Jul 2017								21.6	11.7	
3			MRSA Screening - Elective	=> %	80	80		Jul 2017	84	94	92					91.7	89.3	
3			MRSA Screening - Non Elective	=> %	80	80		Jul 2017	91	93	98					92.0	92.4	

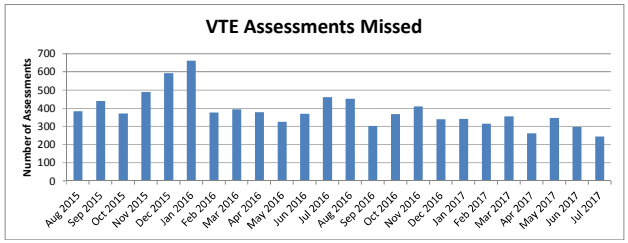


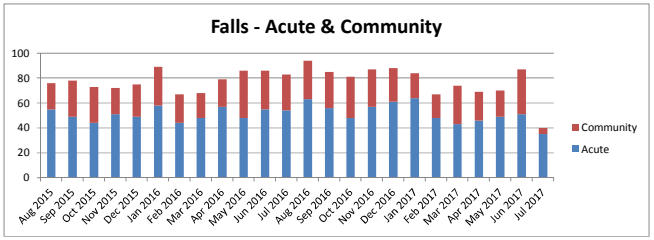


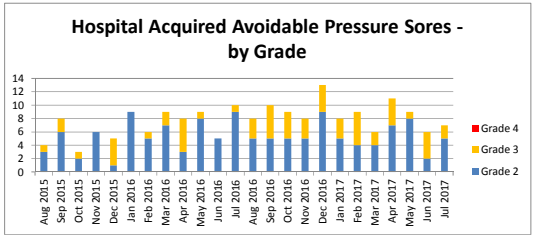


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Feb 2016) F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
8		d	Patient Safety Thermometer - Overall Harm Free Care	=> %	95	95																			Jul 2017								93.9	94.7	
8		d	Patient Safety Thermometer - Catheters & UTIs	%			2.00	1.00	3.00	6.00	2.00	3.00	3.00	3.00	1.00	6.00	2.00	2.00	0.00	0.00	3.00	2.00	1.00	3.00	Jul 2017								0.26	0.19	
	NEW		Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	25	22	15	14	23	15	14	6	27	Jul 2017	12	12	0	-	-	3		27	62	
	NEW		Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	25	22	14	14	23	15	14	6	27	Jul 2017	12	12	0	-	-	3		27	62	
	NEW		Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	6	0	0	0	0	0	0	0	3	Jul 2017	1	0	0	-	-	2		3	3	
	NEW		Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	4	15	14	8	8	15	12	9	7	Jul 2017	4	3	0	-	-	0		7	43	
	NEW		Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	6	6	2	11	6	3	11	7	7	Jul 2017	1	6	0	-	-	0		7	28	
	NEW		Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	1	0	1	1	0	1	0	2	1	Jul 2017	1	0	0	-	-	0		1	4	
	NEW		Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	-	-	-	-	5	2	1	0	0	3	1	1	13	Jul 2017	5	8	0	-	-	0		13	18	
8			Falls	<= No	804	67	67	68	79	86	86	83	94	85	81	87	88	84	67	74	69	70	87	85	Jul 2017	34	11	0	0	2	36		85	311	
9			Falls with a serious injury	<= No	0	0	2	2	1	0	4	1	3	3	1	2	3	3	1	2	1	1	1	1	Jul 2017	0	0	0		0	1		1	4	
8			Grade 2,3 or 4 Pressure Ulcers (Hospital Aquired Avoidable)	<= No	0	0	6	9	8	9	5	10	8	5	9	8	13	8	9	6	11	9	6	7	Jul 2017	4	2	0			1		7	33	
	NEW		Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload Acquired)	<= No	0	0	-	3	3	2	1	4	3	2	0	2	5	6	8	6	5	8	5	8	Jul 2017						8		8	26	
3		d	Venous Thromboembolism (VTE) Assessments	=> %	95	95																			Jul 2017	95.3	98.6	97.5					96.9	96.3	
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	100	100																-			Jul 2017	99.5	99.9	100.0		0.0			99.8	99.8	
3			WHO Safer Surgery - brief (% lists where complete)	=> %	100	100																			Jul 2017	100	99	100		0			99.5	99.3	
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	100																			Jul 2017	98	99	100		0			98.9	98.3	
9		d	Never Events	<= No	0	0	1	0	0	0	1	1	0	0	0	1	0	0	1	0	0	1	1	0	Jul 2017	0	0	0	0	0	0		0	2	
9		d	Medication Errors causing serious harm	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0	-	0	0		0	0	
9		d	Serious Incidents	<= No	0	0	8	5	2	1	10	5	6	4	6	5	10	5	6	5	4	4	3	1	Jul 2017	0	0	0	0	0	1	0	1	12	
9			Open Central Alert System (CAS) Alerts	<= No			6	5	1	13	3	11	12	12	14	10	8	6	5	4	8	9	27	3	Jul 2017								3	47	
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	No	0	0	1	2	0	0	0	0	1	1	2	1	2	0	1	0	0	0	1	1	Jul 2017								1	2	

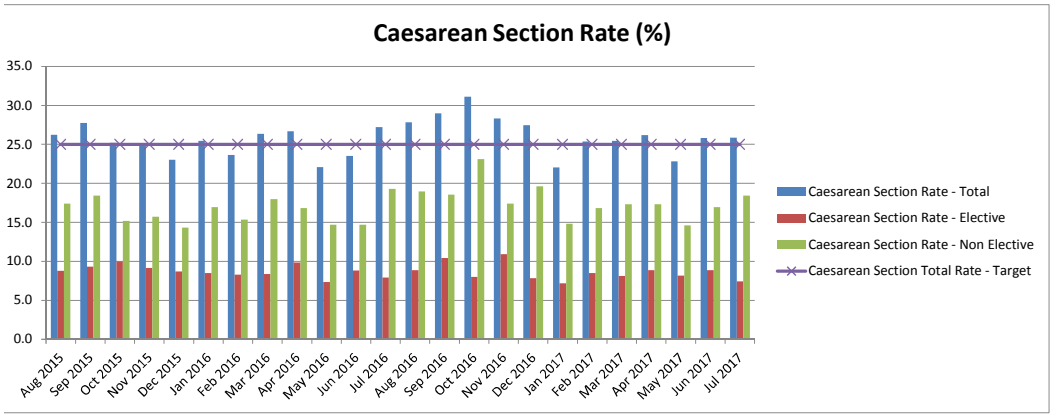


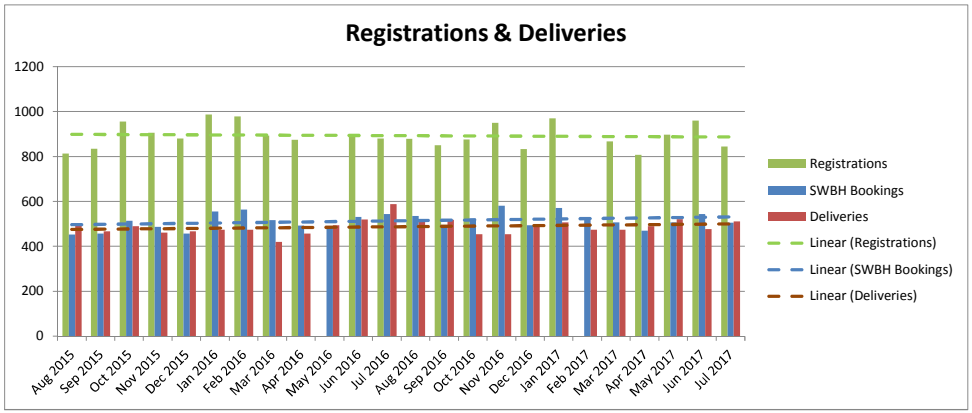




Patient Safety - Obstetrics

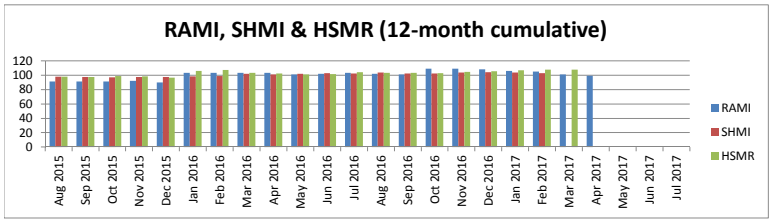
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory 2016-2017 Year	Trajectory 2016-2017 Month	Previous Months Trend (since Feb 2016) F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Month	Year To Date	Trend
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			Jul 2017	25.9	25.2	
3			Caesarean Section Rate - Elective	<= %			8	8	10	7	9	8	9	10	8	11	8	7	9	8	9	8	9	7	Jul 2017	7.5	8.3	
3			Caesarean Section Rate - Non Elective	<= %			15	18	17	15	15	19	19	19	23	17	20	15	17	17	17	15	17	18	Jul 2017	18.4	16.8	
2			Maternal Deaths	<= No	0	0																			Jul 2017	0	0	
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Jul 2017	1	10	
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																			Jul 2017	0.78	1.40	
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Jul 2017	9.67	6.45	
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	90.0	90.0																		-	Jun 2017	77.6	78.5	
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																			Jul 2017	129.8	138.4	
2			Breast Feeding Initiation (Quarterly)	=> %	74.0	74.0	-->		-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		-->	Jul 2017	-	72.43	
2			Puerperal Sepsis and other puerperal infections (variation 1 - ICD10 O85 or O86) (%) -	<= %			1.6	1.8	1.8	3.7	1.9	1.4	1.8	3.2	2.9	2.8	3.5	2.9	1.9	2.6	4.4	2.5	2.5	1.8	Jul 2017	1.83	2.78	
2			Puerperal Sepsis and other puerperal infections (variation 2 - ICD10 O85 or O86 Not O864) (%)	<= %			0.8	1.5	1.3	3.4	1.3	1.4	1.5	3.0	1.8	1.9	1.7	2.5	1.6	2.3	3.0	1.6	1.6	1.0	Jul 2017	1.02	1.78	
2			Puerperal Sepsis and other puerperal infections (variation 3 - ICD10 O85) (%)	<= %			0.8	1.1	1.0	2.4	1.3	1.4	1.5	3.0	1.4	1.3	1.0	2.0	1.6	2.1	2.3	1.4	1.6	1.0	Jul 2017	1.02	1.55	

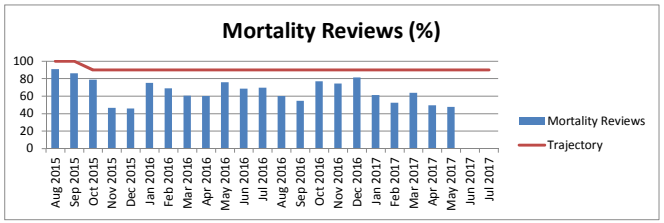


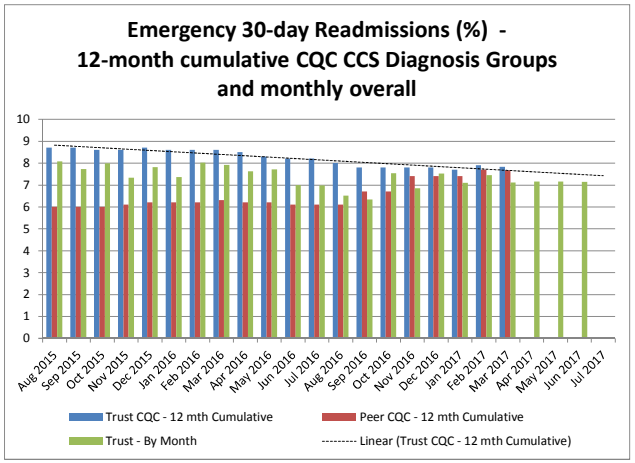


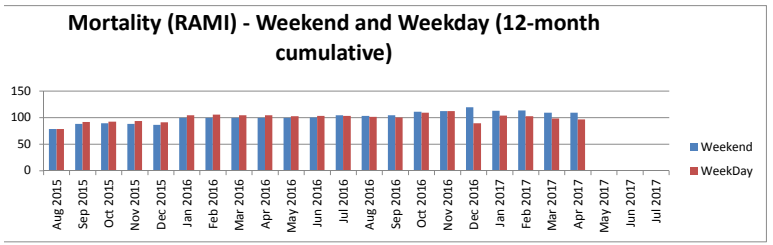
Clinical Effectiveness - Mortality & Readmissions

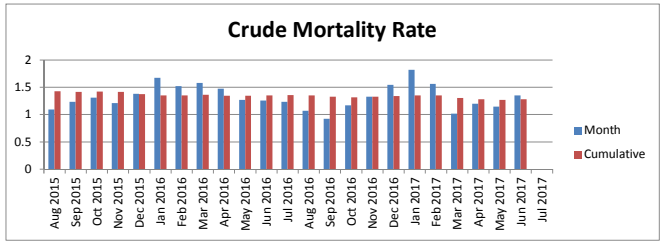
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Feb 2016) F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	103	103	103	101	102	103	102	101	109	109	108	106	105	101	99	-	-	-	Apr 2017									99	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	105	104	104	102	103	103	101	100	109	112	89	104	102	98	96	-	-	-	Apr 2017									96	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	99	99	99	99	100	104	103	104	111	112	119	112	113	109	109	-	-	-	Apr 2017									109	
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	99	102	101	102	103	102	104	102	102	104	104	104	103	-	-	-	-	-	Feb 2017									1130	
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			107	103	102	101	101	104	103	103	103	105	106	107	108	108	-	-	-	-	Mar 2017									1249.6	
5		C	Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	113	82	103	50	3	103	43	56	94	139	84	105	72	88	62	-	-	-	Apr 2017								62		
3			Mortality Reviews within 42 working days	=> %	90	90	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	-	May 2017	51	18	0					48	49	
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.5	1.6	1.5	1.3	1.3	1.2	1.1	0.9	1.2	1.3	1.5	1.8	1.6	1.0	1.2	1.1	1.3	-	Jun 2017								1.35		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.4	1.4	1.3	1.3	1.4	1.4	1.4	1.3	1.3	1.3	1.3	1.3	1.4	1.3	1.3	1.3	1.3	-	Jun 2017									1.27	
	NEW		Deaths in the Trust	No			146	158	142	121	123	119	102	87	108	129	143	172	139	100	105	113	129	-	Jun 2017								129	347	
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			8.0	7.9	7.6	7.7	7.0	7.0	6.5	6.3	7.5	6.8	7.5	7.1	7.4	7.1	7.2	7.2	7.1	-	Jun 2017								7.14		
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			8.2	8.1	8.0	7.9	7.8	7.6	7.5	7.4	8.0	7.3	7.1	7.2	7.2	7.1	7.1	7.0	7.1	-	Jun 2017									7.06	
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			8.6	8.6	8.5	8.3	8.2	8.2	8.0	7.8	7.8	7.8	7.8	7.7	7.9	7.8	-	-	-	-	Mar 2017	-	-	-						-	





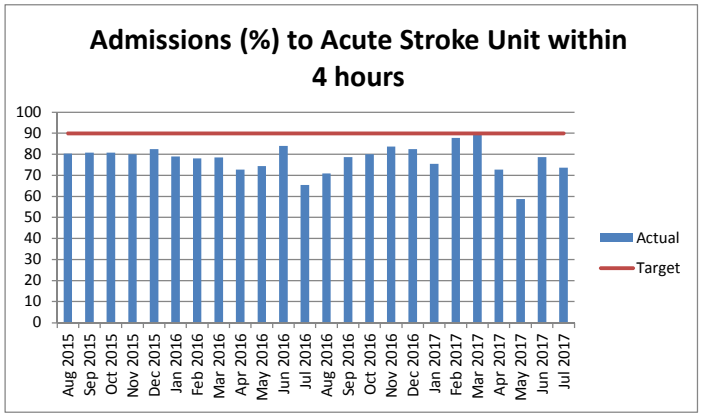


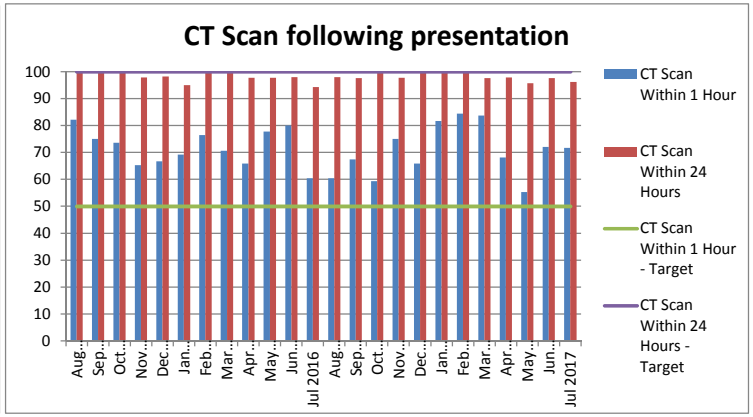


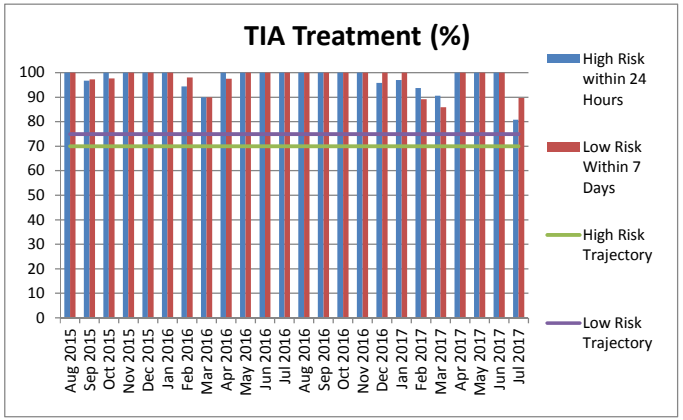


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Feb 2016) F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Month	Year To Date	Trend
3			20WD: Pts spending >90% stay on Acute Stroke Unit	=> %	90.0	90.0																			Jul 2017	92.6	90.1	
3			20WD: Pts admitted to Acute Stroke Unit within 4 hrs	=> %	80.0	80.0																			Jul 2017	73.6	70.8	
3			20WD: Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0																			Jul 2017	71.7	66.8	
3			20WD: Pts receiving CT Scan within 24 hrs of presentation	=> %	95.0	95.0																			Jul 2017	96.2	96.8	
3			20WD: Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			Jul 2017	75.0	60.0	
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0																			Jul 2017	100.0	101.4	
3			20WD: TIA (High Risk) Treatment <24 Hours from receipt of referral	=> %	70.0	70.0																			Jul 2017	80.8	95.5	
3			20WD: TIA (Low Risk) Treatment <7 days from receipt of referral	=> %	75.0	75.0																			Jul 2017	89.7	97.2	
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0																			Jul 2017	100.0	94.7	
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0																			Jul 2017	90.9	94.3	
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0																			Jul 2017	100.0	100.0	





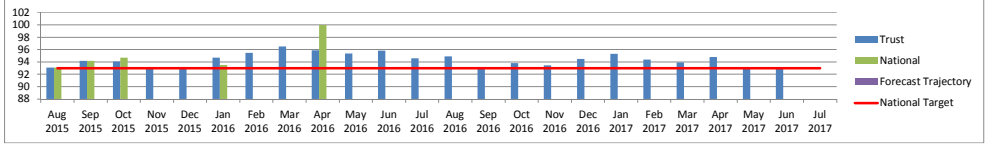


The stroke indicators in the IPR are based on 'patient arrivals' not 'patient discharged' as this monitors pathway performance rather than actual outcomes which may / may not change on discharge.
National SSNAP is based on 'patient discharge' which is more appropriate for outcomes based reporting.
Both are valid but designed for slightly different purposes, however they will align overall, especially over a longer period of time (eg annually)

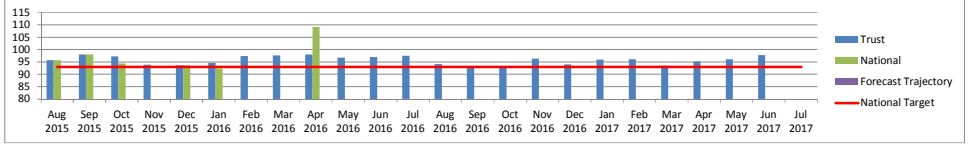
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Feb 2016) F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
1			2 weeks	=> %	93.0	93.0																		-	Jun 2017	92.8	93.3	92.9					93.1	93.7	
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		-	Jun 2017		-						97.8	96.3	
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Jun 2017	100.0	100.0	92.6					98.6	98.5	
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0																		-	Jun 2017								100.0	97.7	
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																		-	Jun 2017								100.0	100.0	
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																		-	Jun 2017								-	0.0	
1			62 Day (urgent GP referral to treatment) Excluding Rare Cancer	=> %	85.0	85.0																		-	Jun 2017	85.4	91.6	84.6					87.6	86.2	
1	NEW		62 Day (urgent GP referral to treatment) Including Rare Cancer	=> %	85.0	85.0																		-	Jun 2017	85.4	91.8	84.6					87.7	86.4	
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																		-	Jun 2017	0.0	100.0	0.0					100.0	100.0	
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																		-	Jun 2017	93.3	88.2	100.0					91.2	95.2	
1			Cancer - Patients Waiting over 62 days	No			10	6	9	11	7	7	12	8	10	11	10	8	15	8	8	10	10	-	Jun 2017	4.5	3.0	2.0					9.5	27.0	
1			Cancer - Patients Waiting over 104 days	No			5	0.5	3.0	1.0	2.0	3.0	3.0	4.0	1.5	1.5	2.5	1.5	4.0	5.0	5.0	2.0	1.0	-	Jun 2017	1.0	0.0	0.0					1.0	8.0	
1			Cancer - Longest Waiter in days	No			154	98	175	95	130	113	131	140	133	77	107	120	150	162	140	139	106	-	Jun 2017	106	98	95					106		
1			Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	=> No	0.0	0.0	-	-	10	8	12	13	5	15	12	12	19	17	8	6	11	6	4	10	Jul 2017	10	0	0					10	31	
	NEW		IPT Referrals - Within 38 Days Of GP Referral for 62 day cancer pathway	%			-	-	-	50	33	50	43	67	50	0	0	33	0	50	0	0	0	-	Jun 2017	-	-	-					0	0	

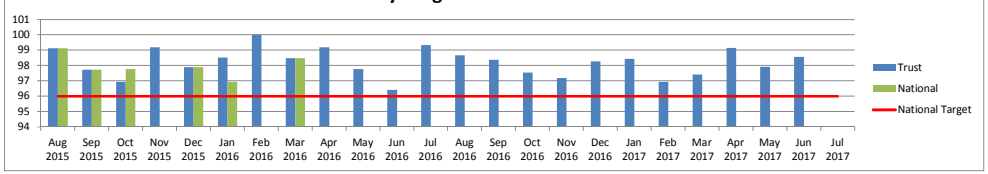
2-week wait from Referral to Date First Seen



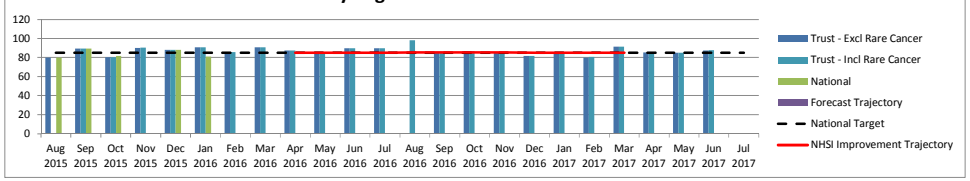
2-week wait from Breast Symptomatic Patients



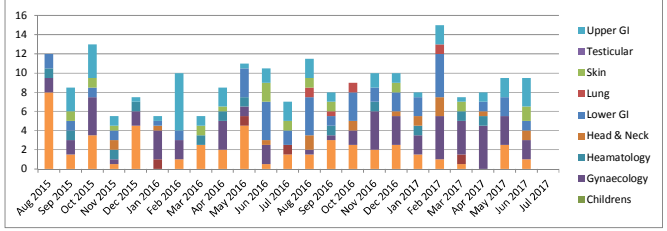
31-day Diagnosis to First Treatment



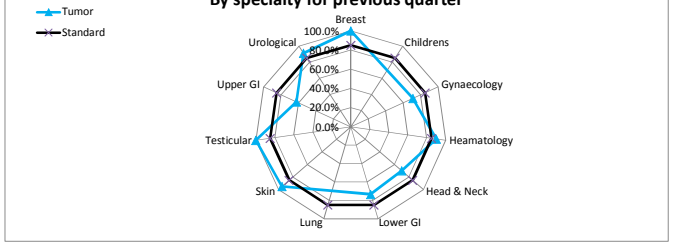
62-day Urgent GP Referral to First Treatment



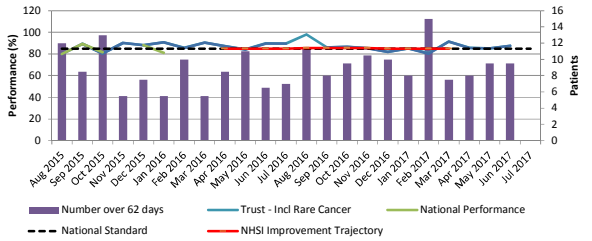
62-day Urgent GP Referral to First Treatment Breach- By Tumour Site



62 Day (Urgent GP referral) wait for first treatment By specialty for previous quarter

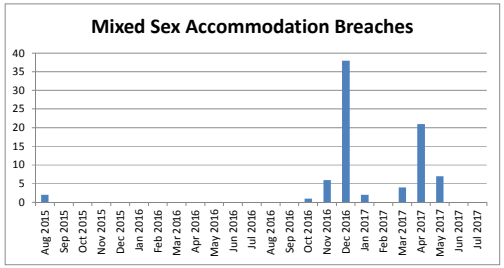


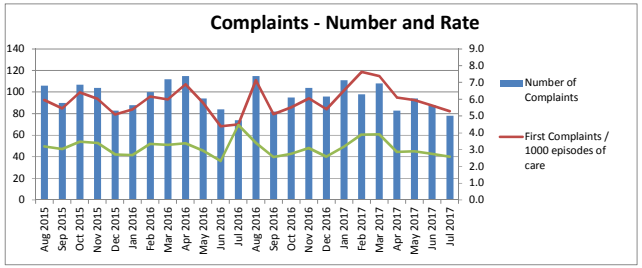
62-day Urgent GP Referral to First Treatment

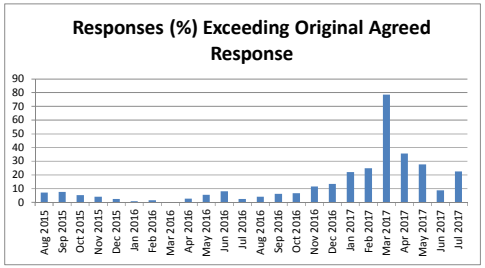


Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Feb 2016) F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Group M	SS	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	15	14	17	16	17	17	13	20	22	17	10	15	9.7	7.9	9.3	11	11	12	Jul 2017								12	11	
8		a	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95.0	95.0	95	95	96	90	83	86	83	86	88	94	97	97	95	96	95	92	92	83	Jul 2017								83		
8		b	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50.0	50.0	6	5.3	5.1	8.3	10	7.8	7.5	7.1	5.6	4.8	5.9	5.4	4.3	4.2	5.5	3.8	2	3.8	Jul 2017	3.8							3.8	3.7	
8		a	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95.0	95.0	74	74	78	85	87	86	83	78	73	75	73	77	76	73	75	71	73	72	Jul 2017	72							72		
8			FFT Response Rate: Type 3 WiU Emergency Department	=> %	50.0	50.0	0.1	0	0.3	2.5	0.1	1.3	0.6	0.5	0.5	0.3	1.2	0.6	0	0	0.1	0	##	0	Jul 2017	-							0.0	0.0	
8			FFT Score - Adult and Children Emergency Department (type 3 WiU)	=> No	95.0	95.0	0	0	100	96	50	95	100	86	64	100	100	65	0	0	0	0	0	0	Jul 2017	-							0		
8			FFT Score - Outpatients	=> No	95.0	95.0	88	87	87	88	88	86	89	88	88	89	90	88	88	90	90	89	88	91	Jul 2017								91		
8	NEW		FFT Score - Maternity Antenatal	=> No	95.0	95.0	100	95	100	91	100	94	86	79	86	90	86	97	11	95	88	90	75	90	Jul 2017								90		
8	NEW		FFT Score - Maternity Postnatal Ward	=> No	95.0	95.0	91	91	97	100	100	100	100	74	81	93	90	91	29	83	91	86	73	73	Jul 2017								73		
8	NEW		FFT Score - Maternity Community	=> No	95.0	95.0	99	99	99	99	100	98	96	91	100	100	50	0	0	80	100	100	0	0	Jul 2017								0		
8			FFT Score - Maternity Birth	=> No	95.0	95.0	94	93	92	90	0	0	100	87	71	88	90	88	23	92	82	83	69	76	Jul 2017								76		
8			FFT Response Rate - Maternity Birth	=> %	50.0	50.0	15	10	12	9	0	0	1.4	15	5.9	17	13	8.2	5.4	21	8.9	11	7	7.1	Jul 2017								7	9	
13		a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	0	0	0	0	0	0	0	1	6	38	2	0	4	21	7	0	0	Jul 2017	0	0	0		0	0		0	28	
9			No. of Complaints Received (formal and link)	No			100	112	115	94	84	74	115	82	95	104	96	111	98	108	83	94	88	78	Jul 2017	27	28	6	0	3	4	10	78	343	
9			No. of Active Complaints in the System (formal and link)	No			128	147	154	144	147	127	143	144	152	148	157	176	177	194	205	184	##	184	Jul 2017	83	57	14	3	5	9	13	184		
9		a	No. of First Formal Complaints received / 1000 bed days	Rate1			3.3	3.3	3.4	2.9	2.3	4.5	3.4	2.6	2.8	3.1	2.6	3.2	3.9	3.9	2.9	2.9	2.8	2.6	Jul 2017	1.9	5.8	1.4					2.59	2.77	
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			6.2	6.0	6.9	5.8	4.4	4.5	7.1	5.1	5.5	6.1	5.4	6.5	7.6	7.4	6.1	6.0	5.6	5.3	Jul 2017	4.7	8.2	2.6			0		5.29	5.74	
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	=> %	100	100	100	100	100	100	100	96	100	100	99	100	100	99	98	94	100	100	##	100	Jul 2017	100	100	100	0	0	100	0	100	100	
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	<= %	0	0	1.6	0	2.6	5.6	8.2	2.4	4.2	6.3	6.6	11	13	22	25	79	36	28	9	23	Jul 2017	26	23	0	0	0	22	0	23	24	
9			No. of responses sent out	No			81	84	98	81	103	103	80	110	87	79	79	76	95	84	67	106	87	83	Jul 2017	28	30	12	1	2	5	9	87	260	
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2016	N	N	N	N	N	N	N	No		

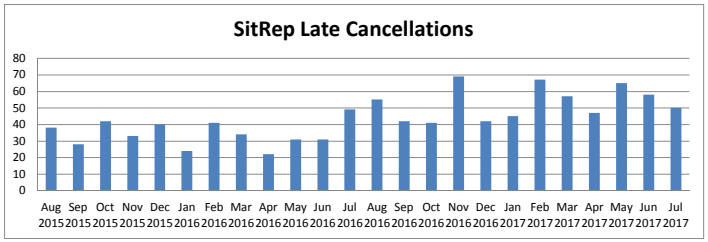


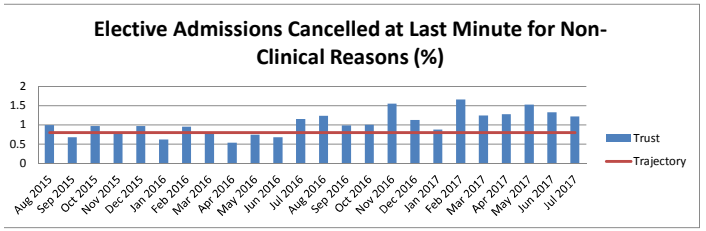


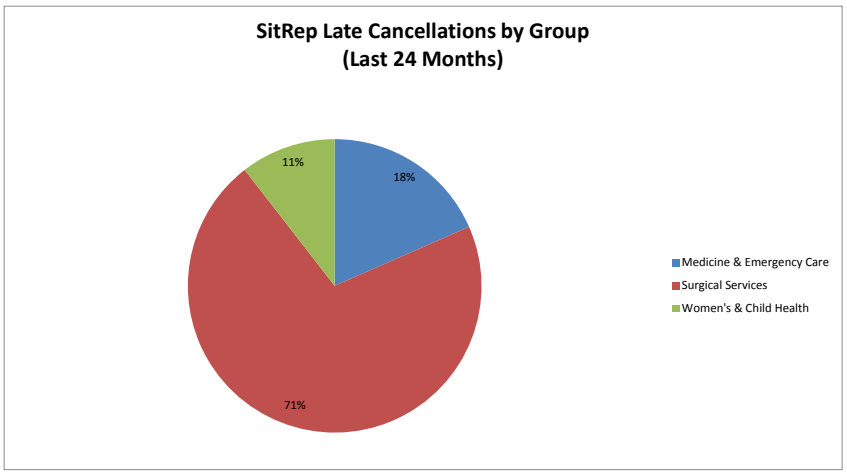


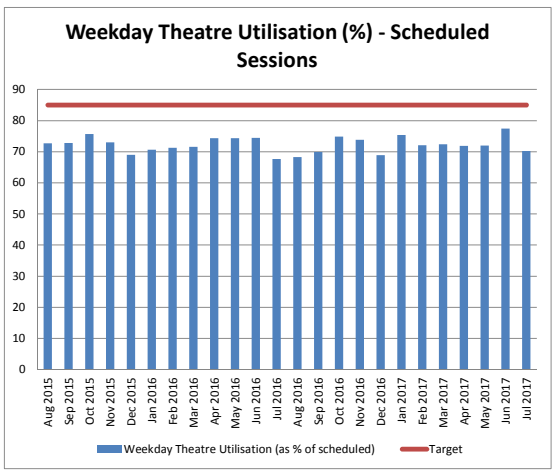
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Feb 2016) F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
2			No. of Sitrep Declared Late Cancellations - Total	<= No	320	27	41	34	22	31	31	49	55	42	41	69	43	45	67	57	47	65	58	50	Jul 2017	5	41	4					50	220	
2			No. of Sitrep Declared Late Cancellations - Avoidable	No			-	-	6	9	11	9	9	15	17	28	19	13	19	17	24	27	20	21	Jul 2017	3	18	-					21	92	
2			No. of Sitrep Declared Late Cancellations - Unavoidable	No			-	-	16	22	19	40	43	27	22	41	18	29	48	37	23	37	37	29	Jul 2017	2	23	4					29	126	
2			Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	0.8	0.8																			Jul 2017	0.29	1.96	1.40					1.2	1.3	
2			Number of 28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	1	0	3	6	0	0	1	0	0	2	Jul 2017	2	0	0					2	3	
2			No. of second or subsequent urgent operations cancelled	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0					0	0	
2			Urgent Cancellations	<= No	0.0	0.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017	0.0	0.0	0.0					0	0	
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	<= No	0	0	0	0	0	0	1	2	0	0	1	3	4	0	3	0	3	1	3	1	Jul 2017	0	1	0					1	8	
			Multiple Hospital Cancellations experienced by same patient (all cancellations)	<= No	0	0	56	57	79	63	43	56	51	60	49	50	63	61	62	67	51	45	72	55	Jul 2017	3	42	10					55	223	
3			All Hospital Cancellations, with 7 or less days notice	<= No	0	0	228	223	229	257	229	241	223	258	234	273	272	269	284	257	219	230	250	245	Jul 2017	33	180	32					245	944	
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0																			Jul 2017	31.5	73.9	79.7					70.1	72.9	



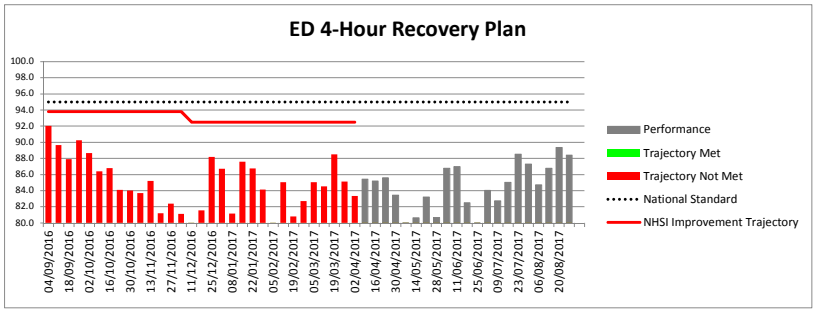


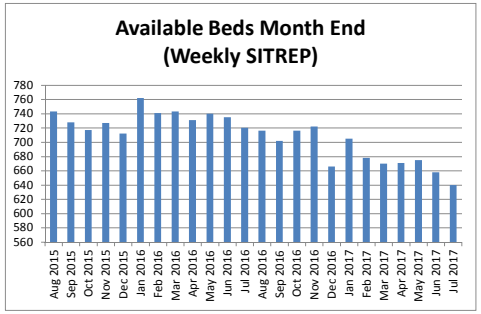


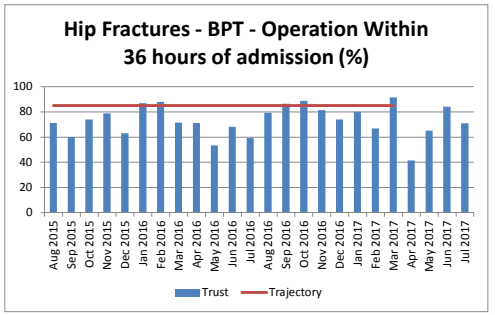


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend
2			Emergency Care 4-hour waits	=> %	95.00	95.00																			Jul 2017	83.7	86.5	97.5	86.00	83.99	
2			Emergency Care 4-hour breach (numbers)	No			1956	2342	1608	1451	1625	2168	1884	2051	2676	3237	3324	2821	3046	2875	2814	3549	3014	2686	Jul 2017	1375	1278	33	2686	12063	
2			Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			Jul 2017	0	0		0	0	
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			Jul 2017	14	14	14	14	14	
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Jul 2017	59	58	117	63	66	
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			Jul 2017	8.94	9.36	3.59	8.72	8.15	
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Jul 2017	5.09	6.90	2.82	5.78	5.84	
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	97	117	81	65	70	122	112	135	112	162	193	162	129	107	110	159	242	111	Jul 2017	63	48		111	622	
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	6	9	2	0	1	8	6	9	16	21	19	11	13	5	0	12	6	1	Jul 2017	0	1		1	19	
11			WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Jul 2017	0.00	0.04		0.02	0.11	
11			WMAS - Emergency Conveyances (total)	No			3961	4513	4115	4604	4099	4363	4204	4138	4233	4261	4622	4410	4034	4206	4137	4376	4254	4429	Jul 2017	2187	2242		4429	17196	
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																			Jul 2017	2.1	4.4		3.0	2	
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	<10 per site	<10 per site																			Jul 2017	7	9.4		16		
2			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	<= No	0	0	426	397	454	494	588	617	530	483	509	503	674	629	512	583	546	501	483	635	Jul 2017				635	2165	
2			Delayed Transfers of Care (Acute) - Finable Bed Days (Birmingham LA only)	<= No	0	0	198	232	234	228	251	245	287	215	266	272	449	435	309	375	324	258	312	370	Jul 2017				370	1264	
2			Patient Bed Moves (10pm - 6am) (No.) -ALL	No			543	546	563	498	451	578	533	525	546	679	666	682	633	586	584	651	536	580	Jul 2017				580	2351	
2			Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units	No			269	232	255	222	204	268	246	248	219	273	251	249	228	221	229	234	205	245	Jul 2017				245	913	
			Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85.0	85.0																			Jul 2017				71	64.8	

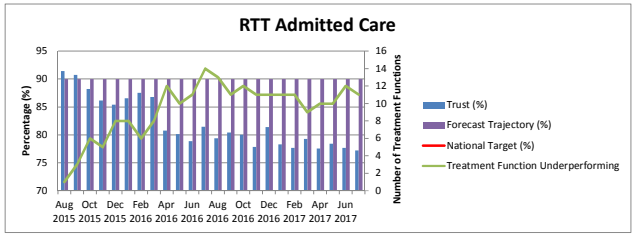


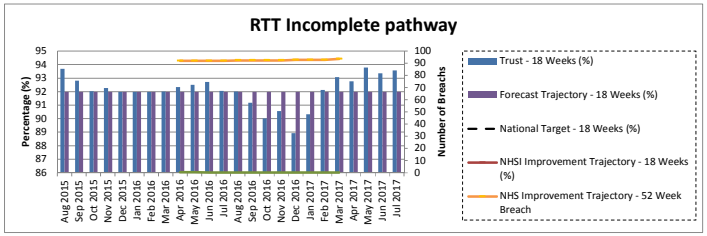


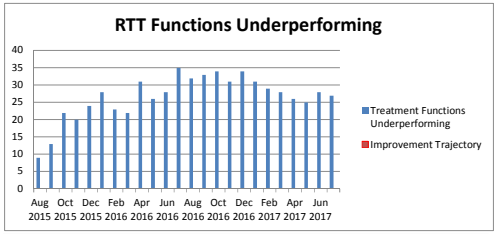


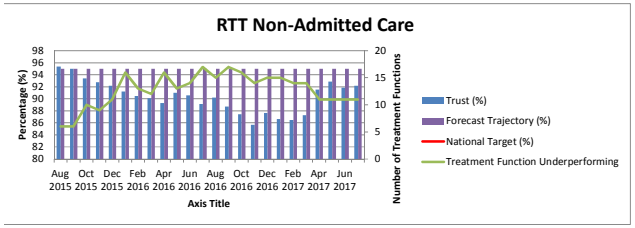
Referral To Treatment

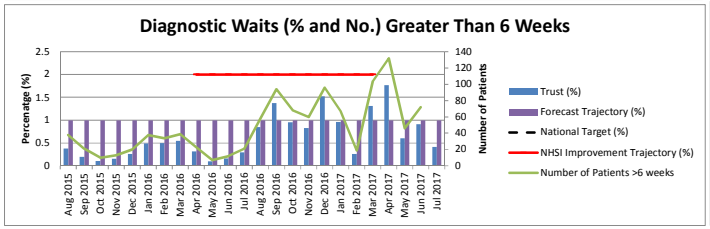
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Feb 2016) F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
2			RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Jul 2017	87.9	74.0	68.1					77.25		
2			RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Jul 2017	83.8	92.4	95.6					92.21		
2			RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Jul 2017	93.8	92.3	94.2					93.59		
	NEW		RTT - Backlog	No			2423	2557	2566	2561	2515	2870	2968	3289	3728	3417	3908	3204	2578	2214	2327	2024	2188	2115	Jul 2017	467	1293	91					2115		
2			Patients Waiting >52 weeks	<= No	0	0	5	8	3	2	4	4	0	1	4	3	2	0	3	6	5	3	2	10	Jul 2017	7	1	0					10	20	
2	NEW		Patients Waiting >52 weeks (Incomplete)	<= No	0	0	3	2	0	2	2	0	0	1	2	2	2	1	3	2	3	3	0	8	Jul 2017	5	1	0					8	14	
2			Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	<= No	0	0	23	22	31	26	28	35	32	33	34	31	34	31	29	28	26	25	28	27	Jul 2017	9	16	1.0					27		
			Treatment Functions Underperforming (Incomplete)	<= No	0	0	4	2	3	3	3	4	4	5	6	6	8	5	4	5	5	4	5	5	Jul 2017	2	3	0					5		
2			Acute Diagnostic Waits in Excess of 6-weeks (End of Month Census)	<= %	1.0	1.0																			Jul 2017	0.6	1.0	0.0		0.2			0.42		
			Acute Diagnostic Waits in Excess of 6-weeks (In Month Waiters)	No			273	281	542	480	419	502	470	500	711	817	498	902	387	577	942	931	650	833	Jul 2017	198	199	-		436			833		

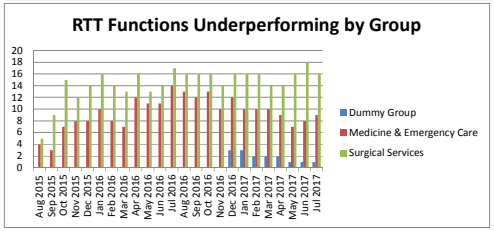


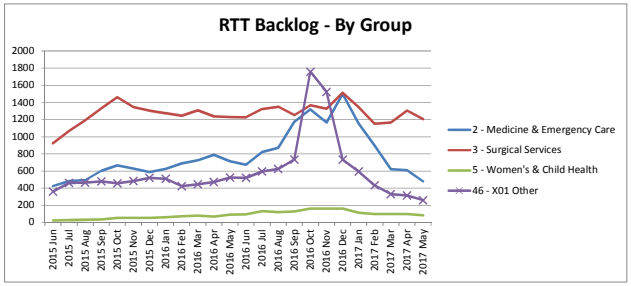


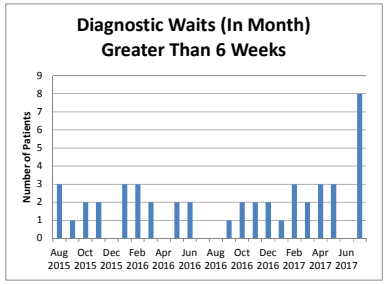


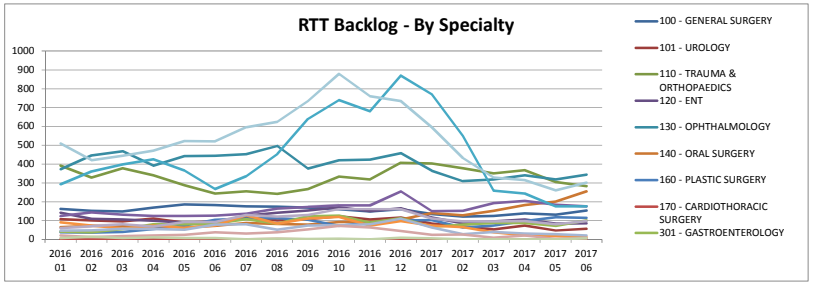






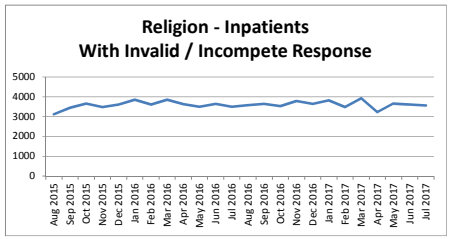


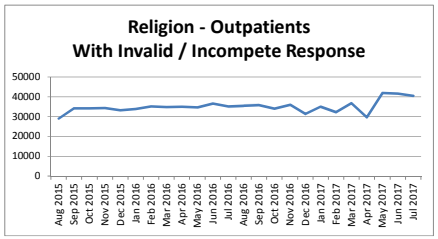


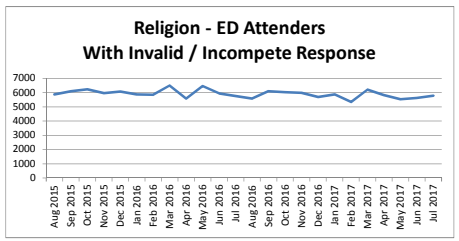


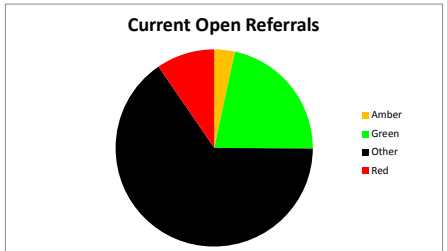
Data Completeness

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Group M	Group SS	Group W	Group P	Group I	Group C	Group CO	Month	Year To Date	Trend
14			Data Completeness Community Services	=> %	50.0	50.0																			Apr 2017							61.2	61.2		
2			Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Jun 2017								99.6		
2			Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Jun 2017								99.0		
2			Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Jun 2017								99.3		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=> %	99.0	99.0	96.5	98.1	96.7	96.7	96.9	96.3	97.9	96.5	97.3	97.5	98.3	97.7	98.3	97.7	98.2	98.3	97.4	-	Jun 2017								97.5	98.0	
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	=> %	99.0	99.0	99.5	99.6	99.5	99.5	99.5	99.4	99.5	99.5	99.5	99.5	99.6	99.6	99.5	99.5	99.4	99.5	99.4	-	Jun 2017								99.4	99.5	
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=> %	95.0	95.0	97.0	97.1	96.7	96.8	97.2	97.0	96.7	97.0	97.2	97.6	97.0	97.7	97.3	97.3	97.3	97.4	96.3	-	Jun 2017								96.3	97.0	
2			Ethnicity Coding - percentage of inpatients with recorded response	=> %	90.0	90.0																		-	Jun 2017								90.5	90.5	
	NEW		Ethnicity Coding - percentage of outpatients with recorded response	=> %	90.0	90.0																		-	Jun 2017								90.0	89.7	
	NEW		Protected Characteristic - Religion - INPATIENTS with recorded response	%			70.3	68.6	69.6	69.9	69.5	69.8	69.2	68.9	69.6	69.2	69.1	68.7	69.2	68.8	70.3	70.6	69.6	70.1	Jul 2017								70.1	70.2	
	NEW		Protected Characteristic - Religion - OUTPATIENTS with recorded response	%			58.4	58.1	58.1	58.2	57.8	58.0	57.8	57.9	58.1	57.5	56.9	57.0	57.2	56.9	56.7	52.9	53.2	53.1	Jul 2017								53.1	53.8	
	NEW		Protected Characteristic - Religion - ED patients with recorded response	%			62.3	62.3	64.8	63.3	64.3	66.5	65.3	64.0	64.3	64.1	64.7	64.1	64.7	64.2	64.7	67.2	65.3	66.2	Jul 2017								66.2	65.9	
	NEW		Protected Characteristic - Marital Status - INPATIENTS with recorded response	%			99.9	99.9	99.9	99.9	100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0	99.9	99.9	99.9	100.0	100.0	100.0	Jul 2017								100.0	100.0	
	NEW		Protected Characteristic - Marital Status - OUTPATIENTS with recorded response	%			40.5	40.5	39.8	39.8	39.9	40.1	40.8	40.3	40.4	39.9	35.8	40.8	41.3	41.5	41.3	41.1	41.9	41.4	Jul 2017								41.4	41.5	
	NEW		Protected Characteristic - Marital Status - ED patients with recorded response	%			42.5	41.2	40.9	41.3	41.9	40.9	39.5	40.6	40.9	41.5	40.8	40.5	41.3	41.1	39.8	42.7	42.0	42.2	Jul 2017								42.2	41.7	
2			Maternity - Percentage of invalid fields completed in SUS submission	<= %	15.0	15.0																		-	Jun 2017								7.0	6.3	
2			Open Referrals	No			187,876	190,396	194,788	199,207	204,824	206,563	210,740	215,396	219,866	222,444	225,175	226,846	230,675	235,998	239,934	245,160	250,072	254,761	Jul 2017	83,160	131,460	32,486	7,039	560	56		254,761		
	NEW		**Of which**: Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			-	-	-	77,139	77,410	77,383	81,209	86,309	87,537	92,360	95,712	99,043	102,885	108,584	111,242	115,133	118,367	123,475	Jul 2017	39,488	59,198	17,454	3,321	506	2,858		123475		

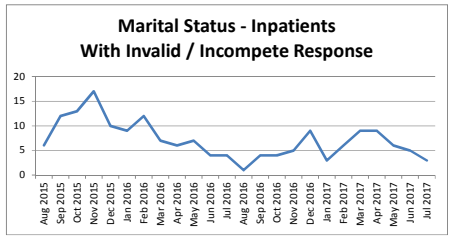


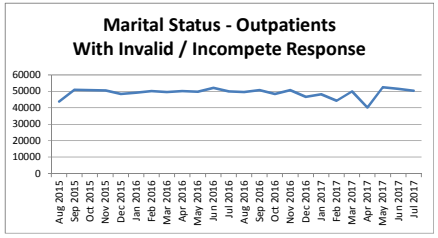


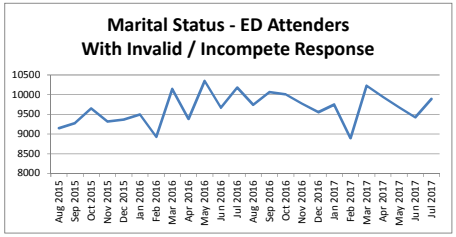




RED : To be Verified and closed By CG's.
AMBER : To be looked at by CG's once RED's are actioned.
GREEN : Automatic Closures.
BLACK- : To be Verified and closed By CG's.

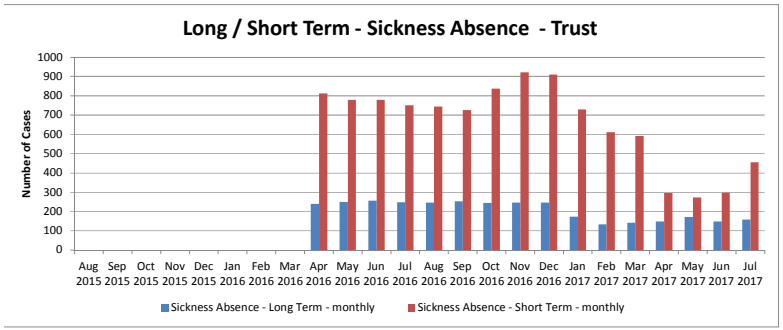


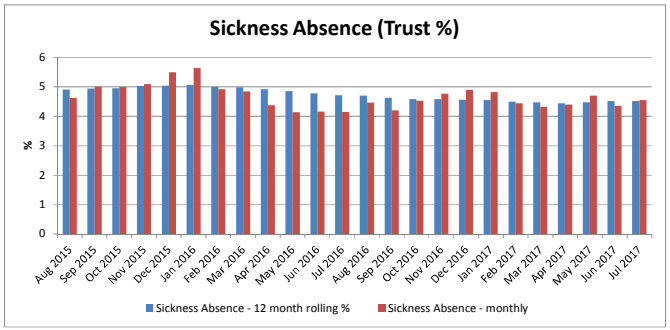




Workforce

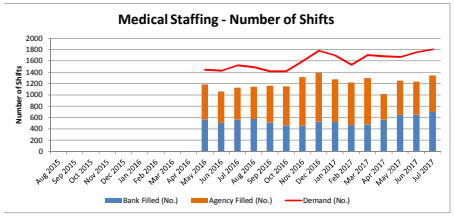
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Feb 2016) F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
3		•b•	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	79.6	86.6	89.2	93.7	83.9	91.6	88.9		88.0	
7		•b	Medical Appraisal	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	72.5	81.7	97.6	81.3	89.7	116.7	50.0	84.5	85.4	
3		•b	Sickness Absence (Rolling 12 Months)	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	4.6	4.8	4.5	3.7	4.3	4.0	4.7	4.53	4.49	
3	NEW		Sickness Absence (Monthly)	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	4.2	5.3	4.4	3.9	3.7	4.2	4.8	4.56	4.51	
3	NEW		Sickness Absence - Long Term (Monthly)	No			-	-	240	250	256	249	247	253	245	247	246	253	205	213	214	241	218	225	Jul 2017	45	51	31	8	7	15	2	225	898	
3	NEW		Sickness Absence - Short Term (Monthly)	No			-	-	812	779	780	752	745	727	837	922	911	956	808	785	414	445	444	612	Jul 2017	131	96	88	40	22	78	1	612	1915	
3			Return to Work Interviews following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	69.2	83.6	85.1	85.5	72.1	77.6	79.6	78.4	78.9	
3			Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	81.4	87.0	88.3	91.1	87.7	90.2	90.6		87.2	
3			Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-		-	
3		•	Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	91.7	0.0	94.8	95.9	95.1	0.0	97.9		95.4	
7		•b•	Employee Turnover (rolling 12 months)	<= %	10.0	10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017								11.8	11.6	
	NEW		Nursing Turnover	%			14.8	13.8	13.6	12.6	11.8	11.3	11.2	11.9	12.4	11.7	11.4	11.6	11.2	11.7	11.7	11.7	12	12.6	Jul 2017								12.6	12	
7			New Investigations in Month	No			12	9	6	4	3	8	4	4	3	0	3	4	3	9	14	1	3	4	Jul 2017	1	2	0	0	0	0	1	4		
7			Vacancy Time to Fill	Weeks			26	23	26	25	23	24	24	21	25	21	21	21	22	21	20	21	23	25	Jul 2017								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	Jul 2017	0	0	0	0	0	0	0	0	0	
7			Qualified Nursing Variance (FIMS) (FTE)	No			274	293	292	315	317	339	343	341	313	293	305	268	246	257	256	276	281	289	Jul 2017								289		
15			Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	16.0	-->	-->	-->	-->	-->	18.8	Jul 2017	11.8	15.3	15.9	23.7	23.8	29	21.2	18.8		
15			Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.70	-->	-->	-->	-->	-->	-->	Jan 2017	3.68	3.79	3.66	3.82	3.58	3.83	3.64	3.7		

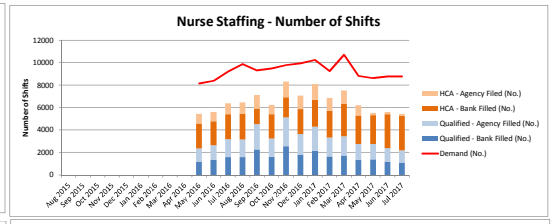


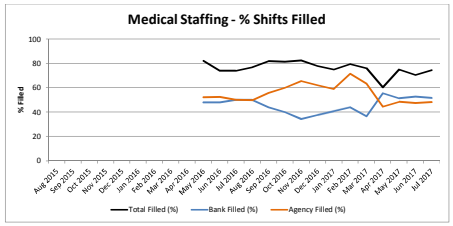


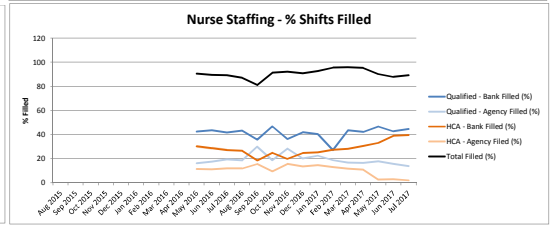
Temporary Workforce

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Feb 2016) F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
	NTCA		Medical Staffing - Number of instances when junior rotas not fully filled	<= %	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	
			Medical Staffing - Demand	No			-	-	-	1443	1429	1523	1491	1419	1419	1596	1786	1699	1534	1703	1682	1669	1753	1805	Jul 2017	1208	360	222	0	15	0	0	1805	6909.0	
			Medical Staffing - Total Filled	%			-	-	-	81.98	74.04	74.06	76.93	81.89	81.25	82.46	77.94	74.93	79.4	76.1	60.4	75.07	70.62	74.52	Jul 2017	72.76	82.22	70.27	0	93.33	0	0	75	70.2	
			Medical Staffing - Bank Filled	%			-	-	-	47.84	47.92	50	50.13	44.06	40.07	34.42	37.79	40.93	44.12	36.65	55.51	51.48	52.58	51.75	Jul 2017	40.84	77.03	64.1	0	64.29	0	0	52	52.7	
			Medical Staffing - Agency Filled	%			-	-	-	52.16	52.36	50	49.87	55.94	59.93	65.58	62.21	59.07	71.44	63.35	44.49	48.52	47.42	48.25	Jul 2017	59.16	22.97	35.9	0	35.71	0	0	48	47.3	
			Medical Staffing - Filled Shifts - Snr Consultant	No			-	-	-	114	110	107	137	177	243	237	187	152	217	270	120	214	219	258	Jul 2017	202	42	0	0	14	0	0	258	811.0	
			Medical Staffing - Filled Shifts - Jnr Doctor	No			-	-	-	1069	951	1021	1010	998	951	1108	1196	1144	1001	1026	896	394	1019	1087	Jul 2017	677	254	156	0	0	0	0	1087	3396.0	
			Nursing - Demand	No			-	-	-	8158	8413	9220	9887	9312	9476	9802	9935	10261	9268	10708	8825	8616	8784	8760	Jul 2017	4418	1819	1068	0	34	1196	225	8760	34985	
			Nursing - Total Filled	%			-	-	-	90.44	89.33	89.21	86.98	81.13	91.18	92.03	90.68	92.75	95.55	95.8	95.29	90.22	87.78	89.1	Jul 2017	88.12	90.49	83.9	0	100	92.89	100	89	90.6	
			Nursing - Qualified - Bank Filled	%			-	-	-	42.3	43.41	41.68	43.12	35.83	46.77	36.3	41.77	40.3	27.07	43.52	42.07	46.67	42.61	44.4	Jul 2017	41.79	27.46	69.42	0	94.12	59.77	31.56	44	43.9	
			Nursing - Qualified - Agency Filled	%			-	-	-	16.01	17.56	19.34	18.41	29.95	18.76	28.38	20.17	22.55	18.71	16.76	16.32	17.77	15.48	13.9	Jul 2017	17.57	18.23	3.01	0	0	5.04	9.33	14	15.9	
			Nursing - HCA - Bank Filled	%			-	-	-	30.18	28.57	26.95	26.56	18.6	25.02	19.83	24.59	25.29	27.18	28.13	30.44	33.05	39.06	39.6	Jul 2017	37.66	53.16	27.34	0	5.88	33.48	59.11	40	35.4	
			Nursing - HCA - Agency Filled	%			-	-	-	11.39	11.07	12.01	11.92	15.62	9.444	15.49	13.48	14.48	12.91	11.59	10.74	2.509	2.84	2.0	Jul 2017	2.98	1.15	0.22	0	0	1.71	0	2	4.7	
			AHPs - Radiography - Demand (Shifts)	No			-	-	-	138	97	79	55	269	332	321	290	526	332	525	332	372	315	334	Jul 2017	0	0	0	0	334	0	0	334	1353	
			AHPs - Radiography - Filled (Shifts)	No			-	-	-	138	97	73	55	249	324	299	256	496	302	502	329	359	315	290	Jul 2017	0	0	0	0	290	0	0	290	1293	
			AHPs - Physiotherapy - Demand (Shifts)	No			-	-	-	191	156	192	55	63	38	190	186	276	478	356	180	242	257	104	Jul 2017	0	0	0	0	0	104	0	104	783	
			AHPs - Physiotherapy - Filled (Shifts)	No			-	-	-	191	156	192	55	63	38	190	186	274	478	346	180	242	257	104	Jul 2017	0	0	0	0	0	104	0	104	783	
			AHPs - Other - Demand (Shifts)	No			-	-	-	301	336	289	66	96	139	96	567	413	530	1009	459	527	471	511	Jul 2017	152	52	29	1	72	108	97	511	1968	
			AHPs - Other - Filled (Shifts)	No			-	-	-	301	336	288	55	95	95	200	567	412	527	885	457	527	471	508	Jul 2017	151	52	29	1	72	108	95	508	1963	
			Admin - Demand (Shifts)	No			-	-	-	1994	1954	1902	2147	2765	2839	2479	2442	2381	4128	5135	4198	4228	4423	4054	Jul 2017	994	612	238	224	94	117	1775	4054	16903	
			Admin - Filled (Shifts)	No			-	-	-	1988	1937	1855	2061	2450	2589	2452	2405	2348	4026	5079	4162	4184	4423	4031	Jul 2017	981	612	231	224	94	115	1774	4031	16800	
			Facilities - Demand (Shifts)	No			-	-	-	1903	1947	1442	1451	2160	2185	1997	2172	2066	1971	2485	1795	2031	2101	1996	Jul 2017	27	102	2	0	17	1	1847	1996	7923	
			Facilities - Filled (Shifts)	No			-	-	-	1898	1933	1405	1397	1942	2135	1969	2107	1992	1926	2425	1737	1999	2101	1966	Jul 2017	20	97	0	0	17	0	1832	1966	7803	
			Interpreters - Demand (Shifts)	No			-	-	-	4925	5358	5110	5034	5321	5026	5508	4803	5159	4983	5634	4511	5139	5291	5101	Jul 2017	-	-	-	-	-	-	-	5101	20042.0	
			Interpreters - Total Filled	%			-	-	-	99.61	99.72	99.75	99.62	99.44	99.58	99.46	99.46	99.5	99.64	99.57	99.89	99.71	99.7	99.76	Jul 2017	-	-	-	-	-	-	-	100	99.8	
			Interpreters - Bank Filled	%			-	-	-	78.96	77.99	76.61	76.35	76.68	78.62	77.58	76.93	78.38	79.52	78.02	77.34	78.45	77.67	77.0	Jul 2017	-	-	-	-	-	-	-	77	77.6	
			Interpreters - Agency Filled	%			-	-	-	21.0	22.0	23.4	23.6	23.3	21.4	22.4	23.1	21.6	20.5	22.0	22.7	21.5	22.3	23.0	Jul 2017	-	-	-	-	-	-	-	23	22.4	
			Interpreters - Unfilled	%			-	-	-	0.4	0.3	0.3	0.4	0.6	0.4	0.5	0.5	0.5	0.4	0.4	0.1	0.3	0.3	0.2	Jul 2017	-	-	-	-	-	-	-	0	0.2	









CQUINs 2017/18 Schemes (page 1 of 2)

Ref	CQUIN	Annual Plan Values (£)	Full Year Delivery	Funding missed (£)	Indicator	Provider Setting	Description of Indicator	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4	Monthly Trend A M J J A S O N D J F M	Comments	Data Period	FULL YEAR	Trend	Next Month	3 Months
1a	National	£1,357,782			**Improving Staff Health & Wellbeing : Improvement of health & wellbeing of NHS staff**	**Acute & Community**	Annual Staff Survey results to improve by 5% in two of the three NHS annual staff survey: on health & well-being, MSK and stress	Baseline 2015/16: Q9a, 9b and 9c			2016/17 Results to 2xQs to improve by 5% for full payment	n/a	Report	MSK remains the single biggest issue in respect of delivery; 15/16 survey indicated that the trust has worsened year on year in respect of the MSK survey	Jun-17				
1b	National				**Staff Health & Wellbeing : Healthy food for NHS staff, visitors and patients**	**Acute & Community**	Firstly, maintain the four outcomes that were implemented in 2016/17. Secondly, introducing three new chances to food and during provision in year 1, 17/18 : 70% of drinks sold must be sugar free, b) 50% of confectionary and sweets do not exceed 250 kcal c) 60% or pre-packed sandwiches and other savoury pre-packed meals available contain 400kcals or less and do not exceed 5.0g saturated fat	No submissions, ensure deliverables are in place			All four outcomes delivered	n/a	Report	Steve Clarke is the lead and confirms general compliance with this scheme, more to be done on the confectionary and sandwiches front.	Jun-17				
1c	National				**Staff Health & Wellbeing : Improving uptake of flu vaccination for front line staff within Providers**	**Acute & Community**	Year 1 - achieving update of flu vaccination for frontline clinical staff of 70%	No returns		Report %age achieved	Report %age achieved	n/a	Report	Campaign planned and the Trust is confident that this target will be delivered again this year.	Jun-17				
2a	National	£678,891		£21,215k	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): **Timely identification of sepsis in emergency departments and acute inpatient settings**	**Acute**	The percentage of patients who met the criteria for sepsis screening (needed it) and were screened for sepsis (applies to all adult and child patients arriving in ED & IP wards)	Q1 Screened in ED & IP (based on sample)	Q1 Screened in ED & IP (based on sample)	Q1 Screened in ED & IP (based on sample)	Q1 Screened in ED & IP (based on sample)	Partially met	Report	Report	Report	Only 74% of sample patients that NEEDED sepsis screening were screened. This needs Exec support and intervention required.	Jun-17				
2b	National			£21,215k	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): **Timely treatment for sepsis in emergency departments and acute inpatient settings**	**Acute**	The percentage of patients who were found to have sepsis in 2a and received IV antibiotics within 1 hour (applies to all adult and child patients arriving in ED & IP wards).	Q1 numbers found to have sepsis in ED & acute settings in sample 2a who received IV AB within 1 hr of diagnosis	Q1 numbers found to have sepsis in ED & acute settings in sample 2a who received IV AB within 1 hr of diagnosis	Q1 numbers found to have sepsis in ED & acute settings in sample 2a who received IV AB within 1 hr of diagnosis	Q1 numbers found to have sepsis in ED & acute settings in sample 2a who received IV AB within 1 hr of diagnosis	Partially met	Report	Report	Report	Of the above screened patients, only 57% of septic patients receive their antibiotics within one hour. Outliers need to be understood and improvements to be led by the ward teams Requires Exec team attention and focus on improvement. MQuAC in August tables an agenda item on why the mortality rate due to sepsis is going up; potentially the lack of screening and timely treatment may be a factor.	Jun-17				
2c	National				Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): **Antibiotic review**	**Acute**	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hrs	Number of AB prescriptions reviewed within 72 hrs	Number of AB prescriptions reviewed within 72 hrs	Number of AB prescriptions reviewed within 72 hrs	Number of AB prescriptions reviewed within 72 hrs	Met	Report	Report	Report	Met for Q1, but more focus required to meet with less effort	Jun-17				
2d	National				Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): **Reduction in antibiotic consumption per 1,000 admissions**	**Acute**	There are three parts to this indicator. 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions There are three parts to this indicator.	No returns			Reduction of 1% or 2%	n/a	Report		Jun-17				
4	National	£678,891			**Improving services for people with mental health needs who present to A&E**	**Acute**		Outline Plan & Baseline data 16/17	DQ data, confirm partnerships in place	Report Progress	20% reduction in A&E attendances of those within the selected cohort	Met	Report	Report	Report	The Trust submitted a robust and well progressed plan which was highlighted as excellent by the CCG	Jun-17				
6	National	£678,891			**Offering Advice & Guidance**	**Acute**	Providers to set up and operate A&G services for non-urgent GP referrals; A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative.	Timetable & Introduction				Met	Report	Report	Report	The Trust offers A&G for all services. The GP referrals to this facility need encouraging.	Jun-17				
7	National	£678,891			**NHS e-Referrals CQUIN**	**Acute**	This indicator relates to GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service. It is not looking at percentage utilisation of the system.	Supply plan to deliver Q2, Q3 and Q4 targets to include	80% of Referrals to 1st O/P Services able to be received through e-RS.	90% of Referrals to 1st O/P Services able to be received through e-RS.	100% of Referrals to 1st O/P Services able to be received through e-RS.	Met	Report	Report	Report	A plan has supplied confirming the delivery of 80% of its 1st GP appointments via eRS by end of September. A roll out programme as per this plan is being managed with the eRS lead in patient access team. Discussions with CCG are required to negotiate expectations of 4% ASIs only by year end which is totally unrealistic in terms of demand patterns and hence not possible to always match with capacity in a given horizon.	Jun-17				
8	National	£1,357,782			**Supporting proactive and safe discharge (Acute & Community Trusts)**	**Acute & Community**	Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17).	Type 1 or 2 A&E provider has demonstrable and credible planning in place to make the required preparations so that the Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017.	Map and streamline existing discharge pathways across acute and community, and roll-out protocols in partnership across local whole-systems.	Providers returning ECDS with at least 95% of completed, valid diagnosis codes.	By the end of Q4 2.5% point increase from baseline in no. patients discharged to usual place of residence.	Met	Report	Report	Report	The Trust submitted a robust and well progressed plan.	Jun-17				
9	National	£1,357,782			**Preventing ill health by risky behaviours - alcohol & tobacco: 9a: Tobacco Screening**	**Acute & Community**								**SCHEME REMOVED:** Clarification received from NHSE that this scheme will now not apply until 2018/19. The impact of this will be that the CCG will have to spread the 1.35m across the other schemes which means there is more funding at stake if other schemes do not deliver. **From a Q1 payment perspective, the funding of £448k will be payable to the Trust.**					
					Preventing ill health by risky behaviours - alcohol & tobacco 9b: Tobacco brief advice	**Acute & Community**													
					Preventing ill health by risky behaviours - alcohol & tobacco 9c: Tobacco referral & medication offer	**Acute & Community**													
					Preventing ill health by risky behaviours - alcohol & tobacco 9d: Alcohol Screening	**Acute & Community**													

CQUINs 2017/18 Schemes (page 1 of 2)

Ref	CQUIN	Annual Plan Values (000s)	Full Year Delivery	Funding missed (£)	Indicator	Provider Setting	Description of Indicator	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4	Monthly Trend A	M	J	J	A	S	O	N	D	J	F	M	Comments	Data Period	FULL YEAR	Trend	Next Month	3 Months
10	National	£678,891			**Improving the assessment of wounds**	**Community**	The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.	Establish Clinical Audit plan	Clinical Audit of wound assessments	Improvement Plan	Repeat Clinical Audit	n/a		Report		Report		Report						Work has commenced in preparation for Q2 reporting	Jun-17				
11	National	£678,891			**Personalised Care / support planning**	**Community**	This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions. In the first year, activity will be focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be identified, the relevant workforce receive appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers.		Submission of a plan to ensure care & support planning is recorded by providers will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted (yes/no).	Provider to identify the number of patients as having multiple LTCs and who will be prioritised for personalised care and support planning (establishment of cohort) compared to the total number of patients served	Provider to confirm what proportion of relevant staff have undertaken training in personalised care and support planning.	n/a		Report		Report		Report						Work has commenced in preparation for Q2 reporting	Jun-17				
	Specialised	£150,000			**Haemoglobinopathy improving pathways**			Baseline Report, annual Q1	Evidence of governance arrangements (quarterly reports)	% of total registered patients in ODN attending for annual review at the Lead / Specialist Centre and plan to demonstrate performance to target of 85% by end of Yr 3 (quarterly reports)	Improvement in agreed patient satisfaction and outcome measure(s) (quarterly against baseline)	Met		Report		Report		Report						This is a well-established scheme which has been in place over the last couple of years.	Jun-17				
	Specialised	£130,000			**Paediatric Networked Care to Reduce Recourse to Critical Care Distant from Home**			Trigger 1 - Part 1: Ensure full and ongoing completion of PCCMDS as per Information Standards Notice SCCI0076 Amd 113/2015 - 'Paediatric Critical Care Minimum Data Set, Version 2.0'. The full conformance date as per the ISN is 1st December 2016.	Trigger 2 - To provide support to the lead PICU centre in conducting a review of the Provider against the Paediatric Intensive Care (PICS) standards prior to July 2017.	Trigger 3 - Ongoing participation with West Midlands Paediatric Critical Care Network meeting, including representation at meetings and implementation of clinical protocols as agreed by the Network. This may include (but is not limited to): • Condition specific treatment and referral protocols • Incident Reporting System (Pedicrid)		n/a		Report		Report		Report						The data set provision is outstanding as Cerner development is awaited (for October 2017) hence partial met	Jun-17				
	Specialised	£141,197			**Activation systems for patients with long term conditions**		HIV					n/a		Report		Report		Report						Work yet to be progressed.	Jun-17				
	Public Health	£55,978			**Secondary Care Dental : Audit of Day Case Activity**		A prospective audit and re-audit of day-case activity carried out in the department in accordance with the Terms of Reference issued by the service commissioner.		Initial audit report by 21 July 2017, Plan to address any identified issues by 20 October 2017, report of Follow up Audit by 20 April 2018.		Follow up Audit to be carried out by 31 March 2018 and reported by 20 April 2018.	n/a		Report		Report		Report						Work yet to be progressed.	Jun-17				
	Public Health	£31,228			**Bowel Screening**			Report	Report	Report	Report	Met		Report		Report		Report						Scheme reports to the national screening programme and has been ongoing for the last 2 years	Jun-17				
	Public Health	£39,417			**Bowel Scoping**			Report	Report	Report	Report	Met		Report		Report		Report						Scheme reports to the national screening programme and has been ongoing for the last 2 years	Jun-17				
	Public Health	£92,044			**Breast Screening**			Report	Report	Report	Report	Met		Report		Report		Report						Scheme reports to the national screening programme and has been ongoing for the last 2 years	Jun-17				

Local Quality Indicators - 2017/2018

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory		Previous Months Trend (From Feb 2016)																Data Period	Group							Month	Year To Date	Trend
					Year	Month	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J		M	SS	W	P	I	C	CO			
			Safeguarding Adults Advanced Training	=> %	85	85	-	-	-	-	-	-	-	80	80	81	81	80	79	81	81	81	79	83	Jul 2017								83.222	80.98	
			Safeguarding Children Level 2 Training	=> %	85	85	-	-	74	73	73	72	73	71	71	73	75	76	77	77	78	79	78	78	Jul 2017								77.9	78.2	
			Safeguarding Children Level 3 Training	=> %	85	85	-	-	71	72	72	75	74	73	73	75	78	78	81	84	85	88	89	88	Jul 2017								87.8	87.4	
			WHO Safer Surgery - Audit - brief and debrief (% lists where complete) - SQPR	=> %	100	100	-	-	99	99	99	100	99	100	98	97	95	97	99	99	98	98	98	99	Jul 2017	98.3	99.4	100					98.9	98.3	
			Morning Discharges (00:00 to 12:00) - SQPR	=> %	35	35	-	-	16	15	17	17	13	16	16	17	17	20	17	16	16	15	17	17	Jul 2017	15.6	11.3	30.8					16.5	16.1	
			ED Diagnosis Coding (Mental Health CQUIN) - SQPR	=> %	85	85	-	-	88	88	87	87	87	87	85	86	86	86	86	87	86	86	85	84	Jul 2017								83.8	85.2	
			CO Level >4ppm Referred For Smoking Cessation - SQPR	=> %	90	90	-	-	91	89	73	80	83	76	83	92	80	78	93	87	80	86	76	82	Jul 2017								82.4	81.2	
			BMI recorded by 12+6 weeks of pregnancy - SQPR	=> %	90	90	-	-	83	81	79	79	78	87	86	82	81	84	81	77	78	80	79	88	Jul 2017								88.3	81.2	
			CO Monitoring by 12+6 weeks of pregnancy - SQPR	=> %	90	90	-	-	79	80	81	82	82	75	76	76	75	73	78	79	76	75	75	74	Jul 2017								73.8	74.7	
			Community Gynae - Referral to first outpatient appointment Within 4 weeks of referral	=> %	90	90	-	-	18	29	24	17	19	29	25	8	11	33	66	83	93	95	92	-	Jun 2017								91.7	93.3	
			Community Gynae - New to follow-up Ratio Less than 1 to 2	=> %	95	95	-	-	91	92	95	97	92	97	95	96	96	95	96	92	97	98	97	-	Jun 2017								97.0	97.4	
			Community - Screening For Dementia - SQPR	=> %	100	100	-	-	40	37	53	30	37	DATA QUALITY REVIEW ONGOING											Aug 2016								37.2	38.4	
			Community - HV Falls Risk Assessment - SQPR	=> %	100	100	-	-	61	67	56	61	55	DATA QUALITY REVIEW ONGOING											Aug 2016								54.8	60.0	

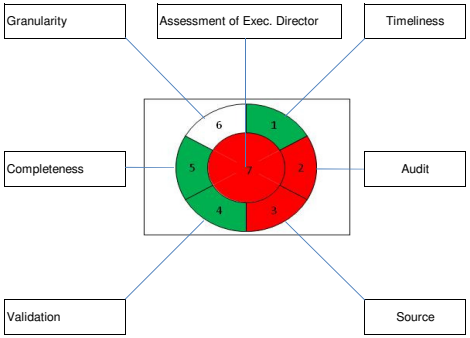
Legend

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 Year	Trajectory Month	Previous Months Trend F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Directorate EC	AC	SC	Month	Year To Date	Trend
Patient Safety - Inf Control	C. Difficile	<= No	30	3																			Jul 2017	0	0	0	0	4	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Jul 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective (%)	=> %	80	80																			Jul 2017	88	86	75	84.1		
Patient Safety - Inf Control	MRSA Screening - Non Elective (%)	=> %	80	80																			Jul 2017	92	87	88	91.4		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	19	20	14	14	16	9	7	5	12	Jul 2017	1	11	0	12	33	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	19	20	12	14	16	9	7	5	12	Jul 2017	1	11	0	12	33	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	4	0	0	0	0	0	0	0	1	Jul 2017	1	0	0	1	1	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	3	14	12	8	8	11	6	6	4	Jul 2017	1	3	0	4	27	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	5	6	2	11	5	1	6	3	1	Jul 2017	0	1	0	1	11	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	1	0	1	1	0	0	0	2	1	Jul 2017	0	1	0	1	3	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	-	-	-	-	5	2	1	0	0	1	1	1	5	Jul 2017	0	5	0	5	-	
Patient Safety - Harm Free Care	Falls	<= No	0	0	35	32	44	37	47	39	47	44	34	41	47	50	38	34	36	39	34	34	Jul 2017	13	21	0	34	143	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	1	1	0	0	2	1	2	2	0	2	3	3	1	2	1	1	0	0	Jul 2017	0	0	0	0	2	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	6	4	4	3	3	5	5	4	5	7	9	5	5	4	5	5	5	4	Jul 2017	0	4	0	4	19	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Jul 2017	93.8	88.7	98.4	95.3		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																	-		Jul 2017	100.0	80.0	98.5	99.5		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Jul 2017	100	99	0	99.7		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Jul 2017	100	95	0	98.3		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Jul 2017	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	Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Jul 2017	0	0	0	0	5	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98																	-	-	May 2017	45	63	42	51		

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Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			9.4	9.6	9.7	10.0	9.2	9.0	8.6	8.3	10.0	9.7	9.9	9.5	9.4	9.4	9.5	9.2	9.2	-	Jun 2017				9.2		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			10.1	10.0	9.8	9.8	9.7	9.5	9.3	9.2	10.0	9.3	9.4	9.4	9.4	9.4	9.4	9.3	9.3	-	Jun 2017					9.3	

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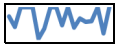
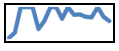
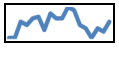
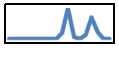
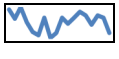
Section	Indicator		Trajectory Year	Trajectory Month	Previous Months Trend F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Directorate EC	AC	SC	Month	Year To Date	
Clinical Effect - Stroke & Card	Pts spending >90% stay on Acute Stroke Unit (%)	=> %	90.0	90.0																			Jul 2017		92.6		92.6	90.1	
Clinical Effect - Stroke & Card	Pts admitted to Acute Stroke Unit within 4 hrs (%)	=> %	90.0	90.0																			Jul 2017		73.6		73.6	70.8	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			Jul 2017		71.7		71.7	66.8	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.0																			Jul 2017		96.2		96.2	96.8	
Clinical Effect - Stroke & Card	Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			Jul 2017		75.0		75.0	60.0	
Clinical Effect - Stroke & Card	Stroke Admissions - Swallowing assessments (<24h) (%)	=> %	98.0	98.0																			Jul 2017		100.0		100.0	101.4	
Clinical Effect - Stroke & Card	TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=> %	70.0	70.0																			Jul 2017		80.8		80.8	95.5	
Clinical Effect - Stroke & Card	TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=> %	75.0	75.0																			Jul 2017		89.7		89.7	97.2	
Clinical Effect - Stroke & Card	Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=> %	80.0	80.0																			Jul 2017		100.0		100.0	94.7	
Clinical Effect - Stroke & Card	Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			Jul 2017		90.9		90.9	94.3	
Clinical Effect - Stroke & Card	Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			Jul 2017		100.0		100.0	100.0	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Jun 2017			92.8	92.8		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Jun 2017			100.0	100.0		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Jun 2017			85.4	85.4		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			6	3	3.5	1.5	3.5	3	4	3.5	1	2.5	2	1.5	3	2.5	2	2	4.5	-	Jun 2017	-	-	4.50	4.50	9	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			4.5	0	2	0	1	2	1.5	2	0	0	1	1	1	1	1	0	1	-	Jun 2017	-	-	1.00	1.00	2	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			154	98	175	95	130	113	107	140	75	71	107	111	135	105	140	91	106	-	Jun 2017	-	-	106	106		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0.0	0.0	-	-	10	8	12	13	5	15	12	12	19	17	8	6	0	6	4	10	Jul 2017	-	-	10	10	20	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	0	0	0	0	0	0	0	0	6	30	2	0	4	21	7	0	0	Jul 2017	0	0	0	0	28	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			47	39	49	36	28	25	40	23	27	40	35	40	45	42	34	42	40	27	Jul 2017	15	11	1	27	143	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			65	63	72	57	62	46	47	55	56	63	62	66	61	75	79	79	91	83	Jul 2017	46	33	4	83		

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Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	
			Year	Month	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J		EC	AC	SC			
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																		Jul 2017	2.86	-	0.25	0.29		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	2	Jul 2017	0.0	0.0	2.0	2	3	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	1	1	0	3	0	0	6	1	0	6	2	4	6	2	3	11	3	5	Jul 2017	1.0	0.0	4.0	5	22	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	32	31	58	56	54	28	32	28	57	44	29	51	37	41	28	35	63	31	Jul 2017	0.0	0.0	31.5	31.5		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017	0.00	0.00	0.00	0.00	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95.0	95.0																			Jul 2017	83.7	86.5	Site S/C	85.2	82.9	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			1560	1908	1246	1046	1187	1333	1227	1280	1579	1750	1866	1776	1769	1721	1662	1742	1580	1483	Jul 2017	1304	0	179	1483	6467	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0																			Jul 2017	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																			Jul 2017	14.0	14.0	Site S/C	14	14	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60.0	60.0																			Jul 2017	59.0	58.0	Site S/C	59	63	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			Jul 2017	8.9	9.4	Site S/C	9.2	8.6	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Jul 2017	5.1	6.9	Site S/C	6.0	6.2	
Emergency Care & Pt. Flow	WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	97	117	81	65	70	122	112	135	112	162	193	162	129	107	110	159	242	111	Jul 2017	63	48		111	622	
Emergency Care & Pt. Flow	WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	6	9	2	0	1	8	6	9	16	21	19	11	13	5	0	12	6	1	Jul 2017	0	1		1	19	
Emergency Care & Pt. Flow	WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Jul 2017	0.00	0.04		0.02	0.11	
Emergency Care & Pt. Flow	WMAS - Emergency Conveyances (total)	No			3961	4513	4115	4604	4099	4363	4204	4138	4233	4261	4622	4410	4034	4206	4137	4376	4254	4429	Jul 2017	2187	2242		4429	17196	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			Jul 2017	0.0	85.1	88.8	87.9		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			Jul 2017	0.0	71.6	90.4	83.8		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			Jul 2017	0.0	92.7	94.6	93.8		
RTT	RTT - Backlog	<= No	0	0	689	725	789	716	674	821	873	1172	1319	1168	1500	1154	897	622	610	479	497	467	Jul 2017	0	233	234	467		
RTT	Patients Waiting >52 weeks	<= No	0	0	3	4	0	0	0	1	0	0	1	2	1	0	0	1	1	2	1	7	Jul 2017	0	2	5	7		
RTT	Treatment Functions Underperforming	<= No	0	0	8	7	12	11	11	14	13	12	13	10	12	10	10	10	9	7	8	9	Jul 2017	0	5	4	9		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Jul 2017	0	0.57	0.65	0.59		

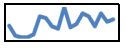
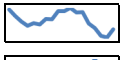
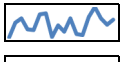
Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J		EC	AC	SC			
Data Completeness	Open Referrals	No			65,055	65,979	67,205	68,646	70,876	69,993	70,424	72,581	74,142	75,046	75,926	75,925	76,880	78,278	78,984	79,971	81,548	83,160	Jul 2017	14,779	24,270	44,111	83160		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Re	No			'	'	'	26,178	27,360	25,493	26,511	28,710	27,787	30,150	31,585	32,319	33,572	35,739	36,247	36,822	37,760	39,488	Jul 2017	11,026	12,972	15,490	39488		
Workforce	WTE - Actual versus Plan	No			201	219	220	207	213	220	229	231	229	231	244	202	194	208	205	199	227	236	Jul 2017	117.8	113.1	0	236		
Workforce	PDRs - 12 month rolling (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	82.51	77.63	0		81.5	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	56.52	80.43	0		81.0	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	4.52	4.68	0.00	4.61	4.65	
Workforce	Sickness Absence - In month	<= No	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	5.33	3.42	0.00	4.18	4.88	
Workforce	Sickness Absence - Long Term - In month	No			-	-	57	62	60	49	47	43	45	40	39	39	33	40	53	59	48	45	Jul 2017	20	16	9	45	205	
Workforce	Sickness Absence - Short Term - In month	No			-	-	212	186	195	180	179	162	194	206	243	223	207	182	66	68	80	131	Jul 2017	45	58	28	131	345	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	62.1	75.0	0.0		70.78	
Workforce	Mandatory Training (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	81.96	80.92	0		81.8	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			6	4	1	0	0	1	1	0	0	0	0	0	1	2	3	0	0	1	Jul 2017	1	0	0	1		
Workforce	Nurse Bank Fill Rate %	=> %	100	100	3002	4159	3992	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016				85		
Workforce	Nurse Bank Shifts Not Filled (number)	<= No	0	0	700	748	710	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016				710		
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-	
Workforce	Your Voice - Response Rate (%)	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	8	-->	-->	-->	-->	-->	11.8	Jul 2017	10.9	9.6	20.5	11.8		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.68	-->	-->	-->	-->	-->	-->	Jan 2017	3.51	3.90	3.58	3.68		

Surgical Services Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Directorate GS	SS	TH	An	O	Month	Year To Date	Trend
Patient Safety - Inf Control	C. Difficile	<= No	7	1	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	0	0	1	0	1	3	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	96.31	96.3	0	0	60.53	93.6		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	93.39	95.19	0	80	77.78	93.2		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	4	0	0	0	2	1	3	0	12	Jul 2017	7	0	0	5	0	12	16	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	4	0	0	0	2	1	3	0	12	Jul 2017	7	0	0	5	0	12	16	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	1	4	0	3	Jul 2017	0	0	0	3	0	3	8	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	0	0	0	0	1	0	3	0	6	Jul 2017	2	0	0	4	0	6	9	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	1	0	0	0	Jul 2017	0	0	0	0	0	0	1	
Patient Safety - Harm Free Care	Falls	<= No	0	0	7	12	8	9	4	12	12	9	10	12	13	8	6	6	10	7	11	11	Jul 2017	2	6	0	0	3	11	39	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	Jul 2017	0	0	0	0	0	0	1	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	1	2	2	0	2	2	0	4	0	1	1	2	1	1	3	0	2	Jul 2017	1	1	0	0	0	2	6	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	98.27	98.92	0	99.09	99.01	98.6		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	●	Jul 2017	99.87	99.75	0	100	100	99.9		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	100	100	98.59	0	100	99.4		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	100	100	98.59	0	100	99.4		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	1	0	0	0	0	1	0	0	0	1	0	0	0	0	0	1	1	0	Jul 2017	0	0	0	0	0	0	2	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	0	0	0	0	0	5	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	-	May 2017	29	0	0	0	0	18.2		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			6.9	7.1	6.4	6.2	5.5	6.6	5.4	5.9	6.0	5.1	5.9	6.0	6.3	5.7	6.2	6.5	6.3	-	Jun 2017						6.3		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.97	7.05	6.98	6.88	6.76	6.73	6.61	6.5	6.99	6.3	6.11	6	5.95	5.84	5.83	5.86	5.92	-	Jun 2017							5.9	

Surgical Services Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Directorate GS	SS	TH	An	O	Month	Year To Date	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Jun 2017	93.3	-	0.0	-	-	93.3		
Clinical Effect - Cancer	2 weeks (Breast Symptomatic)	=> %	93.0	93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Jun 2017	97.8	-	-	-	-	97.83		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Jun 2017	100.0	-	0.0	-	-	100		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Jun 2017	91.6	-	0.0	-	-	91.55		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			2	3	2	9	1	4	7	4	7	4	5	5	8	2	2	5	3	-	Jun 2017	-	-	-	-	-	3	9	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	1	0	1	0	1	2	2	2	2	2	0	2	1	1	1	0	-	Jun 2017	0	-	0	-	-	0	2	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			74	176	73	114	170	201	292	245	351	191	158	103	193	105	119	114	98	-	Jun 2017	98	-	0	-	-	98		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0	0	-	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017	0	-	0	-	-	0	0	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	1	0	8	0	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			28	38	45	29	27	24	38	30	37	29	26	32	25	36	24	29	20	28	Jul 2017	1	3	10	2	12	28	101	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			37	45	49	52	48	41	45	47	51	39	45	62	63	66	78	61	51	57	Jul 2017	5	9	19	5	19	57		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	2.84	0.77	0	0.47	1.72	1.96		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	1	0	3	4	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	33	20	18	18	22	45	43	32	29	57	31	35	49	45	32	49	38	41	Jul 2017	26	2	0	1	12	41	160	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	75.4	74.9	75.1	75.7	76	70.5	71.6	73.7	75.3	75.7	73	77.1	75.3	75.3	76.4	75.8	77.9	73.9	Jul 2017	71.4	75.6	0.0	66.1	77.5	73.87		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (%)	%	95.0	95.0	99.6	98.9	98.3	97.9	98.2	98.0	98.6	98.6	99.4	99.4	99.7	99.3	99.3	98.1	97.6	96.8	96.7	97.5	Jul 2017	-	-	-	-	97.5	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	<= No	0	0	62	98	109	82	80	119	121	63	92	76	109	70	68	112	137	109	93	106	Jul 2017	42	29	0	1	34	106	445	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017	-	-	-	-	0	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0	3.2	2.3	3.8	4.1	2.8	2.4	3.3	2.2	2.9	3.5	2.6	4.1	3.0	3.3	3.3	3.0	3.7	3.6	Jul 2017	-	-	-	-	3.59	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0	1.0	1.7	1.8	2.0	1.1	2.0	1.7	2.5	2.1	1.4	1.1	1.0	1.1	1.7	2.0	2.4	2.7	2.8	Jul 2017	-	-	-	-	2.82	-	-	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15	15	19	14	25	19	14	41	15	26	14	14	0	0	0	0	0	0	0	Jul 2017	-	-	-	-	14	0	0	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60	94	108	115	106	106	121	110	103	107	100	99	-	-	-	-	-	-	-	Jul 2017	-	-	-	-	117	-	-	
Emergency Care & Pt. Flow	Hip Fractures BPT (Operation < 36 hours of admissions	=> %	85.0	85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017						71.0	64.8	

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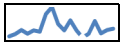
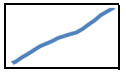
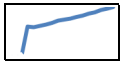
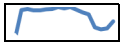
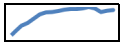
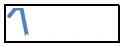
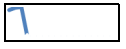
Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Directorate GS	SS	TH	An	O	Month	Year To Date	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	74.9	53.4	0.0	0.0	80.6	74.0		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	89.2	91.4	0.0	0.0	95.2	92.4		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	92.3	86.8	0.0	0.0	94.9	92.3		
RTT	RTT - Backlog	<= No	0	0	1243	1308	1236	1231	1227	1324	1350	1254	1369	1328	1514	1344	1153	1167	1304	1204	1293	1293	Jul 2017	575	400	0	0	318	1293		
RTT	Patients Waiting >52 weeks	<= No	0	0	2	3	3	1	2	3	0	1	2	0	1	0	2	2	4	1	1	1	Jul 2017	0	0	0	0	1	1		
RTT	Treatment Functions Underperforming	<= No	0	0	14	13	16	13	14	17	16	16	16	14	16	16	16	14	14	16	18	16	Jul 2017	9	6	0	0	1	16		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0.5	0.0	4.6	0.0	0.0	1.02		
Data Completeness	Open Referrals	No			96,175	97,723	100,371	102,540	104,891	107,435	109,035	110,630	112,597	113,840	115,090	116,146	118,262	121,184	123,687	126,992	129,204	131,460	Jul 2017	46,010	15,222	0	4,797	65,431	131460		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Req	No			-	-	-	36,039	35,257	36,835	38,367	40,451	42,937	44,084	45,279	47,179	48,985	51,471	53,057	55,792	57,290	59,198	Jul 2017	23,081	6,968	0	2,982	26,167	59198		
Workforce	WTE - Actual versus Plan	No			153	149	144	143	151	158	155	152	146	140	151	185	157	166	168	172	176	196	Jul 2017	52.08	35.32	29.03	23.07	52.52	195.55		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	85.4	86.5	90.2	84.1	88.0		85.9	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	82.76	100	0	76.74	76.92		81.2	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	4.6	5.8	7.1	4.3	2.3	4.8	4.7	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	5.4	7.2	7.3	4.4	2.4	5.3	4.9	
Workforce	Sickness Absence - Long Term - In Month	No			-	-	46	52	62	56	46	53	52	50	53	52	33	32	30	41	38	51	Jul 2017	17.0	11.0	14.0	8.0	0.0	51.0	160.0	
Workforce	Sickness Absence - Short Term - In Month	No			-	-	164	169	161	162	168	169	181	173	181	166	149	138	61	50	55	96	Jul 2017	28.0	19.0	25.0	22.0	0.0	96.0	262.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	86.9	77.0	87.7	81.8	81.8	83.6	83.6	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	86.2	85.2	91.6	87.5	84.4		86.6	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-		-	
Workforce	New Investigations in Month	No			1	2	0	0	0	2	0	1	3	0	0	2	1	2	2	0	0	2	Jul 2017	0	0	2	0	0	2		
Workforce	Nurse Bank Fill Rate	=> %	100.0	100.0	64.9	86.3	88	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016						88.03	88	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	216	233	282	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016						238	238	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00						-	-	

Surgical Services Group

Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	30	-->	-->	-->	-->	-->	15.3	Jul 2017	20.5	13.2	5.2	18.4	14.3	**15.3**	
Workforce	Your Voice - Response Score	%			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.79	-->	-->	-->	-->	-->	-->	Jan 2017	3.53	3.29	3.85	3.6	3.69	**3.79**	

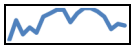
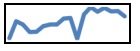
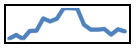
Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J		G	M	P			
Patient Safety - Inf Control	C. Difficile	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.00	80.00	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	93.1			92.4		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80.00	80.00	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	97.9		97.9		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	1	0	0	0	Jul 2017	0	0	0	0	1	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	1	0	0	0	Jul 2017	0	0	0	0	1	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	0	Jan-00	0	0	0	0	0	
Patient Safety - Harm Free Care	Falls	<= No	0	0	0	1	0	1	2	1	1	2	3	1	1	2	1	1	0	3	1	0	Jul 2017	0	0	0	0	4	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	99.4	96.5		97.5		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	●	Jul 2017	100	100		100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	100	100		100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	100	100		100.0		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	0	0	0	1	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Directorate G	Directorate M	Directorate P	Month	Year To Date	
Patient Safety - Obstetrics	Caesarean Section Rate - Total	<= %	25.0	25.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017		25.9		25.9	25.2	
Patient Safety - Obstetrics	Caesarean Section Rate - Elective	%			8	8	10	7	9	8	9	10	8	11	8	7	9	8	9	8	9	7	Jul 2017		7.45		7.5	8.3	
Patient Safety - Obstetrics	Caesarean Section Rate - Non Elective	%			15	18	17	15	15	19	19	19	23	17	20	15	17	17	17	15	17	18	Jul 2017		18.4		18.4	16.8	
Patient Safety - Obstetrics	Maternal Deaths	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017		0		0	0	
Patient Safety - Obstetrics	Post Partum Haemorrhage (>2000ml)	<= No	48	4	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017		1		1	10	
Patient Safety - Obstetrics	Admissions to Neonatal Intensive Care	<= %	10.0	10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017		0.78		0.8	1.4	
Patient Safety - Obstetrics	Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017		9.67		9.7		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	90.0	90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Jun 2017		77.6		77.6		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017		130		129.8		
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100.0	97.0	N/A	●	●	●	●	N/A	●	N/A	●	●	●	●	●	N/A	N/A	N/A	-	-	May 2017	0	0	0	0.0		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			6.7	5.5	4.9	5.0	4.7	4.4	4.2	3.9	5.4	5.9	5.0	4.0	5.4	4.7	4.6	4.5	4.8	-	Jun 2017				4.8		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.1	5.9	5.8	5.6	5.4	5.2	5.2	5.1	5.4	5.0	5.0	5.0	4.9	4.8	4.8	4.7	4.7	-	Jun 2017					4.7	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0	●	●	●	●	●	●	●	●	●	#DIV/0!	●	●	●	●	●	●	●	-	Jun 2017	92.9		0	92.9		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Jun 2017	92.6			92.6		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Jun 2017	84.6			84.6		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			2	0	3	1	2	0	0.5	0.5	1.5	4	3	2	4.5	3.5	4.5	3	2	-	Jun 2017	2	-	0	2	9.5	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	0	1	0	1	0	0	0	0	0	0	0.5	1.5	3.5	3	1	0	-	Jun 2017	0	-	0	0	4	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			97	62	149	86	176	62	70	97	76	98	98	120	150	162	126	139	95	-	Jun 2017	95	-	0	95		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0	0	-	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017	0	-	0	0	0	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Directorate G	M	P	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	Jul 2017	0			0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			4	13	5	10	9	15	15	15	12	9	12	14	14	12	13	8	12	6	Jul 2017	1	3	2	6	39	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			6	17	9	13	10	19	21	23	23	16	21	24	24	22	19	12	15	14	Jul 2017	0	0	0	14		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Jul 2017	2.06		-	1.4		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	Jul 2017	0			0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	7	13	4	10	9	4	6	9	12	6	10	6	12	10	12	5	17	4	Jul 2017	4			4	38	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	71	78	76	73	74	76	76	76	79	79	71	80	83	81	83	82	82	80	Jul 2017	79.7	-		79.7		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017	0	-	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			15	6	16	5	5	10	7	43	18	38	38	20	23	15	9	10	7	11	Jul 2017	9	0	2	11	37	
RTT	RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Jul 2017	68.1			68.1		
RTT	RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Jul 2017	95.6			95.6		
RTT	RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Jul 2017	94.2			94.2		
RTT	RTT - Backlog	<= No	0	0	70	80	69	92	93	130	121	129	161	161	160	111	96	96	98	81	97	91	Jul 2017	91			91		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	Jul 2017	0			0		
RTT	Treatment Functions Underperforming	<= No	0	0	0	1	1	0	1	2	2	2	2	3	3	2	1	2	1	1	1	1	Jul 2017	1			1		
RTT	Acute Diagnostic Waits in Excess of 6-weeks	<= %	0.1	0.1																			Jul 2017	0			0.0		

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Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Directorate G	M	P	Month	Year To Date	
Data Completeness	Open Referrals	No			23,021	22,929	23,294	24,026	24,973	24,866	25,230	25,985	26,671	27,018	27,523	27,970	28,605	29,483	30,091	30,838	31,759	32,486	Jul 2017	8,533	16,023	7,930	32486		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			-	-	-	10,041	10,069	10,168	10,770	11,488	11,421	12,342	12,816	13,222	13,822	14,698	15,253	15,849	16,571	17,454	Jul 2017	4,806	10,308	2,340	17454		
Workforce	WTE - Actual versus Plan	No			94.7	91.8	87.3	101	99.2	97.1	118	116	107	109	126	119	111	116	119	124	116	117	Jul 2017	7.5	76.1	32.9	116.7		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	89.7	88.4	91		90.2	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	92.3	100	100		90.2	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	4.09	5.3	2.88	4.5	4.6	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	2.29	5.45	3.11	4.4	4.5	
Workforce	Sickness Absence - Long Term - in month	No			-	-	40	36	34	39	43	44	43	43	30	30	23	29	27	36	28	31	Jul 2017	4	23	4	31.0	122.0	
Workforce	Sickness Absence - Short Term - in month	No			-	-	99	105	94	111	96	106	113	125	114	142	83	105	50	41	40	88	Jul 2017	8	52	28	88.0	219.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	89.8	84.6	84.6	85.07	84.7	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	81.5	89.8	87.9		88.5	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			1	0	1	0	0	1	1	0	0	0	0	0	0	1	3	1	0	0	Jul 2017	0	0	0	0		
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			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	13	-->	-->	-->	-->	-->	16	Jul 2017	14.1	12.6	24.8	16		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.66	-->	-->	-->	-->	-->	-->	Jan 2017	3.54	3.72	3.6	3.7		

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	
			Year	Month	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J		G	M	P			
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			193	159	207	198	244	253	219	255	119	131	109	126	-	-	-	-	-	-	Jan 2017		126		126	1861	
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	91.9	89	86.9	88.6	86.7	92.4	86.1	87.6	85.3	84.6	95.7	90.5	88.3	-	-	-	-	-	Feb 2017		88.3		88.25	88.5	
WCH Group Only	HV (C3) - % of births that receive a face to face new birth visit by a HV >days	%			6.68	9.33	12.8	11.4	11.8	8.76	12.3	10.5	7.71	1117	3.23	7.22	9.56	4.81	-	-	-	-	Mar 2017		4.81		4.81	18.29	
WCH Group Only	HV (C4) - % of children who received a 12 months review by 12 months	=> %	95.0	95.0	90.3	94.4	98.2	97.7	94.8	98.6	96.6	95.8	90.1	93.9	94.6	95.6	97.2	96.2	-	-	-	-	Mar 2017		96.2		96.23	95.74	
WCH Group Only	HV (C5) - % of children who received a 12 months review by the time they were 15 months	%			97.9	96.2	99.7	99.5	97.1	100	100	99.5	98.8	98.4	98.5	99.3	1.29	95.8	-	-	-	-	Mar 2017		95.8		95.82	90.93	
WCH Group Only	HV (C6i) - % of children who received a 2 - 2.5 year review	=> %	95.0	95.0	88.9	95.6	99	97.5	96.6	96	96	94.3	91.5	95.4	94.1	93	92.1	90.1	-	-	-	-	Mar 2017		90.1		90.07	94.55	
WCH Group Only	HV (C6ii) - % of children who receive a 2 - 2.5 year review using ASQ 3	%			84.2	81.6	89.2	81.9	86	88.7	88.3	91.5	92.8	89.4	89.2	89.7	82.5	84.2	-	-	-	-	Mar 2017		84.2		84.16	87.69	
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	1	1	-	-	-	-	Mar 2017		1		1	12	
WCH Group Only	HV (C8) - % of children who receive a 6 - 8 week review	=> %	95.0	95.0	93.6	96	97.9	92.8	94.9	97.8	99.2	97	95	95.9	93.9	96.9	-	95.5	-	-	-	-	Mar 2017		95.6		95.55	96.16	
WCH Group Only	HV - % of infants for whom breast feeding status is recorded at 6 - 8 week check	=> %	100	100	99.3	99.4	99.8	99.4	99.7	99.8	99.5	99.3	94	93.6	87.9	98.6	-	86.1	-	-	-	-	Mar 2017		86.1		86.13	96.22	
WCH Group Only	HV - % of infants being breastfed at 6 - 8 weeks	%			35.6	43.9	42.8	39.4	41.7	49.3	40.6	39.6	40.7	37.6	43.5	43.5	-	42.2	-	-	-	-	Mar 2017		42.3		42.25	41.99	
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	-	-	100	100	100	100	100	100	100	100	100	100	100	-	-	-	-	-	Feb 2017		100		100	100	
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			391	341	382	400	391	391	365	413	313	132	306	377	-	357	-	-	-	-	Mar 2017		357		357	3827	
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	100	100	100	98.8	98.7	101	97.3	96.3	92.4	91.3	93.5	97.2	-	91.3	-	-	-	-	Mar 2017		91.3		91.3	96.27	
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check	No			322	358	411	322	369	393	376	409	347	330	310	342	-	322	-	-	-	-	Mar 2017		322		322	3931	
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	98.8	100	99.8	99.4	99.7	95.4	96.7	94.9	89.4	86.6	86.5	88.6	-	97.9	-	-	-	-	Mar 2017		97.9		97.87	94.05	
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			294	339	290	341	355	393	375	346	347	339	323	343	-	-	-	-	-	-	Jan 2017		343		343	3452	
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	92.2	91.6	91.2	90.9	92	91.4	85.6	86.3	83.6	86.7	82.4	89.8	-	-	-	-	-	-	Jan 2017		89.8		89.79	87.88	

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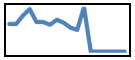
WCH Group Only	HV - movers into provider <1 year of age to be checked =<14 d following notification to HV service	No			39	39	51	60	42	42	38	45	41	34	31	63	-	-	-	-	-	-	Jan 2017	63	63	447	
WCH Group Only	HV - all untested babies <1 year of age will be offered NBBS screening & results to HV.	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	

Pathology Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Directorate HA	HI	B	M	I	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	0	0	0	0	0	0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2017	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2017	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2017	-	-	-	-	-	-		
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			4	2	3	4	2	1	2	1	2	3	2	4	1	2	1	1	1	0	Jul 2017	0	0	0	0	0	0	3	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			4	3	3	5	4	2	2	2	3	3	1	3	4	4	3	2	2	3	Jul 2017	2	0	0	0	1	3		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jul 2017	-	-	-	-	-	-	-	
Data Completeness	Open Referrals	No			3,294	3,420	3,572	3,639	3,701	3,868	5,631	5,764	5,995	6,051	6,140	6,284	6,387	6,495	6,601	6,770	6,960	7,039	Jul 2017	2,061	0	2,373	0	2,605	7,039		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			-	-	-	1,502	1,437	1,510	2,208	2,275	2,407	2,444	2,478	2,613	2,685	2,791	2,845	2,956	3,034	3,321	Jul 2017	1,152	0	1,160	0	1,009	3,321		
Workforce	WTE - Actual versus Plan	No			22.9	30.3	25.7	31.6	35.2	39	39.8	38.4	40	37	31	34.7	30.3	23.7	18.7	28.1	27.9	30.2	Jul 2017	10.4	5.27	8.89	3.96	-1.2	30		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	96.4	88.6	94.2	93.1	96.2		94.62	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	75	100	100	66.7		79.69	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	3.37	2.96	4.2	3.37	3	3.72	3.88	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	3.7	0.6	4.0	4.3	2.7	3.86	3.16	
Workforce	Sickness Absence - Long Term - In Month	No			-	-	10	12	14	14	15	13	12	14	6	5	6	8	6	6	6	8	Jul 2017	3.0	0.0	2.0	2.0	0.0	8	26	
Workforce	Sickness Absence - Short Term - In Month	No			-	-	47	45	38	35	36	30	43	49	41	36	35	45	30	30	39	40	Jul 2017	6.0	0.0	17.0	6.0	3.0	40	139	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	90.5	92.9	75.1	97.7	97.1	85.5	85.5	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	90.8	93.9	90.3	91.8	96.8		91.2	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	0	0	0	0	0	2	0	0	0	1	0	0	0	0	0	0	Jul 2017	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			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	22	-->	-->	-->	-->	-->	23.7	Jul 2017	14.8	31.4	20.2	35.7	33.3	24		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.82	-->	-->	-->	-->	-->	-->	Jan 2017	3.54	3.32	3.89	4.01	3.93	3.82		

Imaging Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	Data Period	Directorate DR	IR	NM	BS	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	0	0	0	0	0	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	<= No	0	0	2.0	-	2.0	1.0	2.0	1.0	3.0	1.0	-	2.0	2.0	1.0	-	1.0	1.0	2.0	2.0	-	Jun 2017					6.7		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	=> %	0	0	12.0	12.0	14.0	13.0	13.0	12.0	14.0	14.0	13.0	15.0	17.0	17.0	15.0	16.0	15.0	16.0	16.0	-	Jun 2017						4.37	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017			71.7		71.7	66.84	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.00	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017			96.23		96.23	96.84	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2017	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2017	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2017	-	-	-	-	-		
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	Jul 2017	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			6	5	2	0	1	1	2	1	1	4	5	4	1	1	4	2	2	3	Jul 2017	3	0	0	0	3	11	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			6	5	2	1	2	2	2	0	1	4	9	3	2	2	1	3	4	5	Jul 2017	5	0	0	0	5		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jul 2017	-	-	-	-	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			49	62	36	67	69	86	66	54	55	60	55	66	54	100	102	128	94	106	Jul 2017	106	0	0	0	106	430	
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0.2				0.2		
Data Completeness	Open Referrals	No			271	286	288	298	325	342	361	376	399	428	438	461	481	498	512	532	545	560	Jul 2017	560	0	0	0	560		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			'	'	'	267	267	299	315	331	346	373	396	403	421	438	454	474	492	506	Jul 2017	506	0	0	0	506		
Workforce	WTE - Actual versus Plan	No			44.2	46.3	48.5	51	44.2	44.5	47	45.4	40.8	40.2	38.5	32.4	31.4	32	35	38.9	35.7	34.7	Jul 2017	21.7	2.95	2.01	3.99	34.7		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	84.1	80	88.9	87.5		87.5	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	100	0	50	50		89.7	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	3.3	9.5	2.4	3.9	4.30	4.26	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	2.9	0.0	1.4	3.5	3.70	3.99	
Workforce	Sickness Absence - Long Term - in month	No			-	-	10	10	8	8	7	6	7	13	10	15	13	9	6	10	7	7	Jul 2017	0.0	1.0	0.0	2.0	7.00	30.00	
Workforce	Sickness Absence - Short Term - in month	No			-	-	33	39	38	31	23	26	29	41	40	53	36	32	29	22	24	22	Jul 2017	11.0	0.0	2.0	2.0	22.00	97.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	71	14.3	79.5	65.9	72.1	71.4	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	83.4	92.9	91.6	93.6		87.7	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-		-	
Workforce	New Investigations in Month	No			0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jul 2017					0		
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	20	-->	-->	-->	-->	-->	23.8	Jul 2017	20.2	10	51.9	22.8	23.8		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.58	-->	-->	-->	-->	-->	-->	Jan 2017	3.43	0	4.07	4.17	3.58		
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	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J		AT	IB	IC			
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.0	80.0																			Jul 2017	0	0	0	0		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	2	2	1	0	5	4	4	1	3	Jul 2017	0	3	0	3	12	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	2	2	2	0	5	4	4	1	3	Jul 2017	0	3	0	3	12	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	2	0	0	0	0	0	0	0	2	Jul 2017	0	2	0	2	2	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	1	1	2	0	0	3	2	3	0	Jul 2017	0	0	0	0	8	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	1	0	0	0	0	2	2	4	0	Jul 2017	0	0	0	0	8	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	0	Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	-	-	-	-	0	0	0	0	0	2	0	0	0	Jul 2017	0	0	0	0	2	
Patient Safety - Harm Free Care	Falls	<= No	0	0	23	20	22	38	31	29	31	29	33	30	27	20	19	31	23	21	36	36	Jul 2017	5	31	0	36	116	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	1	1	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	1	Jul 2017	0	0	1	1	1	
Patient Safety - Harm Free Care	Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	0	4	2	4	2	3	1	1	0	1	3	2	2	1	5	1	1	1	Jul 2017	-	1	-	1	8	
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Jul 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Jul 2017	0	0	1	1	1	
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	Jul 2017	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			6	7	3	5	5	4	5	4	3	8	4	6	1	1	4	3	8	4	Jul 2017	2	2	0	4	19	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			6	7	11	7	9	8	9	7	5	5	6	6	6	6	9	10	12	9	Jul 2017	2	6	1	9		

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J		AT	IB	IC			
Workforce	WTE - Actual versus Plan	No			100	106	102	123	128	154	152	135	104	109	122	115	112	118	128	130	131	132	Jul 2017	35.5	56	40.6	132.09		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	88.8	92.6	92.5		92.3	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	3.14	4.91	3.89	4.04	4.01	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	3.15	6.34	2.91	4.22	3.87	
Workforce	Sickness Absence - Long Term - in month	No			-	-	26	25	26	24	27	29	22	23	29	32	24	24	24	19	19	15	Jul 2017	2	-	-	15	77	
Workforce	Sickness Absence - Short Term - in month	No			-	-	65	59	81	80	83	53	74	104	101	102	93	82	57	60	57	78	Jul 2017	7	38	32	78	252	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	68.8	80.1	80	77.57	78.23	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	90.2	0		90.2	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			2	0	0	0	2	0	1	0	0	0	1	0	0	0	0	0	1	0	Jul 2017				0		
Workforce	Nurse Bank Fill Rate	=> %	100	100	78.3	89.3	87.9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	87.87	87.87	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	78	86	87	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	87	87	
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	29	-->	-->	-->	-->	-->	29	Jul 2017	31.1	24.1	31.1	29		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.83	-->	-->	-->	-->	-->	-->	Jan 2017	3.72	3.72	3.96	3.83		

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	
			Year	Month	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J		AT	IB	IC			
Community & Therapies Group Only	DVT numbers	=> No	730	61	65	51	53	55	74	-	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2016				74	182	
Community & Therapies Group Only	Adults Therapy DNA rate OP services	<= %	9	9	9	8.06	9.9	8.82	9.6	8.85	9.01	9.22	7.88	7.37	12.2	12.2	8.97	8.04	8.47	8.18	1177	-	Jun 2017				1177.1	56.2	
Community & Therapies Group Only	Therapy DNA rate Paediatric Therapy services	<= %	9	9	-	-	-	1.58	1.58	1.58	1.58	1.29	0	1.42	0.87	3.94	1.15	-	-	-	-	-	Feb 2017				1.2	1.4	
Community & Therapies Group Only	Therapy DNA rate S1 based OP Therapy services	<= %	9	9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-	
Community & Therapies Group Only	STEIS	<= No	0	0	1	1	0	0	2	0	0	2	1	1	0	0	0	0	0	0	-	1	Jul 2017				1	1	
Community & Therapies Group Only	Green Stream Community Rehab response time for treatment (days)	<= No	11.0	11.0	24	24	23	17	17	-	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2016				17	57	
Community & Therapies Group Only	DNA/No Access Visits	%			1	0	1	1	2	3	2	2	2	2	2	1	2	-	-	-	-	-	Feb 2017				2.1		
Community & Therapies Group Only	Baseline Observations for DN	=> %	100	100	-	-	-	-	38.5	42.4	41.5	60.1	36.8	53	57.3	55.8	59.2	56.3	66.8	-	-	56.3	Jul 2017				56.25	61.41	
Community & Therapies Group Only	Falls Assessments - DN Intial Assessments only	%			55	54	61	161	70	61	55	65	42	77	69	60	62	58	69	-	-	58	Jul 2017				57.81		
Community & Therapies Group Only	Pressure Ulcer Assessment - DN Intial Assessments only	%			56	58	64	67	75	65	63	71	47	80	71	63	65	63	77	-	-	65	Jul 2017				64.71		
Community & Therapies Group Only	MUST Assessments - DN Intial Assessments only	%			32	32	37	35	40	36	32	37	26	52	46	48	36	46	58	-	-	49	Jul 2017				49.35		
Community & Therapies Group Only	Dementia Assessments - DN Intial Assessments only	%			31	21	40	37	11	30	37	45	14	53	53	52	62	44	55	-	-	60	Jul 2017				60.29		
Community & Therapies Group Only	48 hour inputting rate - DN Service Only	%			94	94	93	91	90	90	92	86	94	93	93	69	93	94	92	-	-	-	Apr 2017				91.84		
Community & Therapies Group Only	Making Every Contact (MECC) - DN Intial Assessments only	%			-	7	-	-	200	222	222	270	177	251	369	308	382	460	488	-	-	428	Jul 2017				55.73	60.94	
Community & Therapies Group Only	Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload acquired)	No			-	3	3	2	1	4	3	2	0	2	5	6	8	6	5	8	5	8	Jul 2017				8	26	
Community & Therapies Group Only	Avoidable Grade 2 Pressure Ulcers (DN caseload acquired)	No			-	3	3	2	1	3	1	1	0	2	2	4	6	3	5	8	3	5	Jul 2017				5	21	
Community & Therapies Group Only	Avoidable Grade 3 Pressure Ulcers (DN caseload acquired)	No			-	0	0	0	0	1	1	1	0	0	3	2	2	2	0	0	2	3	Jul 2017				3	5	
Community & Therapies Group Only	Avoidable Grade 4 Pressure Ulcers (DN caseload acquired)	No			-	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	Jul 2017				0	0	

Corporate Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate							Month	Year To Date	Trend
			Year	Month	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J		SG	F	W	M	E	N	O			
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			5	8	8	10	12	4	13	8	13	11	12	11	11	14	3	9	5	10	Jul 2017	2	0	0	1	0	4	3	10	27	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			4	7	8	9	12	9	17	10	13	18	13	12	17	19	16	17	10	13	Jul 2017	4	0	0	1	0	7	1	13		
Workforce	WTE - Actual versus Plan	No			83.2	96.4	102	128	101	106	130	146	123	118	133	98.6	94.5	105	99.5	103	102	102	Jul 2017	8.48	2.36	3.18	13.4	-3.07	40.1	37.8	102.16		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	62	80	89	89	94	92	89		90.2	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017			95					50.0	50	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	1.95	2.99	4.01	3.03	3.94	5.62	5.14	4.72	4.56	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	4.32	1.83	4.14	5.49	5.28	5.06	5.02	4.83	4.67	
Workforce	Sickness Absence - Long Term - in month	No			-	-	51	53	52	59	62	65	64	64	79	0	1	0	2	1	2	2	Jul 2017	2.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	7.00	
Workforce	Sickness Absence - Short Term - in month	No			-	-	192	176	173	153	160	181	203	224	191	7	8	8	3	2	3	1	Jul 2017	1.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	9.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	87.3	77.5	74.0	75.3	76.3	81.7	79.1	79.6	80.4	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul 2017	0	96	97	86	100	89	91	90.6	90	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	
Workforce	New Investigations in Month	No			2	2	4	4	1	4	1	1	0	0	2	1	1	4	6	0	2	1	Jul 2017	0	0	0	0	0	1	0	1		
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	18	-->	-->	-->	-->	-->	21	Jul 2017	67.7	41.5	42.9	30.4	30.3	6.6	21.9	21.2		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.64	-->	-->	-->	-->	-->	-->	Jan 2017	3.83	3.61	3.98	3.55	3.52	3.62	3.37	3.64		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	IPR Persistent Reds
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Finance & Performance Director
AUTHOR:	Yasmina Gainer, Head Performance Management & Costing
DATE OF MEETING:	7 September 2017

EXECUTIVE SUMMARY:

IPR - Indicators where Performance during the Last Year was Consistently below Targets

The Board has previously challenged and confirmed the relative priority and timescale for remediation of performance in respect of these KPIs.

This report has a focus on the 5 KPIs falling due for remediation in Q1 & Q2 of this year and which can be summarised as follows:

KPI	Due	Achieved now?	Revised target date	RAP
Early Booking Assessment [90% within 12 weeks]	Q1	NO 78% Q1	Change – now Q3	YES
Patient Safety Thermometer – Overall Harm Free Care [95%]	Q2	NO – marginal fail 2/4 mnths 94%	No change – P06 September	N/A
WHO safer surgery checklist – brief & debrief [100%]	Q2	NO 98% Q1; 99% P04	No change - P06 September	N/A
Neutropenic sepsis – treatment within 1 hour	Q2	NO 21 breaches Q1; 10 breaches P04	No change - P06 September	N/A
ED timeliness to initial assessment – 95th %ile within 15 minutes	Q2	YES Delivered P01-P04	N/A	N/A

The relevant remedial action plans [RAP] are appended to this report.

Work is on-going to determine specific milestone plans for delivery and month on month target trajectories against which performance can be monitored & reported.

Oversight and assurance shall continue to be provided through routine consideration at the executive PMC and non-executive Q&S Committee.

REPORT RECOMMENDATION:

The Board is recommended to:

1. challenge and confirm the revised remediation date and action plans
2. require at its next meeting a prospective assessment of those indicators falling due for remediation in Q3

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

Accept	Approve the recommendation	Discuss
		X

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	**x**
Clinical	**x**	Equality and Diversity		Workforce	
Comments:					
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
Accessible and Responsive Care, High Quality Care and Good Use of Resources.					
PREVIOUS CONSIDERATION:					
Operational Management Committee, Performance Management Committee, CLE, Q&S Committee					

Early Booking Assessment – Action Plan

Ref	Issue identified	Action to be taken	Lead[1]	By when
IPR / RED KPI	The Trust Is failing to meet the Nationally set target of 90% for early booking of all pregnant women before 12+6 weeks gestation.	1. SWBH have taken part in National Project to review early booking access in line with National Screening programme- awaiting feedback.	PHE	September 2017
		2. Fast track bookings continue to be utilised.	CMW Matron	In progress
		3. Centralised referral, from GPs using standardised referral.	CMW Matron	In progress
		4. Transformation team reviewing current referral pathways within the community setting.	Transformation Team	November 2017
		5. Re audit to be undertaken to reconfirm reasons for late bookings. Allowing identification of areas for focus to improve early access.	DOM	November 2017
		6. Given the wider stakeholder inputs required to meet this target, agree improvement trajectory / joint action plan with commissioners / public health leads.	DOM / PHE/ CCG	October 2017
		7. Continue to work with GPs to encourage early access by women to maternity services.	DOM / PHE/ CCG	

[1] Leads

DOM	Director of Midwifery	CN	Chief Nurse
Mat CMW	Matron Community Midwifery	PHE	Public Health England
CCG	Clinical Commissioning Group	TT	Transformation Team

Persistent Red Recovery Plan

	Indicator	Directors' Priority Assessment			Lead	Plan In Place	Delivery Trajectory			
		NOW	SOON	LATER		Yes / No	Q1	Q2	Q3	Q4
Obstetric	Caesarean Section Rate - Total			√	Amanda Geary	Yes				x
	Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	√			Amanda Geary	Yes	x	→	→	
Harm Free Care	Patient Safety Thermometer - Overall Harm Free Care	√			Paul Hooton	Yes		x		
	Falls			√	Paul Hooton	Yes				Align to Quality Plan
	WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	√			Ajai Tyagi	Yes		x		
	Mortality Reviews within 42 working days		√		Roger Stedman	Yes			x	
	Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	√			Michelle Harris	Yes		x		
Cancelled Operations	Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	√			Tina Robinson	Yes	Scoping Theatre Improvement Programme		x	
	No. of Sitrep Declared Late Cancellations - Total	√				Yes			x	
	Weekday Theatre Utilisation (as % of scheduled)	√			Liam Kennedy	Yes				x
Access To Emergency Care & Patient Flow	Emergency Care 4-hour waits	√			Phil Holland	Yes				x
	Emergency Care 4-hour breach (numbers)	√			Phil Holland	Yes				x
	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	√			Michelle Harris	Yes	←	x		
	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	√			Michelle Harris	Yes			x	
	Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)		√		Phil Holland	No				x
	Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS		√		Phil Holland	No				x
	Patient Bed Moves (10pm - 6am) (No.) -ALL		√		Phil Holland	Yes			x	
	Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units		√		Phil Holland	Yes			x	
	Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	√			Tina Robinson	Yes			x	
Workforce	PDRs - 12 month rolling	√			Raffaela Goodby	Yes	Implementation of new PDR programme			Q4 for 2018/19
	Medical Appraisal	√			Roger Stedman	Yes			x	
	Sickness Absence (Rolling 12 Months)	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Sickness Absence (Monthly)	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Sickness Absence - Long Term (Monthly)	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Sickness Absence - Short Term (Monthly)	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Return to Work Interviews following Sickness Absence	√			Raffaela Goodby	Yes			x	
	Mandatory Training	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Mandatory Training - Health & Safety (% staff)	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Employee Turnover (rolling 12 months)	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Nursing Turnover	√			Raffaela Goodby	Yes	On-going programme of actions			x
Referral to Treatment (RTT)	RTT - Admittted Care (18-weeks)		√		Liam Kennedy	No			x	
	RTT - Non Admittted Care (18-weeks)		√		Liam Kennedy	No			x	
	Patients Waiting >52 weeks	√			Liam Kennedy	No				x
	Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	√			Liam Kennedy	Yes			x	
Open Referrals	Open Referrals - Without Future Appointments	√			Liam Kennedy	Yes	Resume project plan, kick off mtg in place			x
Friends and Family	FFT Response Rate - Adult and Children Inpatients (including day cases and community)			√	Elaine Newell	No				Q4 for 2018/19
	FFT Score - Adult and Children Inpatients (including day cases and community)			√		No				
	FFT Response Rate: Type 1 and 2 Emergency Department			√		No				
	FFT Score - Adult and Children Emergency Department (type 1 and type 2)			√		No				
	FFT Response Rate: Type 3 WiU Emergency Department			√		No				
	FFT Score - Outpatients			√		No				
	FFT Score - Maternity Birth			√		No				
	FFT Response Rate - Maternity Birth			√		No				
LD	Access to healthcare for people with Learning Disability (full compliance)		√		Elaine Newell	No				Q4 for 2018/19

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Cancelled operations in Ophthalmology - our improvement approach pan Trust to reduce theatre cancellations**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow, Chief Operating Officer**
AUTHOR:	**Tina Robinson, Group Director of Operations Surgical Services**
DATE OF MEETING:	**7th September 2017**

EXECUTIVE SUMMARY:

Over the past 12 months, the Trust has failed to achieve the national standard of less than 0.8% of elective operations being cancelled at the last minute for non-clinical reasons (as a percentage of elective admissions).

Hospital cancelations on the day of surgery result in delayed access to treatment and impact negatively on patients who have both emotionally prepared themselves for surgery and have re-organised their lives to support it.

Organisationally, excessive cancelations erode the ability of the Trust to meet its delivery of planned care to time and budget.

Review of the last 5 months performance in 2017 compared with the previous year demonstrates that performance has markedly deteriorated, although there has been a 47% improvement between April and August 2017.

The improvement focus on ophthalmology is significant due to the context of the proportional profile of surgical activity and the predictable nature of the surgical workload. To master the improvement and consistent practice here will be reassuring in terms of sustainable Trust wide improvement.

Improvement effort is focused on effective preoperative preparation and scheduling as well as compliance with the Trust cancellation policy. It is anticipated that we will achieve less than 0.8% cancellation performance at the end of Quarter 3.

REPORT RECOMMENDATION:

The Trust Board are asked to discuss this report and the actions identified with associated recovery trajectory.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

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

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

Excellence in the use of resources.
Sustainable finances
Patient experience

PREVIOUS CONSIDERATION:

Cancelled operations in Ophthalmology - our improvement approach pan Trust to reduce theatre cancellations

1. Background

Over the past 12 months, the Trust has failed to achieve the national standard of less than 0.8% of elective operations being cancelled at the last minute for non-clinical reasons (as a percentage of elective admissions).

	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17
%	1.2	1.0	1.0	1.5	1.1	0.9	1.7	1.2	1.3	1.5	1.3	1.2
No.	55	42	41	69	43	45	67	57	47	65	58	51

Hospital cancelations on the day of surgery result in delayed access to treatment and impact negatively on patients who have both emotionally prepared themselves for surgery and have re-organised their lives to support it. Organisationally, excessive cancelations erode the ability of the Trust to meet its delivery of planned care to time and budget.

2. Current Position

30 fewer patients were cancelled in August 2017 compared to April 2017 due to an improvement approach realising a 47% improvement. Very exceptional circumstances in August contributed to 5 of the 7 gynaecology breaches. Excluding these as a non-recurrent issue, gynaecology is demonstrating a sustained improvement over the period as are orthopaedics and progress is being made in Dermatology , ENT and General Surgery.

Review of the last 5 months performance in 2017 compared with the previous year demonstrates where performance has markedly deteriorated (highlighted in red); this informed the improvement approach by the top 4 reasons for non-clinical cancellations in the Trust:

- Lack of theatre time (not always aligned to utilisation rates)
- Notes and pre-operative preparation not satisfactorily completed
- No bed
- Equipment failure

The first 2 reasons accounted for 62% of cancellations pan Trust. The effectiveness of compliance with the cancellation policy which takes the decision making of cancellation to the Director of Operations, thus supporting and enabling mitigation to be put in place has also been critical to the improvement.

	Apr		May		Jun		Jul		Aug (MTD)	
Specialty	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Breast Surgery								1		
Cardiology			2	5					1	
Dermatology		2		4		2		4	5	2
Ent	3		2	3	9	4		6	4	3
General Surgery	6	7	1	4	10	2		6	7	4
Gynae Onc	1	1	1	2	5	6		1	1	1
Gynaecology	3	11	9	3	5	11	3	3	5	7
Ophthalmology	4	9	10	23		6	29	11	15	13
Oral Surgery	1	1		3		3	6	8	1	2
Paed Ophthalmology						1		1		1
Pain	2	1		5		2	1	1		
Plastic Surgery		1		1		1	4	2	2	
Rheumatology		1	1	2		1				
T&O		9	1	4		8	1		7	1
Urology	1	3	4	6		8	7	4	6	1
Vascular Surgery	1	1				3		1	1	
Grand Total	**22**	**47**	**31**	**65**	**29**	**58**	**51**	**49**	**55**	**35**

Ophthalmology

Although Ophthalmology has seen fewer cancellations during July and August compared with the previous year, the service continues to see the highest number of cancellations overall and as such a deep dive has been undertaken to understand the reason for late cancellations.

Of note, the number of cancellations in ophthalmology is proportionately comparable to other areas as they also undertake the highest number of elective procedures at c30%.

50% of cancellations in Ophthalmology are recorded as due to a lack of theatre time, missing notes/notes not checked fully or pre-operative planning; the theatre utilisation is below the expected 85%.

Reason	April	May	June	July	August	Grand Total
Hosp Cancel - Anaesthetist Sick					3	3
Hosp Cancel - Communication Error			1	1		2
Hosp Cancel - Consultant sick					3	3
Hosp Cancel - Doctor cancelled		1				1
Hosp Cancel - Emergency Fitted In	3	1	1	2		7
Hosp Cancel - Emergency In Theatre	1					1
Hosp Cancel - Equipment Failure		5				5
Hosp Cancel - Equipment not available		3		1		4
Hosp Cancel - Incomplete pre-ad carried out	1					1
Hosp Cancel - Incorrectly booked	1				1	2
Hosp Cancel - Infection Control - Theatres	1					1
Hosp Cancel - No Anaesthetist				2		2
Hosp Cancel - No Theatre Time	1	2	1	3	3	10
Hosp Cancel - Notes Missing	1	1	1	2		5
Hosp Cancel - Notes not checked fully			2		3	5
Hosp Cancel - Nurse Sick		10				10
Grand Total	9	23	6	11	13	62

25% of cancelations are due to staff sickness and 12% due to emergency work being undertaken in elective operating time.

The current improvement effort in this speciality includes:

- Preoperative preparation of lists with ‘completeness’ checks through the local scheduling meeting
- Ring-fenced time for emergency activity
- Review of maintenance schedule of equipment and availability to transfer equipment between sites
- Sickness management in line with Trust policy
- Consistent application of the cancellation policy

This improvement activity informs the performance trajectory below:

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
%	1.5%	1.3%	1.0%	0.9%	0.8%	0.8%	0.8%
No	10	8	7	6	5	5	5

To assist the rate of improvement additional operational capacity is being put into this speciality with emphasis on preoperative pathways and administration as well as effective scheduling in line with the production plan.

3. Conclusion

Actions implemented throughout July and August 2017 across all services have begun to show improvements across services with intensive focus demonstrated a marked reduction in cancellations. Other actions and supportive governance include:

- Improvement in timely escalation and support in the development of mitigation.
- Improvement in reporting accuracy challenge & timely validation
- Root Cause Assessment Completion and sign-off and sharing of learning through the Directorate structures.
- Senior attendance at weekly Theatre Scheduling meetings

Actions already in place will be continued with additional steps to include:

- Sandwell Theatre Team is conducting a 3 month trial in which it is revising shift patterns to slightly overshoot the traditional working day giving flexibility to list finishing times. If successful, the trial will be made permanent.
- Surgical Services is routinely reviewing the next day's predicted discharges / surgical take and re-assessing its potential to accommodate its overnight stay activity. The development of a bed prediction tool is being explored in support of this.
- Instances where 'patterns' of cancelations over time are being explored & plans developed to reduce or eliminate these. Proposed activities include; the planning of sessions using individual consultant procedure time in specialties that use team averages (& those averages result in regular cancelations).

The improvement approach informs the following improvement trajectory at Trust level as below:

	Sep-17	Oct-17	Nov-17	Dec-17	Jan18	Feb-18	Mar-18
%	1.1%	1.0%	0.9%	0.8%	0.8%	0.8%	0.8%
No	40	36	32	29	29	29	29

The Trust Board are asked to consider and discuss the report, improvement focus and associated trajectory.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Financial performance – P04 July 2017**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Finance Director**
AUTHOR:	**Tim Reardon – Associate Director of Finance**
DATE OF MEETING:	**7 September 2017**

EXECUTIVE SUMMARY:

Headline messages

This report deals with the financial performance for P04 July 2017/18 and indications for the performance in relation to statutory duties for the full year.

Year to date the trust is £2.1m behind plan (before STF) and which is being covered for reporting purposes by unplanned contingencies and flexibilities. This adverse position is driven by £1.9m under-delivery of the production plan with consequent shortfall on planned care income and £1.1m (25%) under-delivery of planned CIPs. The trust's monthly pay bill is flat at £26m and needs to be reduced at short order. Agency costs reduced to £1.4m [from £1.6m last month & £2.4m at December 2016].

It is foreseeable that at end Q2 the trust shall be £4m behind plan. This assumes step improvement in production plan delivery but with delivery risk against CIP plans which by P06 ramp up by c£1m a month. The headline results at Q2 will show this shortfall on plan being covered by a £16m one-off profit on the disposal of assets which was secured in P05.

Our plan for this year was for the delivery of (pre-STF) financial balance. An initial forecast out-turn for the year shows significant risk to that plan. Importantly it also shows an exit run rate of costs for March 2018 significantly higher than plan. This would perpetuate issues into the 2018.19 financial year and compound the scale of financial challenge for that year.

A specific risk is that relating to income recovery on SLAs with CCG commissioners. For P01 £0.5m remains in dispute. This is subject to a mediation process expected to be concluded on 8 September. The outcome to that process should set a precedent for resolving CCG data challenges related to subsequent periods.

The executive shall return to the Board at short order with a refined view of the forecast and how it intends to remediate that problem.

Key actions:

- Remedy production plan to meet target including income CIPs & stretch.
- Remedy ED 4hr performance to 90% by P06 to secure Q3/Q4 STF.
- Resolution of 2017.18 contract disputed items with SWBCCG.
- Accelerate CIP identification and delivery through implementation of FIP2 next steps plan.
- Secure Taper Relief funding from NHSE & CRL from NHSi.
- Complete forecast 2017.18 and confirm plausible route to delivery of pre-STF control total.

Key numbers:

- Headline year to date deficit -£6.0m being £0.3m behind plan due to STF A&E under-recovery.
- Underlying YTD deficit -£11.1m being £2.1m adverse to plan.
- STF of £1.9m assumed earned for year to date.
- Pay bill £26.2m (vs. £26.4m each of previous three months); Agency spend £1.5m (vs. £1.6m in P3).
- Capital spend at £6.9m is £4.3m behind plan to date.
- Cash at 31st July £12.6m being above plan by £11.8m.

REPORT RECOMMENDATION:

The Board is recommended to

- NOTE the report and specifically the requirement for remedial actions to address significant risks to forecast out-turn and exit run rate.
- REQUIRE those actions necessary to secure the required plan out-turn for FY 2017/18.

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	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:

PREVIOUS CONSIDERATION:

Finance Report

Period 04 2017/18
July 2017

Trust Board
7 September 2017

Contents

Finance Report

Summary & Recommendations

Period 04 2017/18

Statutory Financial Duties	Value	Outlook	Note
I&E control total surplus	£9.79m	X	1
Live within Capital Resource Limit	£46.6m	√	2
Live within External Finance Limit	£93.0m	√	3

1. Forecast surplus £9.7m formally reported. Downside risk.
2. CRL as plan submission and remains to be confirmed by NHSi.
3. EFL based on £9.9m surplus and opening cash of £14.4m. Compliance risk from P&L downside. Accelerated surplus asset disposal provides mitigation.

Outlook

- NHSI P04 return forecast surplus £9.4m, £549k below control total due to H1 A&E STF failure.
- Plausible route to pre-STF control total delivery identified but with risk. Over delivery on asset disposal profit but income stretch and CIP / expenditure avoidance need to make enhanced contribution. Formal re-forecast at P05.
- Capacity & capability build on-going through implementation of Board agreed FIP2 action plan.

P04 key issues & remedial actions

- P04 YTD headline performance reported as £341k behind plan due to STF A&E performance failure.
- Position is reliant on significant unplanned technical support and requires remediation by real CIP
- Planned care income significantly off target in P04 and requires remediation & stretch in remaining months.
- SLA income recovery risk from CCG data challenges
- Plausible route to pre-STF control total to be validated.
- Forecast exit run rate inconsistent with financial plan for recurrent balance going into 2018/19. Remediation plan requires accelerated [pay] cost reduction. TBC.
- Capex programme being pursued as plan. CRL remains to be confirmed by NHSi. Dialogue on-going.
- Near term revenue cash requirement covered by revised capex timing and asset disposal receipt now secured. Consequent revenue borrowing requirement pushed back to January 2018.
- Reduced agency spend P04 on P03; mobilisation of plan to secure first £10m reduction on-going.

Recommendation

- Challenge and confirm:
  - Forecast change to reflect H1 A&E failure
  - reported P04 position & specifically the assumptions underpinning the deployment of technical support.
  - plausible route to control total and require mitigating actions to reduce costs to be expedited.

Finance Report

Performance to date – I&E and cash

Period 04 2017/18

Financial Performance to Date

For the period to the end of July 2017 the Trust is reporting:

- P04 year to date reported as delivering to plan excluding STF
- Headline I&E deficit of £5,980k, a shortfall of £341k against NHSI profiled plan of £5,639k as a result of STF A&E failure.
- Underlying I&E deficit £11,051k being £2.1m adverse to plan
- Capital spend of £6,956k being £4,285k behind plan;
- Cash at 31 July £12,556k being £11,838k more than plan.
- Use of resources rating at 4 year to date.

I&E

P04 year to date reported as delivering to plan excluding STF, with A&E waiting time performance failure year to date at £341k .

The underlying delivery is dependent on the benefits from £2.1m of unplanned contingencies and flexibility.

Patient related income and pay are the main drivers of I&E underperformance. Planned Care is significantly behind internal plan to date and faces a step up in Q2 which remains to be fully secured.

SLA income recovery at significant risk from unresolved commissioner data challenges. £0.5m in dispute for P01.

Savings

Savings required in 2017/18 are £33m. Of this total £13.2m remain unidentified covered N/R by profit on disposal of surplus assets. CIP delivery to date is reported as £3.3m being in line with NHSI plan but £1.1m adverse to TPRS plans.

Immediate x8 work-streams being progressed to expedite savings identification and delivery.

Capital

Capital expenditure to date stands at £6.9m against a full year plan of £46.7m. Key variance to date in is respect of timing of milestone payments re EPR. The full year programme is subject to review having regard to MMH delay.

Cash

The cash position is £11.8m above plan at 31st July. This is due to the I&E position being offset, and funded, by capital cash in the first quarter.

The key issue for the Trust is the impact of prior year underlying deficits on the cash position. Year to date financials indicate that current year I&E performance is not making good these shortfalls. Achievement of EFL is based on I&E recovery and securing STF in full.

Any immediate requirement for revenue cash support is being covered by timing of capital cash outgoings. The revenue borrowing requirement anticipated for July in the plan will now be required in January 2018. This is as a result of the asset disposal proceeds receipt in August 2017.

Better Payments Practice Code

Performance in July deteriorated when measured by value and volume and continues to be below the target of 95%. It is expected that this target will not be achieved in FY 2017/18 given the cash position and the resulting extension of creditor terms that will be maintained.

Finance Report

Use of Resources Rating

Period 04 2017/18

Finance and use of resources rating	Expected Sign	03PLANYTD Plan 31/07/2017 YTD £'000	03ACTYTD Actual 31/07/2017 YTD £'000	03VARYTD Variance 31/07/2017 YTD £'000	03PLANCY Plan 31/03/2018 Year ending £'000	03FOTCY Forecast 31/03/2018 Year ending £'000	03VARCY Variance 31/03/2018 Year ending £'000	Maincode Subcode
Capital service cover rating	+	4	4		1	1		PRR0160
Liquidity rating	+	4	4		4	4		PRR0170
I&E margin rating	+	4	4		1	1		PRR0180
I&E margin: distance from financial plan	+		2			2		PRR0190
Agency rating	+	3	4		2	2		PRR0200

Overall finance and use of resources risk rating	Expected Sign	03PLANYTD Plan 31/07/2017 YTD £'000	03ACTYTD Actual 31/07/2017 YTD £'000	03VARYTD Variance 31/07/2017 YTD £'000	03PLANCY Plan 31/03/2018 Year ending £'000	03FOTCY Forecast 31/03/2018 Year ending £'000	03VARCY Variance 31/03/2018 Year ending £'000	Maincode Subcode
Overall rating unrounded	+		3.60			2.00		PRR0202
If unrounded score ends in 0.5	+		0.00			0.00		PRR0204
Plan risk ratings before overrides	+		4			2		PRR0206
Plan risk ratings overrides:								
Any ratings in table 6 with a score of 4 override - if any 4s "trigger" will show here	Text		Trigger			Trigger		PRR0208
Any ratings in table 6 with a score of 4 override - maximum score override of 3 if any rating in table 6 scored as a 4	+		4			3		PRR0210

The Trust use of resources rating year to date is 4 (red) with all metrics other than distance from financial plan showing 4.

- Capital service cover at 0.75 is marginally off plan due to I&E performance;
- Liquidity remains better than the plan due to lower levels of capital spending;
- I&E margin at -3.8% is marginally off -3.6% planned;
- Distance from financial plan is -0.2%;
- Agency spend is £1.1m more than plan resulting in a score of 4.

Finance Report

I&E Performance – Full Year

Period 04 2017/18

Period 4	CP Plan £'000s	CP Actual £'000s	CP Variance £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s	FY Plan £'000s	FY Forecast £'000s	FY Variance £'000s
Patient Related Income	35,436	35,057	(379)	141,418	136,663	(4,755)	424,405	424,405	0
Other Income	4,057	5,448	1,391	15,720	19,475	3,755	59,706	59,157	(549)
Income total	**39,493**	**40,505**	**1,012**	**157,138**	**156,138**	**(1,000)**	**484,111**	**483,562**	**(549)**
Pay	(25,560)	(26,188)	(628)	(103,772)	(105,447)	(1,675)	(300,666)	(300,666)	0
Non-Pay	(12,566)	(13,057)	(492)	(50,721)	(48,327)	2,394	(155,280)	(155,280)	0
Expenditure total	**(38,126)**	**(39,246)**	**(1,120)**	**(154,493)**	**(153,774)**	**719**	**(455,946)**	**(455,946)**	**0**
EBITDA	**1,367**	**1,259**	**(109)**	**2,645**	**2,364**	**(281)**	**28,165**	**27,616**	**(549)**
Non-Operating Expenditure	(2,099)	(2,098)	1	(8,352)	(8,353)	(1)	(9,271)	(9,271)	0
Technical Adjustments	18	19	1	68	10	(58)	(8,961)	(8,961)	0
DH Surplus/(Deficit)	**(714)**	**(820)**	**(107)**	**(5,639)**	**(5,980)**	**(341)**	**9,933**	**9,384**	**(549)**
Add back STF	*(699)*	*(594)*	*105*	*(2,271)*	*(1,930)*	*341*	*(10,483)*	*(9,934)*	*549*
Adjusted position	***(1,413)***	***(1,414)***	***(2)***	***(7,910)***	***(7,910)***	***(0)***	***(550)***	***(550)***	***0***
Technical Support (inc. Taper Relief)	*(250)*	*(491)*	*(241)*	*(1,000)*	*(3,141)*	*(2,141)*	*(3,000)*	*(3,000)*	*0*
Underlying position	***(1,663)***	***(1,906)***	***(243)***	***(8,910)***	***(11,051)***	***(2,141)***	***(3,550)***	***(3,550)***	***0***

The table shows performance against the NHSI planned levels of income, pay and non-pay spend. Internal plans have flexed budgets between these headings (eg to reflect NHSE commissioning oncology rather than it being provided by UHB) but maintain the year to date phasing of the bottom line surplus / deficit.

The trust reported a headline deficit for P04 YTD of £6.0m being £0.3m behind plan due to STF failure related to A&E 4hr waiting times performance.

This was reliant on the benefit of £3.1m of contingency and support of which £2.1m was unplanned.
This includes the use of taper relief funding which remains to be secured and against which there may be calls in future months.

The underlying deficit for P04 YTD is therefore recorded as £11.1m. This is £2.1m adverse compared with the plan underlying deficit of £8.9m.

Finance Report

Income Analysis

Period 04 2017/18

Performance Against SLA by Patient Type	Activity				Finance				Straight Forecast £000
	Annual Plan	Planned	Actual	Variance	Annual Plan £000	Planned £000	Actual £000	Variance £000	
A&E	227,129	76,582	75,592	-989	£24,194	£8,157	£8,345	£188	£25,036
Emergencies	43,972	14,707	15,002	295	£84,367	£28,290	£30,065	£1,775	£90,196
Emergency Short Stay	11,645	4,278	2,441	-1,837	£9,069	£3,328	£1,847	-£1,481	£5,542
Excess bed days	10,495	3,636	5,486	1,850	£2,906	£1,014	£1,448	£434	£4,344
Urgent Care					**£120,535**	**£40,790**	**£41,706**	**£916**	**£125,118**
OP New	169,764	58,380	61,355	2,974	£25,548	£8,791	£9,023	£232	£27,068
OP Procedures	61,597	21,190	23,486	2,296	£10,487	£3,607	£3,764	£157	£11,292
OP Review	387,088	133,091	111,421	-21,670	£27,008	£9,284	£8,103	-£1,181	£24,309
OP Telephone	12,965	4,447	4,555	108	£298	£102	£103	£1	£310
DC	39,887	12,889	11,517	-1,373	£32,844	£10,616	£9,280	-£1,336	£27,839
EL	6,408	2,071	2,173	102	£16,430	£5,315	£5,220	-£95	£15,660
Planned Care - production plan					**£112,615**	**£37,716**	**£35,493**	**-£2,223**	**£106,478**
Planned care outside production plan	24,234	10,923	11,866	943	£4,114	1,710	£1,676	-£35	£5,027
Maternity	20,284	6,722	6,680	-42	£19,193	£6,360	£6,449	£89	£19,347
Renal dialysis	565	184	204	20	£68	£22	£24	£2	£73
Community	619,003	212,303	218,691	6,389	£36,658	£12,482	£12,529	£46	£37,586
Cot days	12,932	4,464	4,451	-13	£6,782	£2,341	£2,243	-£99	£6,728
Other contract lines	3,623,854	1,210,471	1,301,076	90,605	£94,419	£32,410	£31,788	-£622	£95,365
Unbundled activity	68,721	25,738	23,829	-1,909	£7,629	£3,101	£2,931	-£170	£8,793
Other					**£168,863**	**£58,427**	**£57,639**	**-£788**	**£172,918**
Sub-Total: Main SLA income (excl fines)					**£402,013**	**£136,932**	**£134,838**	**-£2,094**	**£404,514**
Year to date refresh of prior months' data					£1	£1	£0	-£1	£0
Income adjustment - pass through drugs					£746	£242	£1,034	£792	£3,101
Fines and penalties					-£600	-£200	-£1,066	-£866	-£3,198
Cancer Drugs Fund					£2,636	£879	£264	-£615	£792
NHSE Oncology top up					£992	£0	£0	£0	£0
UHB Oncology					£3,970	£0	£0	£0	£0
National Poisons					£734	£245	£242	-£3	£725
SLA income -interpreting					£255	£85	£88	£4	£265
SLA income -Neurophys / Maternity etc					£1,735	£578	£511	-£68	£1,533
Mental Health Trust SLA					£29	£10	£7	-£2	£22
Individual funding requests					£0	£0	£23	£23	£70
Private patients					£236	£80	£27	-£53	£81
Overseas patients					£768	£256	£341	£85	£1,024
Prescription Charges Income					£39	£13	£12	-£1	£36
Injury cost recovery					£1,249	£416	£300	-£117	£899
NHSI Plan phasing adjustment					-£4	-£1,156	£0	£1,156	£0
Other adjustments					£3	-£1	£41	£42	£123
GRAND TOTAL patient related income					**£414,803**	**£138,381**	**£136,663**	**-£1,718**	**£409,989**

This table shows the Trust's year to date patient related income including SLA income performance by point of delivery as measured against the draft contract price & activity schedule.

Planned care within the production plan is behind by £2.2m for the year to date as measured against the [CCG] contract plan profile. The variance against the internal production plan profile is £1.6m.

Urgent care is over-performing in A&E and in excess bed days.
New outpatients is £0.2m ahead of plan at this stage.

The SWBCCG has disputed invoiced activity and which has potential for material impact to the trust forecast if not satisfactorily resolved.
P01 £0.5m remains in dispute and resolution process shall provide a basis for income recognition for the remainder of the year.
An assessment of the impact on forecast shall be indicated with P05 results.

Finance Report

CIP achievement

Period 04 2017/18

Year to Date up to Period 4	17/18 In Year Target	In Year Actual and Forecast Delivery												In Year 17/18 YTD
		Apr Actual 1	May Actual 2	Jun Actual 3	Jul Actual 4	Aug F/Cast 5	Sep F/Cast 6	Oct F/Cast 7	Nov F/Cast 8	Dec F/Cast 9	Jan F/Cast 10	Feb F/Cast 11	Mar F/Cast 12	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Medicine and Emergency Care	5,925	237	274	154	447	736	771	650	669	669	587	577	577	6,348
Surgical Services	8,327	130	92	128	115	227	289	336	346	348	351	353	352	3,069
Women and Child Health	2,519	33	50	19	34	185	88	86	86	86	89	89	189	1,034
Primary Care,Community and Thera	2,456	78	87	109	169	163	208	208	270	270	270	291	270	2,390
Pathology	640	49	78	177	80	94	130	101	99	152	114	114	128	1,316
Imaging	1,035	35	32	96	85	112	172	175	175	183	192	192	200	1,650
Sub-Total Clinical Groups	**20,902**	**562**	**613**	**683**	**930**	**1,517**	**1,657**	**1,556**	**1,645**	**1,708**	**1,603**	**1,616**	**1,716**	**15,807**
Strategy and Governance	344	14	14	14	14	14	14	14	14	14	14	14	14	170
Finance	392	24	24	25	24	24	24	24	24	24	24	24	24	289
Medical Director	418	34	34	34	34	34	34	34	34	34	34	34	34	403
Operations	524	0	0	0	0	84	84	84	89	89	89	89	89	696
Organisation Development	166	2	5	(3)	1	18	18	18	18	18	18	18	18	146
Estates and NHP	723	48	48	37	(50)	20	20	20	20	20	20	20	20	242
Corporate Nursing and Facilities	1,435	47	47	1	38	52	64	64	59	59	59	59	59	609
Sub-Total Corporate	**4,003**	**168**	**171**	**108**	**61**	**246**	**258**	**258**	**258**	**258**	**258**	**258**	**258**	**2,555**
Central	8,095	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**33,000**	**730**	**784**	**791**	**991**	**1,763**	**1,915**	**1,814**	**1,902**	**1,965**	**1,860**	**1,873**	**1,974**	**18,362**
NHSI Plan - March 2017 submission		666	667	667	1,330	1,330	1,330	2,007	2,007	2,007	2,661	2,663	15,666	33,001
TPRS Plan		795	992	1,280	1,316	1,719	1,843	2,005	1,928	1,991	1,951	1,943	2,050	19,813
Planning gap		129	325	613	-14	389	513	-2	-79	-16	-710	-720	-13,616	-13,188
Delivery gap		-66	-209	-489	-326									-1,089
% Delivery Failure		-8%	-21%	-38%	-25%									

CIP delivery to date is reported as being in line with NHSI plan but importantly £1.1m adverse to the internal plan on TPRS. Detailed forecasts are being worked up for review during August.

The £13m unidentified CIP risk shown in P12 plan will be covered by a £16.3m profit on disposal of surplus assets.

Finance Report

Pay bill & Workforce

Period 04 2017/18

Pay and Workforce	Current Period	Previous Period	Change between periods	%	Plan YTD	Actual YTD	Variance YTD
Pay - total spend	£26,188k	£26,431k	-£243k	-1%	£103,772k	£105,447k	£1,675k
Pay - substantive	£21,781k	£21,925k	-£144k	-1%	£89,961k	£88,100k	-£1,861k
Pay - agency spend	£1,453k	£1,621k	-£168k	-10%	£4,917k	£6,052k	£1,135k
Pay - bank (inc. locum) spend	£2,954k	£2,885k	£69k	2%	£8,894k	£11,295k	£2,401k
WTE - total	6,857	6,912	-55	-1%	6,783	6,857	74
WTE - substantive	5,979	6,012	-33	-1%	5,971	5,979	8
WTE - agency	180	188	-8	-4%	221	180	-41
WTE - bank (inc. locum)	698	712	-14	-2%	591	698	107
Memo: locum spend	£765k	£744k	£20k	3%	£185k	£2,856k	£2,671k
Memo: locum WTE	67	65	3	4%	4	67	63

NHSI locum spend target	£6,307k

Paybill & Workforce

- Total workforce at the end of July of 6,857 WTE [being 74 higher than plan] and including 180 WTE of agency staff.
- Total pay costs (including agency workers) were £26.2m in July, showing some improvement from June but being £0.6m over NHSI plan.
- Significant reduction in temporary pay costs required to be consistent with FY 2017/18 plan assumptions. Focus on reduction in capacity and improved roster management.
- The Trust did not comply with national agency framework guidance for agency suppliers in July. 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.
- Target have been set for locum spend reduction in FY 2017/18. For SWBH the target is a spend reduction of £545k compared to FY 2016/17.

Finance Report

Group I&E Performance

Period 04 2017/18

Period 4	Current Period			Run rate change	Year to Date			Full Year
	Plan	Actual	Variance	since P3	Plan	Actual	Variance	Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Medicine & Emergency Care	2,236	1,066	(1,171)	(262)	6,759	4,487	(2,272)	20,329
Surgical Services	2,519	846	(1,672)	(139)	5,399	2,711	(2,687)	17,820
Women's & Child Health	2,495	1,764	(731)	122	7,848	6,369	(1,479)	23,453
Primary Care, Community and Therapies	1,481	878	(603)	(155)	3,462	1,981	(1,481)	10,934
Pathology	413	348	(65)	(203)	1,226	1,189	(38)	3,973
Imaging	289	51	(238)	(199)	1,066	612	(454)	3,593
Clinical Groups	**9,433**	**4,954**	**(4,480)**	**(837)**	**25,759**	**17,349**	**(8,410)**	**80,101**
Strategy and Governance	(1,290)	(1,205)	85	104	(5,196)	(5,023)	174	(15,414)
Finance	(351)	(324)	26	38	(1,433)	(1,408)	25	(4,151)
Medical Director	(1,009)	(1,035)	(26)	(307)	(2,993)	(3,000)	(8)	(8,743)
Operations	(1,216)	(1,255)	(38)	121	(4,927)	(5,033)	(106)	(14,475)
Workforce & Organisation Development	(463)	(435)	28	102	(1,895)	(1,904)	(8)	(5,472)
Estates & New Hospital Project	(994)	(1,088)	(94)	(1)	(4,057)	(3,999)	58	(11,752)
Corporate Nursing & Facilities	(1,429)	(1,455)	(25)	194	(5,861)	(6,146)	(285)	(16,920)
Corporate Directorates	**(6,752)**	**(6,796)**	**(43)**	**253**	**(26,363)**	**(26,513)**	**(150)**	**(76,927)**
Central	(107)	(501)	(394)	(973)	(1,019)	(686)	333	1,090
Income	(1,568)	1,528	3,097	1,057	4,178	4,978	800	16,001
Reserves	(1,737)	(24)	1,713	1,069	(8,263)	(1,117)	7,145	(10,542)
Technical Adjustments	17	19	2	0	69	10	(60)	208
DH Surplus/(Deficit)	**(715)**	**(820)**	**(106)**	**568**	**(5,638)**	**(5,980)**	**(342)**	**9,932**

While the bottom line Trust variance year to date is £341k adverse related to STF failure of A&E performance, the underlying Group variance of £8.4m adverse is highlighted as being offset by central items and release of reserves.
Group forecasts based on this performance are being prepared for consideration in P5.

Finance Report

Group I&E Variances

Period 04 2017/18

Period 4	Year to Date Variances													
	Main SLA excl P/T £'000s	Pass Thru SLA Inc £'000s	CDF and FP10s £'000s	Other PRI £'000s	STF £'000s	Other Income £'000s	Pay Substantive £'000s	Pay Bank £'000s	Pay Agency £'000s	Pay Other £'000s	Non Pay Pass Thru £'000s	Non Pay Other £'000s	Non Opex £'000s	TOTAL £'000s
Medicine & Emergency Care	860	418	0	385		(66)	3,126	(3,151)	(3,363)	594	(418)	(656)	0	(2,272)
Surgical Services	(2,932)	42	(46)	737		26	2,165	(1,500)	(945)	72	4	(310)	0	(2,687)
Women's & Child Health	(585)	37	0	(258)		(151)	1,645	(806)	(325)	(827)	(37)	(171)	0	(1,479)
Primary Care, Community and Therapie	232	(6)	(615)	82		5	1,438	(1,048)	(452)	(816)	621	(923)	0	(1,481)
Pathology	80	90	0	(139)		183	484	(127)	0	(393)	(90)	(126)	0	(38)
Imaging	(123)	0	0	10		(101)	312	(349)	(128)	111	0	(187)	0	(454)
Clinical Groups	**(2,468)**	**580**	**(660)**	**817**	**0**	**(104)**	**9,170**	**(6,980)**	**(5,213)**	**(1,260)**	**80**	**(2,372)**	**0**	**(8,410)**
Strategy and Governance	0	0	0	156		171	(11)	(39)	(17)	(22)	0	(65)	0	174
Finance	0	0	0	0		14	130	(58)	(82)	31	0	(10)	0	25
Medical Director	0	0	0	0		(177)	230	(188)	(1)	16	0	112	0	(8)
Operations	0	(72)	(28)	27		134	824	(239)	(214)	(166)	100	(472)	0	(106)
Workforce & Organisation Developmer	0	0	0	0		(151)	(76)	(50)	(2)	97	0	174	0	(8)
Estates & New Hospital Project	0	0	0	0		(2)	20	(7)	10	(113)	0	150	0	58
Corporate Nursing & Facilities	2	0	0	3		(52)	623	(646)	(31)	(86)	0	(97)	0	(285)
Corporate Directorates	**2**	**(72)**	**(28)**	**186**	**0**	**(62)**	**1,740**	**(1,227)**	**(337)**	**(243)**	**100**	**(208)**	**0**	**(150)**
Central	(135)	0	0	(224)	(341)	171	(28)	(16)	(0)	0	(0)	896	11	333
Income	1,866		0	(1,581)		495	31	0	0	0	0	0	(11)	800
Reserves	0	0	0	0		1	0	0	0	2,498	0	4,647	0	7,145
Technical Adjustments	0	0	0	0		0	0	0	0	0	0	0	(60)	(60)
DH Surplus/(Deficit)	**(735)**	**508**	**(688)**	**(802)**	**(341)**	**500**	**10,914**	**(8,224)**	**(5,550)**	**995**	**180**	**2,962**	**(60)**	**(342)**

This shows the Group variances from their internal control totals in more detail. The adverse income variance due to the NHSI plan phasing adjustment is shown in central – income. The STF failure driving the bottom line variance is seen in Central. The significant reliance on bank and agency staff is shown. Other pay relates to unidentified CIPs in Groups and the benefit of the reserve held for incremental drift. The pass through variance including cancer drugs fund and FP10 prescribing is net nil with Group overspends on other non-pay and the release of non-pay reserves benefiting the position.

Finance Report

Prospective View – P04+08

Period 04 2017/18

Reported Position	Apr-17 Act £'000s	May-17 Act £'000s	Jun-17 Act £'000s	Jul-17 Act £'000s	Aug-17 Plan £'000s	Sep-17 Plan £'000s	Oct-17 Plan £'000s	Nov-17 Plan £'000s	Dec-17 Plan £'000s	Jan-18 Plan £'000s	Feb-18 Plan £'000s	Mar-18 Plan £'000s	2017/18 FY 4+8 £'000s
Patient Related Income	31,894	34,323	35,389	35,057	34,670	34,607	34,507	34,507	34,507	34,540	34,540	34,540	413,080
Other Income	4,970	4,936	4,122	5,448	4,959	4,959	5,309	5,309	5,309	5,484	5,484	14,384	70,671
Income total	**36,863**	**39,259**	**39,511**	**40,505**	**39,630**	**39,566**	**39,816**	**39,816**	**39,816**	**40,024**	**40,024**	**48,924**	**483,752**
Pay	(26,426)	(26,345)	(26,431)	(26,188)	(25,503)	(25,436)	(24,925)	(24,925)	(24,925)	(24,441)	(24,441)	(21,366)	(301,354)
Non-Pay	(10,011)	(12,411)	(12,903)	(13,057)	(12,759)	(12,763)	(12,594)	(12,594)	(12,594)	(12,382)	(12,382)	(11,355)	(147,807)
Expenditure total	**(36,437)**	**(38,756)**	**(39,334)**	**(39,246)**	**(38,262)**	**(38,199)**	**(37,519)**	**(37,519)**	**(37,519)**	**(36,823)**	**(36,823)**	**(32,722)**	**(449,161)**
EBITDA	**426**	**503**	**176**	**1,259**	**1,367**	**1,367**	**2,296**	**2,296**	**2,296**	**3,200**	**3,200**	**16,202**	**34,591**
Non-Operating Expenditure	(2,083)	(2,117)	(2,056)	(2,098)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(25,147)
Technical Adjustments	19	(47)	19	19	17	17	17	17	17	17	17	17	148
Reported DH Surplus/(Deficit)	**(1,638)**	**(1,662)**	**(1,860)**	**(820)**	**(715)**	**(715)**	**215**	**215**	**215**	**1,118**	**1,118**	**14,120**	**9,592**
Variance against NHSI plan	***7***	***(21)***	***(220)***	***(107)***	***(0)***	***(0)***	***(0)***	***(0)***	***(0)***	***(0)***	***(0)***	***0***	***(341)***

- The reportd I&E prospective view for FY 2017/18 at £9,384k indicates pre-STF control total being met and anticipates under-recovery of STF of £549k being H1 failure due to A&E performance. This includes the now confirmed benefit of profit on disposal.
- There is significant risk to pre-STF plan delivery. This is currently estimated at £8.7m. This is subject to review as a formal forecast to be undertaken on the back of P05 results.
- A plausible route to delivery is shown at Appendix 5 but which remains subject to review & validation.
- The trust planned to exit 2017.18 in underlying run-rate balance. This is important as part of the route back to sustainable finances. Current estimates indicate that run rate costs will be significantly ahead of those consistent with exit run rate balance.
- A plausible route to delivery of exit run rate balance will be assessed on back of the formal forecast.

Finance Report

Capital

Period 04 2017/18

Programme	Year to Date Flex Plan £'000s	Actual £'000s	Gap £'000s	*Orders Placed £'000s*	Full Year NHSI Plan £'000s	Flex Plan £'000s	Outlook £'000s	Variance £'000s
Estates	7,115	5,648	(1,467)	*6,764*	20,624	20,624	20,624	0
Information	3,496	739	(2,757)	*2,022*	10,572	10,572	10,572	0
Medical equipment / Imaging	350	64	(286)	*297*	5,006	5,006	5,006	0
Contingency	0	0	0	*0*	0	0	0	0
Sub-Total	**10,961**	**6,451**	**(4,510)**	*9,083*	**36,202**	**36,202**	**36,202**	**0**
Technical schemes	252	439	187	*0*	10,386	10,386	10,386	0
Donated assets	28	66	38	*0*	84	84	84	0
Total Programme	**11,241**	**6,956**	**(4,285)**	*9,083*	**46,672**	**46,672**	**46,672**	**0**

The table shows the status of the capital programme, analysed by category, at the end of period 4.
Spending is £4.3m behind plan year to date associated with delays to payments for the EPR (within Information) and estates schemes related to MMH, the Sandwell Treatment Centre and the Medical Education Centre.

In line with good practice a stock take of the forward capital programme is on-going. This will consider any prospective timing changes as well as emergent cost pressures. There is little meaningful prospect of significant additional capital resources and as such mitigation of those pressures within the extant capital programme resources shall be necessary. This will include review of specification, scope and re-prioritisation as necessary.

The £46,7m CRL includes £34.7m of anticipated adjustments NHSI have yet to confirm.
A reduced in year capital programme may be required if full NHSI approval is not forthcoming and if the outlook on I&E surpluses deteriorates or medium term cash remediation is compromised.

Finance Report

SOFP

Period 04 2017/18

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION 2017/18

	Balance as at 31st March 2017	Balance as at 31st July 2017	NHSI Planned Balance as at 31st July 2017	Variance to plan as at 31st July 2017	NHSI Plan as at 31st March 2018	Forecast 31st March 2018
	£000	£000	£000	£000	£000	£000
Non Current Assets						
Property, Plant and Equipment	207,434	209,128	213,448	(4,320)	242,166	242,166
Intangible Assets	166	143	239	(96)	239	239
Trade and Other Receivables	43,017	52,996	60,595	(7,599)	92,045	92,045
Current Assets						
Inventories	5,268	5,511	4,179	1,332	4,177	4,177
Trade and Other Receivables	25,151	36,527	20,946	15,581	20,946	20,946
Cash and Cash Equivalents	23,902	12,556	718	11,838	309	309
Current Liabilities						
Trade and Other Payables	(68,516)	(69,219)	(55,544)	(13,675)	(38,646)	(38,646)
Provisions	(1,138)	(1,017)	(1,196)	179	(1,196)	(1,196)
Borrowings	(903)	(1,306)	(1,023)	(283)	(3,353)	(3,353)
DH Capital Loan	0	0	0	0	0	0
Non Current Liabilities						
Provisions	(3,404)	(3,335)	(2,955)	(380)	(3,012)	(3,012)
Borrowings	(33,954)	(35,263)	(29,519)	(5,744)	(50,077)	(50,077)
DH Capital Loan	0	0	0	0	0	0
	197,023	**206,721**	**209,888**	**(3,167)**	**263,598**	**263,598**
Financed By						
Taxpayers Equity						
Public Dividend Capital	205,362	221,050	223,578	(2,528)	252,540	252,540
Retained Earnings reserve	(24,972)	(30,962)	(30,423)	(539)	(5,822)	(5,822)
Revaluation Reserve	7,575	7,575	7,675	(100)	7,822	7,822
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	197,023	**206,721**	**209,888**	**(3,167)**	**263,598**	**263,598**

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

Slippage on capital and working capital management, including long-term debtors, account for the variance from plan for cash. Continued use of capital cash to support I&E failure will continue through to January 2018.

The Receivables variance from plan relates to the prepayment associated with the MES contract. Analysis and commentary in relation to working capital is available on the next slide.

A task & finish group initiated a cash remediation plan in 2017/18. The actions of this are reflected in the favourable variance on cash.

Finance Report

SOCF

Period 04 2017/18

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW 2017/18

PLAN, ACTUAL AND YEAR END FORECAST 2017-18

ACTUAL/FORECAST	April Actual £000s	May Actual £000s	June Actual £000s	July Actual £000s	August Forecast £000s	September Forecast £000s	October Forecast £000s	November Forecast £000s	December Forecast £000s	January Forecast £000s	February Forecast £000s	March Forecast £000s
Receipts												
SLAs: SWB CCG	22,627	22,930	22,303	22,269	22,603	22,603	22,603	22,603	22,603	22,603	22,603	22,603
Associates	6,278	6,675	6,356	6,393	6,466	6,466	6,466	6,466	6,466	6,466	6,466	6,466
Other NHS	1,980	750	646	1,151	602	1,912	1,131	866	795	1,161	1,428	1,806
Specialised Services	3,583	3,374	3,838	6,668	4,548	4,490	4,058	7,279	4,094	3,858	4,520	5,420
STF Funding and Taper Relief	0	0	0	0	0	1,749	2,097	0	1,749	0	0	1,749
Over Performance	0	0	0	0	0	0	0	0	0	0	0	0
Education & Training - HEE	353	0	4,353	0	0	4,405	0	0	4,405	0	0	4,405
Public Dividend Capital	5,050	5,138	0	5,500	0	3,684	3,618	8,411	3,951	3,836	3,297	3,039
Loans	0	0	0	0	0	0	0	0	0	0	0	0
Other Receipts	1,769	4,237	2,759	2,770	1,375	1,375	1,375	1,375	1,375	1,375	1,375	1,375
Land Sale Receipt					18,800							
Total Receipts	41,641	43,105	40,255	44,751	54,394	46,684	41,348	47,000	45,439	39,299	39,690	46,863
Payments												
Payroll	13,431	13,789	14,017	13,567	13,504	13,504	13,504	13,504	13,253	13,504	13,504	13,504
Tax, NI and Pensions	9,910	10,133	10,202	10,047	9,930	9,930	9,930	9,930	9,930	9,930	9,930	9,930
Non Pay - NHS	1,550	1,550	1,550	1,550	1,550	1,550	1,550	1,550	1,550	1,550	1,550	1,550
Non Pay - Trade	3,892	14,248	13,785	10,991	15,218	13,515	13,110	13,310	13,015	13,515	13,015	13,015
Non Pay - Capital	11,368	4,422	1,720	1,645	3,240	2,403	5,148	1,863	2,487	1,925	2,068	1,544
MMH PFI	3,397	2,055	2,552	2,022	3,528	3,656	3,618	8,411	3,951	5,997	3,297	3,039
PDC Dividend	0	2	0	0	0	3,637	0	0	0	0	0	3,637
Repayment of Loans & Interest	0	0	0	0	0	0	0	0	0	0	0	0
BTC Unitary Charge	440	440	440	440	440	440	440	440	440	440	440	440
NHS Litigation Authority	1,092	1,092	1,092	1,092	1,092	1,092	1,092	1,092	1,092	1,092	0	0
Other Payments	514	710	186	133	140	140	140	140	105	140	140	140
Total Payments	45,595	48,442	45,544	41,487	48,642	49,867	48,532	50,240	45,823	48,093	43,944	46,799
Cash Brought Forward	23,873	19,919	14,582	9,292	12,556	18,307	15,124	7,941	4,700	4,316	(4,478)	(8,732)
Net Receipts/(Payments)	(3,954)	(5,337)	(5,290)	3,264	5,751	(3,183)	(7,184)	(3,240)	(384)	(8,794)	(4,254)	64
Cash Carried Forward	19,919	14,582	9,292	12,556	18,307	15,124	7,941	4,700	4,316	(4,478)	(8,732)	(8,668)

This cash flow is based on actual cash flows for April to July. The future months forecast incorporates intelligence from the following teams:

- Capital planning
- Income and contracting
- Exchequer services
- Estates

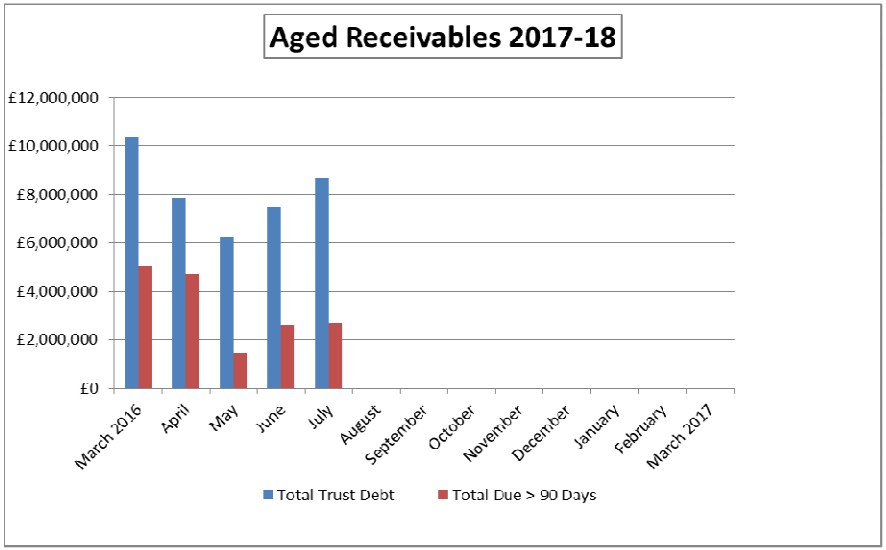
Consequently this cash flow statement reflects the latest collective view of cash flows, crucially the land sale. It can be seen that the Trust is expecting a cash shortage by January 2018. In the absence of the land sale the cash shortage would crystallise in October.

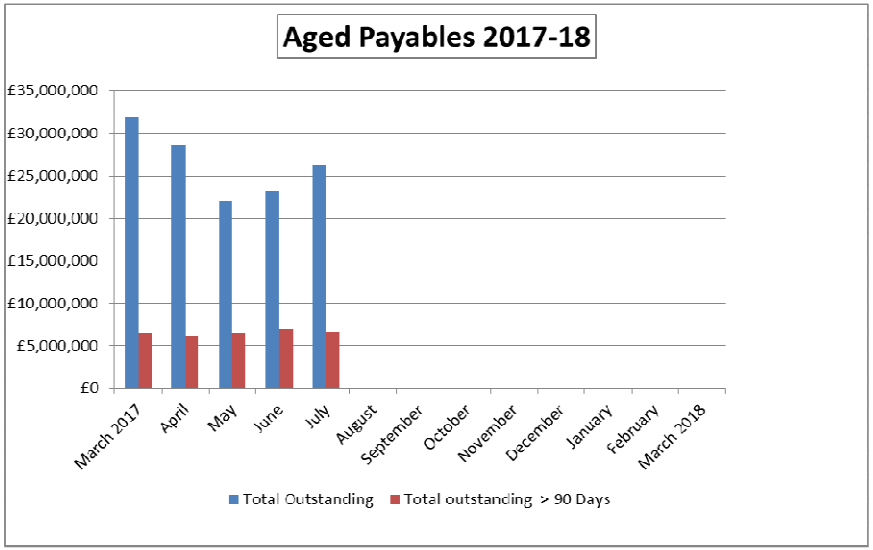
NHSI requested a split of capital and revenue cash. This identified a revenue cash shortfall from June. However, they have advised that they expect land sale cash is utilised before a loan application is made.

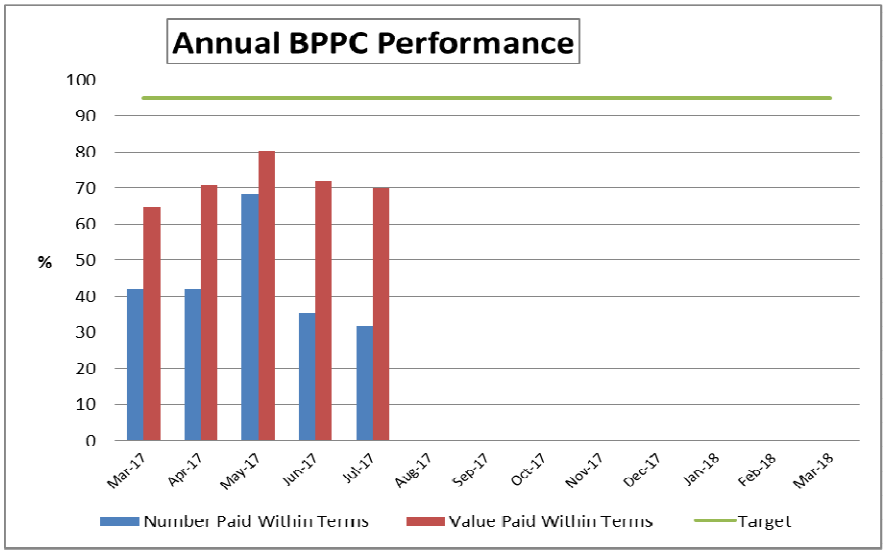
Finance Report

Aged Receivables, Aged Payables, BPPC and Cash Forecast

Period 04 2017/18







Note

- The July debt position increased as additional invoices were raised in month for Commissioners and Overseas visitors. Non NHS debt increased as local government debt and Overseas Patient income aged further, however the >90 day debt remained constant.
- The overall Payables position has increased and the overall levels remain high as the Trust continues to manage cash pressures. The overall level of over 90 days liability reduced marginally. The Trust anticipates an improvement in this position as the cash plan improves following receipt of land sale proceeds.
- BPPC is below target of 95% by volume and value as the Trust looks to effectively manage cash. Underlying performance remains the subject of improvement work with finance and procurement teams.

Appendix 1 - Technical support

Period 03 2017/18

Contingency & flexibility utilised in delivering actual performance to date

	P04 Month	P04 YTD
Unplanned contingency & flexibility	£k	£k
GRNI accrual released from balance sheet	(92)	808
Taper relief - timing - income excess over costs accrued	333	1,333
Other contingency & flexibilities utilised	0	0
	241	2,141
Planned contingency & flexibility		
Taper relief - income used to fund planned capex	250	1,000
Other contingency & flexibilities utilised	0	0
	250	1,000
Total contingency & flexibility utlised	491	3,141

It is considered that, taking the high risk and lower risk technical support in the round that the assumptions made are reasonable.

Crucially management contend that the treatment does not miss-inform decisions and triggers in relation to STF monies.

This details the £3.1m of non-operational support that has been utilised to achieved the reported I&E position and maintain alignment with pre-STF plan and is subject to the following risks:

- Taper relief income is being fully accrued but, to date, no costs have been incurred and none are included in the I&E position. Plan anticipates £1.3m of costs would have incurred by the end of P04. Costs will be incurred but this treatment is consistent with prior year practice which was subject to the year end audit. Consequently this risk relates to the funding of expenditure in future periods as opposed to the treatment of income.
- GRNI of £808k has been assumed. The Trust is working through £1.2m of GRNI realisation of which requires the Trust to clear down GRNI prior to September 2016. This is considered a balanced and prudent approach.
- Fines and penalties in relation to main commissioner contract performance have now been anticipated in the position. There is significant risk from the CCG disputing invoiced activity which is reported in the main body of this report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Chief Executive's Report to the Public Trust Board

September 2017

Almost half way through the public sector year, there is a focus in our Board papers on delivery for 2017-18. This period will include deployment of our electronic patient record, as well as further steps towards reconfiguring services to match our future estate footprint. These programmes are funded through our own operating surpluses, and we entered 2017-18 behind expectation. Accordingly, the welcome early cash release from the surplus estate land sale at City creates a small amount of cash headroom with which to manage our investments.

The key safety programme for 2017-18, outwith our year of digital, is the full deployment of our Safety Plan. Elaine Newell presents our latest data on the always events which underpin the programme, now expanded to 20 key standards with the addition of DNA CPR. Latest data on compliance on that item is extremely encouraging and marks a step change from four weeks ago.

The two year Board Assurance Framework comes for consideration further to our workshop in June. This document will take a strategic approach to the issues and risks faced by our organisation. Once we receive the output of the wider Sandwell and West Birmingham whole system sustainability review we can examine whether there are further 'beyond boundary' issues which merit addition. It is envisaged that the audit committee chair and executive director of governance will scrutinise the BAF position bi-monthly prior to joint presentation of this material to the Board. This is a shift in our traditional approach designed to give greater prominence to the BAF within our Board.

1. Our patients

We continue to meet national elective care wait time standards. This is a distinctive position, and one in which the teams involved should take pride. At a time when long wait figures nationally are growing we are continued to reduce our waiting list and hold steady our wait time. Regrettably volumes of care in July fell short of the assured model, and it will take until October to recover to a revised trajectory consistent with our income plans. We will discuss how we can regain assurance on this matter, with a specific focus on orthopaedics, ophthalmology and general surgery. At the same time we are working to arbitrate and mediate contractual challenges by September 8th, which, if perpetuated, would guarantee a significant financial deficit in 2017-18.

Our emergency care wait times fall short of the 90% interim standard we had agreed, and therefore of the 95% standard we aim to be delivering from January. There are signs of progress in our sub-indicators for first assessment. We have cut the number of people waiting a little over four hours (but less than five) and if we can continue that improvement we will hit our 90% standard. We continue to focus on quality as well as 'quantity', seeing patients in clinically indicated sequence. The IPR shows progress on neutropenic sepsis, but also demonstrates that we are still not meeting our sepsis CQUIN. Given the last two years have seen us deliver marked reductions in sepsis mortality and CCS admission, we have further work to do in this area.

The local area Winter Plan is due for national submission during September. This will show encouraging news on Delayed Transfers of Care in Birmingham, with a commitment from the city council to open additional bed capacity by the end of October. This, if combined with a seven day

discharge model, as distinct from a seven day assessment model, and with full use of our ADAPT pathway offers a prospect that we can both deliver our care standards and close the remaining beds which we have open above our funded bed base. There is no question that our agenda is ambitious and it will require sustained effort by the medicine group leadership and new operations management structure to succeed.

Given that we are now able to reported Expected Dates of Discharge we are seeking to migrate our whole system to focusing first on this key measure of both effectiveness and patient experience. There is detailed work going on with frontline clinicians to get an aligned view of what an EDD is for, and how we apply standard lengths of stay as a norm to most admissions. At the next Board meeting we will explore September data for EDD performance and forward look in improvement needed to execute on our winter plan.

Attached to my report, and in keeping with our traditions of openness is our response to a recent Regulation 28 finding by the local coroner. This gave rise to the Safety Summit in Trauma and Orthopaedics that I outlined orally at the last meeting. Scrutiny of the scorecard for improvement arising from the plan built by our clinical teams will take place via the Board's quality and safety committee.

The Board's papers also contain further explanation of our revised governance of serious incidents and our approach to implementing national guidance on learning from deaths. By November we aim to be using the new system, which will replace our prior mortality review system, where the majority of unexpected deaths were examined. Among other changes with the new approach will be consideration of all deaths, whether anticipated or not. That will provide a further chance to scrutinise our end of life care processes. Those remain a major focus for the board, and are also a key strand to the Sandwell Vision for 2030 which is being launched at the end of the month. It is very encouraging that End of Life Care has such a high priority within the Trust and the borough. Our next steps include work on cultural sensitivity in managing these issues, further work to support care homes, and work with local GPs on their role in helping us all to integrate the work we do to support patients.

On September 4th, we opened the new Non Invasive Ventilation Unit at Sandwell, which by October will service care across the Trust. This considerable investment in both staffing and staff training reflects learning from adverse incidents in the past, as well as a response to the national NCEPOD report into these services NHS wide. It will take us until the opening of the new hospital to truly aggregate expertise onto a single site, but for some groups of patients we are looking to move ahead of that timescale to ensure the best is delivered locally. In Q4 we will ask the Quality and Safety Committee to review whether these changes have delivered the benefits we sought.

2. Our workforce

We continue to drive down expensive agency usage. We have demonstrated considerable success since December 2016 with nursing and HCA roles. By October we need to go further by implementing Trust-wide our changes to focused care. We have ended the use of Thornbury, and have not accessed their services since June 1st. The Board's papers show we have to go further and faster in cutting medical agency, and we will be able to outline the work programme in more detail when the Board next meets. The new trainee contract is not driving our cost base, in that we have successfully implemented that regime, with a large number of rotas going into place the beginning of August. Christine Wright has taken over the role of Hours Guardian.

Recruitment efforts continue and the latest data is attached to this report. Earlier this week, our teams attended the RCN Jobs Fair. It remains the case that all vacant Healthcare Assistant roles now have an offer in place. Rostering deployment has continued and is showing improved grip, and from Q3 'self-rostering' will go into operation in some facilities areas. Work to remodel facilities services will come to a future Workforce and OD Committee but broadly, after several months of scrutiny, we do now have an affordable future state model for these services, and some early changes will go to PPAC and

other suitable bodies in coming weeks. We have decided to retain catering and security services in house against agreed improvement targets. Our outlets will operate as a distinct business model for the next three years including for the move into Midland Met. This is a vote of confidence in the current staff and that support must be matched by improvements in revenue in bringing new customers into our canteens and other facilities. Our future facilities model is not based on price hikes.

The Trust continues to work to ensure internal reporting of issues and concerns is encouraged and straightforward. Our incident reporting rates remain high. Over the next six weeks we have further work to do to ensure that our risk registers best reflect the issues and considerations we face at frontline level. Our cultural aim remains distinctive transparency, and we need to continue to feed back to employees on changes made as a result of issues raised. Based on our latest seminar with our Freedom to Speak Up Guardians we will be organising a "Speak Up Day" on Thursday September 28th to promote the many and varied ways in which we make it ok to raise concerns. When we launch the 'purple phones' project in November, a similar emphasis will be given to patient and carer concerns, in collaboration with bodies such as Healthwatch.

Our staff awards process is proceeding apace. Over 500 nominations have produce shortlists in 20 categories. Voting for four of the awards has just commenced and continues in coming weeks. Our ceremony will take place on October 13th at Villa Park. This year the awards are the culmination of a process that has taken place all through the year with our Shout Out campaign, and monthly awards. At a team level, the process for accrediting Quality Improvement Half Day is imminent, with self-assessment and then peer review against a series of standards designed to embed effective team based improvement work.

The latest safe staffing data is appended to my report for Board consideration.

3. Our partners

The Trust continues to collaborate with local GPs to develop improved pathways into key services. Presently we are reviewing with local partners in particular (a) the process for accessing specialist opinions in an emergency outwith ED and (b) the right basket of enhanced services to provide within the 'Scott Arms' part of the A34. We recognise the preference within the STP to develop separately the integrated care offer in West Birmingham and Sandwell. We have received an undertaking that a numeric analysis of cross border flows will be published beforehand to confirm the volume of patients who reside in one district and get their primary care (and therefore their NHS funding) in the other. This assessment will be important in examining how services cluster around the vertically integrated platform for care which Midland Met represents a part of.

We are an active participant in the Sandwell Better Care Fund, which will be looking to invest a further £7m in service improvements in the year ahead to tackle delayed discharges and prevent avoidable admissions and readmissions. We are exploring how best to use current facilities to better develop joined up services on a population basis, recognising that a sizeable minority of Sandwell residents currently receive local services outside the borough and can experience delays in care associated with less integrated care pathways.

Good initial discussions have taken place with the Sandwell Children's Care Trust, chaired by Jacqui Smith. This important 'spin off' from the Local Authority, regulated directly by DfE, will want on inception later in 2017-18 to work closely with local paediatric health provision. The Trust is contracted for a number of these services via our collaborative working agreement with the Local Authority, and all of these services are rated either good or outstanding by the CQC. What our services and council services share is a need to recruit and retain the very best staff into rewarding but very challenging roles. The commitment to active team building and service level leadership is a shared mission and there is much for the two organisations to learn from each other.

4. Our commissioners

We continue to work with local CCGs to make progress on in year service development and contracting issues. The month 1 dispute process has been activated with our host commissioner and this should conclude in coming days. We are hopeful that this will create a framework precedent for the balance of the year which reduces transaction costs.

The programme to transfer specialist gynae-cancer surgery to another provider continues to be overseen by NHS England. We expect services to be changed from January 2018. The vast majority of care will remain as is. Work continues with staff to ensure there is visibility about the future direction of the service and that patient care is uninhibited by changes in responsibilities.

Regulators continue to work with us and local commissioners to ensure 2017-18 revenues are forecast in alignment. Latest data suggests our expected commissioner outturn does reconcile to the CCGs forecast spend position and we are seeking to crystallise that congruence in advance of month six year end forecasting.

The private Board considers an early draft paper on the clinical and commercial issues associated with planned changes to how specialised services are commissioned. This would create a primary provider who then purchases downstream services from units such as our Trust. The possible intention to create a top sliced 'lead provider premium' for this role, by price discounting local services and creating a cut in income is a new, and worrying, idea within this strategy.

5. Black Country STP

Attached to this report is the latest proposed memorandums of understanding proposed for all local organisations to affirm. We will consider the basis on which this represents a reasonable balance between statutory accountability and ceded mutual decision making. There is some emerging discrepancies between what is co-decided by sector, with the risk that the large NHS provider sector is invited to undertake more decision making together, where other sectors continue as before. This may be a wise model but equally could at variance with pooled budgets shaped around patients.

The pathology outline business case which was not approved per se at the last Trust Board will be considered in revised form at today's meeting in private, given the commercial information sought by the Board.

In addition is my standard report on the business of the Clinical Leadership Executive (CLE) drawing Board members' attention to the key consideration we addressed there in the prior month.

Toby Lewis
Chief Executive

August 31st 2017

Appendix A: SWBH response to a recent Regulation 28 finding by the local coroner
Appendix B: Recruitment Scorecard
Appendix C: Safe Staffing
Appendix D: Black Country STP – Memorandum of Understanding
Appendix E: August CLE Outbrief

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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11 August 2017

Mr Zafar Siddique
Senior Coroner, Black Country Area
Black Country Coroner's Court
Jack Judge House, Halesowen Street
Oldbury
West Midlands
B69 2AJ

Dear Mr Siddique

Response to the Regulation 28 Report – the late Mrs Lily Townsend

I am in receipt of your Regulation 28 Report following the Inquest and your ruling on 12 June 2017, in respect of the late Lily Townsend. I should extend again the condolences of the Trust to Mrs Townsend's family, to whom I am copying this letter.

The important issues you raise have been taken very seriously within the Trust. I attach a presentation by the relevant clinical team which sets out their promises to us about how they will change their service. This is being tracked each month by the Clinical Group Management team using a data scorecard (also attached).

The consultant body within orthopaedics, geriatric medicine and anaesthetics attended, with other professionals, a Safety Summit which I chaired. Here we discussed the issues which had given rise to your report, and the planned actions. The summit was also attended by our medical and nursing directors, and the non-executive chair of our Quality and Safety Committee. The Trust's Board are fully involved with the improvement required.

One issue you notified me about relates to our practice around high risk patients, where a 'do not resuscitate order' may be relevant. Since August 1st, recording such orders on a specific computer system within the Trust has become a requirement underpinned by disciplinary

action for deviation. This allows us to ensure the quality of each order is assessed. I should be clear that our audit data to date attests to good quality decision making and involvement but we are striving for excellence.

I anticipate the majority of the actions in the plan being complete by the end of October and will write to you again in November to update you on the status of our work.

Do contact me, or my colleague Kam Dhami, should this documentation give rise to questions or concerns.

Yours sincerely,

Toby Lewis
Chief Executive

Enclosures

cc Miss Townsend's family
Care Quality Commission
NHS England
Kam Dhami, Director of Governance
Elaine Newell, Chief Nurse
Roger Stedman, Medical Director

Sandwell and West Birmingham Hospitals NHS
NHS Trust

T&O Safety Summit

Mr Abhay Tillu

28 July 2017

Where EVERYONE Matters

Background

Concerns have been raised regarding clinical leadership and adherence to Trust Policies and Procedures, which have resulted in substandard care provided to our Trauma and Orthopaedic patients.

2 recent deaths and the receipt of a Regulation 28 have further increased our level of concern. The following actions are being taken to improve performance across the T&O service.

ALL staff involved in the care of T&O patients commit to the following standards. Compliance will be monitored using the T&O Safety Summit Dashboard

Areas of Focus

- Consent and Mental Capacity
- Medical Assessment and Management
- Consistency of care
- Mortality
- Infection control
- Safety Culture

Consent and Mental Capacity

To improve performance we will always….

- Have daily consultant led ward / board rounds
- Ensure every patient is consented by a clinician competent to do so using standardised proforma
- Ensure every patient has a mental capacity assessment
- Ensure clinicians involve relatives in the consent decision where mental capacity indicates this is required
- Communicate and document the risks associated with procedures, including death, and ensure they are understood

Medical Assessment and Management

To improve performance we will always….

- Fully assess every patient within 12 hours of admission including a review of CDA and historic medical records
- Ensure every patient going to theatre will be assessed by an anaesthetist using standardised proforma
- Ensure Comorbidities will be discussed at team brief
- Take Orthogeriatrician review for all complex patients pre- and post-operatively
- Use the Team Brief check list (updated)

Consistency of Care

To improve performance we will always….

- Ensure medical presence at Board Rounds and safety huddles
- Have a named consultant ward clinical lead who will meet weekly with the ward manager
- Participate in completion of every patients safety plan including in particular VTE, EDD, Medicines Reconciliation, MCA/DOLS
- Respectfully challenge each other where we see non-compliance with basic safety standards

Mortality

To improve performance we will always….

- Undertake mortality reviews within agreed timeframes (42 days currently)
- Treat unexpected deaths as a serious incident and investigate appropriately
- Calculate Nottingham Hip # score on admission
- Discuss predicted mortality with patients as part of the consent process
- Monitor 30 day mortality on a continuous basis

Infection Control

To improve performance we will always….

- Be bare below the elbow in clinical areas
- Abide by theatre protocols for cleanliness
- Challenge poor compliance from colleagues
- Comply with SSI bundles
- Review antibiotics at 72 hours
- Treat every deep wound infection as a serious incident and complete RCAs

Safety Culture

To improve performance we will always….

- Follow up actions and learning from incidents at QIHDs (including learning video)
- Publish all departmental learning alerts
- Have an up to date and regularly discussed risk register
- Comply with Trust policies and procedures on risk
- Comply with all actions arising from previous never events (e.g., consent, team brief, stop before you block, xray time out, WHO checklist etc)
- Look for opportunities to reduce risk of the occurrence of never events and other serious untoward incidents.
- Undertake CD/Matron peer reviews monthly

Evidence

The T&O Safety Summit Dashboard will be used to evidence improved performance. They will be standing agenda items on Directorate and Group Management Boards.

- Fortnightly MDT meeting to review NOF cases, mortality and morbidity, BPT breeches and feedback to team
- Continuous data collection of vital peri-operative data, audit and feedback
- T&O Safety Summit Dashboard
  - Safety checklist
  - Safety Plan
  - IPC dashboard
  - WHO checklist
  - Audit
  - Team Brief checklist

Transformation of "Usually" to "Always"

Commitments	How	When	Who	Details
•Consent and Mental Capacity				
•Have daily consultant led ward / board rounds	Daily Senior ward round	Daily	All	There will be a senior led ward round 7 days a week whereby standardised documentationwill be completed. A Stamp will be used to remind, reiterate and record that all actions are taken. Information booklets wil also be rolled out to assist the informed consent process.
•Ensure every patient is consented by a clinician competent to do so using standardised proforma	Daily Senior ward round	Daily	All	
•Ensure every patient has a mental capacity assessment	Daily Senior ward round	Daily	All	
•Ensure clinicians involve relatives in the consent decision where mental capacity indicates this is required	Daily Senior ward round	Daily	All	
•Communicate and document the risks associated with procedures, including death, and ensure they are understood	Daily Senior ward round	Daily	All	
•Medical Assessment and Management				
•Fully assess every patient within 12 hours of admission including a review of CDA and historic medical records	MDT management	Daily	All	Standard process and policy will be embedded, enforced and tracked across all levels of staff involved within the patients experience. All cases, where applicable will be discussed widely whereby all views, opinion will be ackowledged and discussed
•Ensure every patient going to theatre will be assessed by an anaesthetist using standardised proforma	MDT management	Daily	All	
•Ensure Comorbidities will be discussed at team brief	MDT management	Daily	All	
•Take Orthogeriatrician review for all complex patients pre- and post-operatively	MDT management	Daily	All	
•Use the Team Brief check list (updated)	MDT management	Daily	All	
•Consistency of care				
•Ensure medical presence at Board Rounds and safety huddles	MDT management	Daily	All	Standard process and policy will be embedded, enforced and tracked across all levels of staff involved within the patients experience. All cases, where applicable will be discussed widely whereby all views, opinion will be ackowledged and discussed
•Have a named consultant ward clinical lead who will meet weekly with the ward manager	MDT management	Daily	All	
•Participate in completion of every patients safety plan including in particular VTE, EDD, Medicines Reconciliation, MCA/DOLS	MDT management	Daily	All	
•Respectfully challenge each other where we see non-compliance with basic safety standards	MDT management	Daily	All	
•Mortality				
•Undertake mortality reviews within agreed timeframes (42 days currently)	Quality and Safety Management	Daily	All	Robust governance management embedded, Directorate review agenda change, QIHD agenda changed, Lead roles for clinical lead, risk lead, mortality lead etc reinforced.
•Treat unexpected deaths as a serious incident and investigate appropriately	Quality and Safety Management	Daily	All	
•Calculate Nottingham Hip # score on admission	Quality and Safety Management	Daily	All	
•Discuss predicted mortality with patients as part of the consent process	Quality and Safety Management	Daily	All	
•Monitor 30 day mortality on a continuous basis	Quality and Safety Management	Daily	All	
•Infection control				
•Be bare below the elbow in clinical areas	Quality and Safety Management	Daily	All	Ward leads nominteed to create clear responsility. CD/Matron monthly reviews to occur
•Abide by theatre protocols for cleanliness	Quality and Safety Management	Daily	All	
•Challenge poor compliance from colleagues	Quality and Safety Management	Daily	All	
•Comply with SSI bundles	Quality and Safety Management	Daily	All	
•Review antibiotics at 72 hours	Quality and Safety Management	Daily	All	
•Treat every deep wound infection as a serious incident and complete RCAs	Quality and Safety Management	Daily	All	
•Safety Culture				
•Follow up actions and learning from incidents at QIHDs (including learning video)	Quality and Safety Management	Daily	All	Robust governance management embedded, Directorate review agenda change, QIHD agenda changed, Lead roles for clinical lead, risk lead, mortality lead etc reinforced.
•Publish all departmental learning alerts	Quality and Safety Management	Daily	All	
•Have an up to date and regularly discussed risk register	Quality and Safety Management	Daily	All	
•Comply with Trust policies and procedures on risk	Quality and Safety Management	Daily	All	
•Comply with all actions arising from previous never events (e.g., consent, team brief, stop before you block, xray time out, WHO checklist etc)	Quality and Safety Management	Daily	All	
•Look for opportunities to reduce risk of the occurrence of never events and other serious untoward incidents.	Quality and Safety Management	Daily	All	
•Undertake CD/Matron peer reviews monthly	Quality and Safety Management	Daily	All	

T&O Safety Summit Action Tracker

B	Action completed
R	Action not yet started, slipped - unlikely to deliver within timescale
A	Action at risk of not achieving within timescale
G	Action expected to achieve within timescale

Item	Description	Owner	Deadline	Comments	BRAG
1	Amend QIHD agenda to include - Opportunities to reduce risk of NE and SUIs , T&O Safety Summit Dashboard, Peer Review Updates and Actions from each ward review (Ward Manager / Clinical Lead)	TR	11/08/2017	Agenda updated. September	B
2	Safety Summit Dashboard defined, agreed and implemented	TR	11/08/2017	Dashboard complete (04/08/17) with AT for agreement	G
3	Audit 1 tool designed to capture information associate with consent, mental capacity, medical assessment and infection control	TR	11/08/2017	Audit questionnaire completed	B
4	Plan weekly Ward Manager / Clinical Lead meeting with peer review assessing cleanliness, areas of concern, safety plan	Ward Manager	11/08/2017		
5	Improve Emergancy clinical presence 7 days a week-Implement revised job plans	SC/AT	04/09/2017		G
6	Ensure Mortality compliance of 42 day review at 100%	MV	11/08/2017	KPI measure added to dashboard. Process defined.	B
7	Implementation of Nottingham Hip Score	SG	30/08/2017	Booklet for completionto be rolled out across ward	G
8	Revised/Robust Governance structure for risk management	BT	30/08/2017	Training on Safeguard to be rolled out	G
9	Review fracture cliniic C+D and pathway review	SC/AT	30/08/2017		G
10	Improve team work/MDT management and collabrative working process	SC/AT	30/08/2017		G
11	Improve data collation through use of Dashboard	TR	11/08/2017		B
12	Embed regular consistant theatre teams	AT/JS/SR	30/09/2017		R
13	Implemnetation of Stamp to ensure robustness of completion or paperwork	DP	11/08/2017	Stamp introduced	B
14	Agree standardised norms	ALL	30/08/2017	Standardise process	G
15	Change culture from "usually" to "always"	All	On going		G
16	Implement SOP's where appropriate to ensure standard safety practice	SC	30/08/2017		G
17	Utalise EBMS to Flag high risk patients	SC	15/8/8/17		G
18	Define sytandard for cemented v uncemented usage	AT	15/08/2017		G
19	Confirm the WHO, WHAT, WHERE, WHEN of our commitments to ensure safety	ALL	11/08/2017		G
20	Clarity on R+R of RSO	AT	15/08/2017		G
21	Embed DNACPR rules	AT	15/08/2017		G
22	Circulate clinic ward leads and clarify expectations	SC/AT	15/08/2017		G
23	Develop and use patient/family information leaflets for NOF	JD	30/08/2017		G

T&O Safety Summit Dashboard

Green	NA

Section	Indicator	Evidence	Resp Staff	Measure	Trajectory		Previous Months Trend																Data Period	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				
Consent & Mental Capacity	MDT attendance at Board Round / Ward Round	Audit 1	MDT	=> %	100																					
Consent & Mental Capacity	Completion of consent proforma (MCA, family communication)	Audit 1	Consultant	=> %	100																					
Consent & Mental Capacity	Risks and mortality communicated and documented in notes	Audit 1	Consultant	=> %	100																					
Medical Assessment	Medical assessment by Registrar or above within 12 hours of admission to the ward (including CDA check)	Audit 1	Registrar	=> %	100																					
Medical Assessment	Fully completed clerking proforma	Audit 1	Registrar	=> %	100																					
Medical Assessment	Attendance at 0800 Handover	Audit 2	CSP	=> %	100																					
Medical Assessment	Fully completed anaesthetic proforma	Audit 3	Anaesthetist	=> %	100																					
Medical Assessment	Attendance at Team Brief and utilisation of Team Brief Checklist	Audit 4	Consultant	=> %	100																					
Medical Assessment	Orthogeriatric review of all complex patients pre- and post-operatively	Audit 1	Ortho-geri	=> %	100																					
Medical Assessment	Compliance with DNA CPR protocols documented on eBMS	Data	Consultant	=> %	100																					
Consistency of Care	Named clinical lead for each ward attending weekly meetings with the ward manager	QIHD Minutes	Consultant	=> %	75																					
Consistency of Care	Compliance with Ward Safety Checklist	Data	Clinical Lead	=> %	100																					
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	Data	Mortality Lead	=> %	100	100.0	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	Mar-17	33.0	33	
Patient Safety - Harm Free Care	Serious Incidents investigated through MDT	SI Reports	All	=> %	100																					
Emergency Care & Pt. Flow	Hip Fractures BPT (Operation < 36 hours of admissions)	Data	CSP	=> %	85	85.0	✗	✓	✓	✗	✗	✗	✗	✗	✗	✓	✓	✗	✗	✗	✗	✓	✗	✗	May-17	65.0	51.0	
Infection Control	Cleanliness Audit (Theatre and Wards) (National Standards of Cleanliness)	Data	Matron/CD	=> %																						
Infection Control	Compliance with SSI Bundle including RCA completion for every deep wound infection	Data	All	=> %																						
Infection Control	Antibiotic review at 72 hours	Audit 1	Registrar / Ortho-geri	=> %																						
Safety Culture	QIHD review of Action Plans from incidents, Never Events and risk register	QIHD Minutes	QIHD Lead	=> %	100																					
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	Data	Consultant	=> %	100	100.0	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	May-17	100.0		
Patient Safety - Harm Free Care	Fracture Clinic Wait ≤ 72 hours	Data	Consultant	=> %	100																					
Safety Culture	Attendance at QIHD	Data	All	=> %	80																					

Recruitment Activity Report

Report Date: 23/08/2017

Criteria		Measure/Month		Actual				Notified as at Report Date		Forecast					
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Band 5 Nurses	SIP	FTE	Establishment	983.64	992.21	981.67	981.95	991.00	991.00	991.00	991.00	991.00	991.00	991.00	991.00
		FTE	FTE In Post	839.93	819.86	815.91	807.19	802.23	806.34	838.86	850.74	848.01	852.28	892.03	897.30
		FTE	New Starters	5.83	7.77	7.65	6.92	8.44	45.42	22.23	7.62	14.62	50.10	15.62	7.62
		FTE	Leavers	14.21	7.29	14.05	11.88	4.33	12.90	10.35	10.35	10.35	10.35	10.35	10.35
		FTE	Vacancies in month	143.71	172.35	165.76	174.76	188.77	184.66	152.14	140.26	142.99	138.72	98.97	93.70
	Offers External Applicants	FTE	Conditional offers (in month)	5.60	9.44	25.80	40.92	9.47							
		FTE	Offers Confirmed (in month)	3.00	11.54	5.33	15.55	25.86							
Band 6 Nurses	SIP	FTE	Establishment	582.16	585.28	585.28	585.48	585.48	585.48	585.48	585.48	585.48	585.48	585.48	585.48
		FTE	FTE In Post	531.19	538.07	536.75	539.65	537.02	539.58	537.51	537.99	538.46	538.94	539.42	539.89
		FTE	New Starters	2.40	2.45	5.50	1.80	4.56	3.73	3.73	3.73	3.73	3.73	3.73	3.73
		FTE	Leavers	2.80	1.92	2.68	4.43	2.00	5.80	3.25	3.25	3.25	3.25	3.25	3.25
		FTE	Vacancies in month	50.97	47.21	48.53	45.83	48.46	45.90	47.97	47.49	47.02	46.54	46.06	45.59
	Offers External/Internal Applicants	FTE	Conditional offers (in month)	9.80	3.52	9.51	2.00	6.80							
		FTE	Offers Confirmed (in month)	2.00	2.72	6.16	1.00	6.00							
Band 5 Midwives	SIP	FTE	Establishment	8.25	8.25	8.25	8.25	8.25	8.25	8.25	8.25	8.25	8.25	8.25	8.25
		FTE	FTE In Post	28.28	27.16	23.96	24.16	26.16	26.16	25.58	26.99	27.60	25.18	25.60	26.01
		FTE	New Starters	0.00	0.80	0.60	2.00	0.00	2.10	2.10	2.10	2.10	2.10	2.10	2.10
		FTE	Leavers	0.00	0.00	0.00	0.00	0.00	2.68	0.69	1.48	4.52	1.68	1.69	1.69
		FTE	Vacancies in month	-20.03	-18.91	-15.71	-15.91	-17.91	-17.91	-17.33	-18.74	-19.35	-16.93	-17.35	-17.76
	Offers External Applicants	FTE	Conditional offers (in month)	0.00	0.00	0.80	4.92	4.00							
		FTE	Offers Confirmed (in month)	0.00	1.80	0.00	0.00	0.00							
Band 6 Midwives	SIP	FTE	Establishment	208.10	208.10	184.30	184.30	183.80	183.80	183.80	183.80	183.80	183.80	183.80	183.80
		FTE	FTE In Post	129.87	127.67	124.49	126.89	124.56	123.56	123.61	123.40	123.19	122.99	122.78	122.57
		FTE	New Starters	0.00	0.00	1.00	0.60	0.00	1.05	1.05	1.05	1.05	1.05	1.05	1.05
		FTE	Leavers	0.81	0.00	2.72	2.93	1.00	1.00	1.26	1.26	1.26	1.26	1.26	1.26
		FTE	Vacancies in month	78.23	80.43	59.81	57.41	59.24	60.24	60.19	60.40	60.61	60.81	61.02	61.23
	Offers External/Internal Applicants	FTE	Conditional offers (in month)	1.00	1.00	0.60	4.00	0.00							
		FTE	Offers Confirmed (in month)	0.00	0.80	0.00	0.00	0.00							
Consultants	SIP	FTE	Establishment	313.96	315.53	313.73	313.73	313.73	313.73	313.73	313.73	313.73	313.73	313.73	313.73
		FTE	FTE In Post	284.47	285.17	281.97	280.57	279.57	278.57	278.96	278.81	278.66	278.51	278.36	278.21
		FTE	New Starters	2.00	6.00	1.40	2.00	2.00	2.39	2.39	2.39	2.39	2.39	2.39	2.39
		FTE	Leavers	3.30	3.00	5.85	3.00	3.00	2.00	2.54	2.54	2.54	2.54	2.54	2.54
		FTE	Vacancies in month	29.49	30.36	31.76	33.16	34.16	35.16	34.77	34.92	35.07	35.22	35.37	35.52
	Offers External Applicants	FTE	Conditional offers (in month)	3.00	0.00	3.00	3.00	0.00							
		FTE	Offers Confirmed (in month)	0.00	0.00	1.00	0.00	1.00							
Band 2 HCAs	SIP	FTE	Establishment	499.95	504.70	500.70	513.20	513.20	513.20	513.20	513.20	513.20	513.20	513.20	513.20
		FTE	FTE In Post	437.09	442.07	454.05	445.58	450.33	448.32	468.72	504.54	504.97	505.40	505.83	506.27
		FTE	New Starters	2.53	10.41	2.00	10.00	6.50	25.00	40.00	4.61	4.61	4.61	4.61	4.61
		FTE	Leavers	3.92	1.40	3.00	5.25	8.51	4.60	4.18	4.18	4.18	4.18	4.18	4.18
		FTE	Vacancies in month	62.86	62.63	46.65	67.62	62.87	64.88	44.48	8.66	8.23	7.80	7.37	6.93
	Offers External Applicants	FTE	Conditional offers (in month)	11.61	10.16	28.41	58.00	11.00							
		FTE	Offers Confirmed (in month)	7.25	2.61	3.00	1.00	15.50							
Band 3 HCAs	SIP	FTE	Establishment	93.14	93.38	93.38	93.54	93.54	93.54	93.54	93.54	93.54	93.54	93.54	93.54
		FTE	FTE In Post	92.71	92.63	88.57	88.57	88.57	89.83	88.23	87.64	87.04	86.44	85.85	85.25
		FTE	New Starters	0.00	0.00	0.00	0.00	1.26	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		FTE	Leavers	1.00	1.80	1.92	0.00	0.00	1.60	0.60	0.60	0.60	0.60	0.60	0.60
		FTE	Vacancies in month	0.43	0.75	4.81	4.97	4.97	3.71	5.31	5.90	6.50	7.10	7.69	8.29
	Offers External/Internal Applicants	FTE	Conditional offers (in month)	0.00	2.26	0.00	1.00	0.00							
		FTE	Offers Confirmed (in month)	0.00	5.21	1.80	0.00	0.00							

Notes:

Establishment: WTE contracted numbers still to be adjusted for HCA Apprentices as part of vacancy reconcillation exercise. It is expected that this will increase the FTE Establishment figure. WTE conracted numbers to be adjusted for Surgical HDU, NIV and gynaecology oncology

New starters - July: Figures based on agreed dates with new hires

New starters forecast: Based on average number of new recruits due to recruitment campaigns and number of student nurses likely to accept offers.

Leavers - July: Figures based on terminations received into ESR and assuming that managers are submitting termination data in a timely fashion.

Leavers: With the exception of band 5 staff nurses and midwives, the leaver figure is based on the wet leaving the organisation. For band 5 staff nurses/midwives, this also includes the wet moving internally to take into account the impact of internal promotion.

Turnover forecast: Based on average for the staff group/band over the previous year.

Student Nurse Offers: Forecast assumes that 50% of offers made to date will be successful (based on 2016 student recruitment)

Band 5 Midwives: Decision taken to over establish at band 5 and develop post holders to fill band 6 midwifery vacancies.

Band 6 Midwives: New starters includes an assessment of the number of band 5 midwives due to move to band 6 positions following successful completion of training (see note above).

Band 5 Nurses: Report includes data on band 5 nursing posts within the Trust with the exception of midwives. Reporting on external recruitment activity i.e. activity that improves vacancy bottom line given this is an entry level post.

Band 6 Nurses: Figures include all band 6 nurses i.e. charge nurses, sisters, community practitioners with the exclusion of midwives

Data source: ESR and Recruitment data base

Band 5 Nurses	Definition includes all band 5 nurses employed in the Trust with the exception of midwives Assuming appointing 3 wte per month based on general recruitment Have identified the number leaving band 5 positions for internal promotion - had to inflate the leavers figure by 0.60 wte (normally just includes people exiting the organisation) to take into account the impact of internal promotion.
Revised Forecast Updated on 24.8.17	Sept confirmed starters 39.62, no start date but pre-employment checks completed 5.8, DBS checks on-going 13.61, ID check done on 22.8.17 1.00
	Oct confirmed starters 4.12, no start date but pre-employment checks completed 1.00 DBS checks on-going Note 25 candidates have withdrawn
Forecast for Student Nurses	Recruitment Fairs forecast additional 45 offers from SWBH fair in July (35 to commence in 2017 and 10 to commence in 2018), 7 offers from RCN fair in Liverpool in Sept, 12 offers from RCN fair London in Oct and 8 offers from RCN 19.8 students appointed through normal recruitment, 18.8 via FYS offer letter and 22 via RCN jobs fair . We have removed candidates who have withdrawn their application and are assuming 80% of those still going through the process 2 students offered posts due to qualify in Jan '18 January '18 - Assume that we will be able to offer a further 66 final placement students a job with the Trust. Assume that 50% wil accept = 33 wte Total students = 92 - assuming 50% will commence in September i.e. 46
Band 6 Nurses	Band 6's - counting all band 6 nurses with the exception of midwives **Band 6 nurses - new starters of 2.85 based on average number of new starters (internal and external) to the band**
Band 5 Midwives	Band 5 Midwives - New starters - median number of new starters based on last 12 months - 1.97
Band 6 Midwives	New starters - median based on recruitment activity over the last 12 months + number of band 5's due to commence in band 6 roles following successful completion of training.
Band 3 HCA's	New starters - median based on recruitment activity over the last 12 months.
Band 2 HCAS	Excludes care support workers (Occ code - all H1's)

Appendix C

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Safe staffing
SPONSOR (EXECUTIVE DIRECTOR):	Elaine Newell –Chief Nurse
AUTHOR:	Elaine Newell
DATE OF MEETING:	7th September 2017

EXECUTIVE SUMMARY:

July Summary

The summary level Unify data does not demonstrate any major variance across this period. The average in month CHPPD for registered nurses across the trust is 5.1 hours which is slightly higher than the rolling 3 month average. The average fill rates across the trust for registered nurses, which includes permanent, bank and agency staff for both day and night shifts has remained stable in July at 98.1 and 97% respectively. HCA fill rates are also stable at 96% and 102% respectively.

Fill rates appear low in the following areas:

- Paediatrics – due to a planned reduction in staff to offset seasonal activity
- Eliza Tinsley – due to skill mix changes and flexible deployment of staff at times of lower demand.
- Delivery Suite due to vacancies and high sickness absence. All vacancies have been recruited with start dates planned from Sept onwards. Maternity has a well-rehearsed escalation plan which includes the deployment of managers and community staff in order to mitigate risks within delivery suite.

Progress continues to be made in terms of effective rostering, bed closure programmes and recruitment, all of which are contributing to a continued reduction in Bank and agency use.

REPORT RECOMMENDATION:

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

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	x
Clinical	**x**	Equality and Diversity		Workforce	x

Comments:

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

PREVIOUS CONSIDERATION:

Aug Trust Board

Safe Staffing Return Summary

			Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
			Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff						Cumulative count over the month of patients at 23:59 each day	Registered midwives / nurses	Care Staff	Overall
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/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)				
Jul-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2138	2330	526	527	414	500	0	18	109.0%	100.2%	120.8%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	25676	27032	15249	16705	14064	17337	6905	8503	105.3%	109.5%	123.3%	123.1%				
	RXK10	ROWLEY REGIS HOSPITAL	2826	3265	4417	4556	1243	1985	1788	2085	115.5%	103.2%	159.7%	116.6%				
	RXK01	SANDWELL GENERAL HOSPITAL	30666	32776	19123	22015	15612	18588	8817	13232	106.9%	115.1%	119.1%	150.1%				
	Total		61305	65403	39314	43803	31332	38409	17510	23837	106.7%	111.4%	122.6%	136.1%				
Aug-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1839	1807	497	475	472	560	0	28	98.3%	95.6%	118.7%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	24155	24753	13808	14687	13967	16362	6858	8233	102.5%	106.4%	117.2%	120.0%				
	RXK10	ROWLEY REGIS HOSPITAL	2964	3200	3816	3937	1176	1794	1553	1860	107.9%	103.2%	152.6%	119.8%				
	RXK01	SANDWELL GENERAL HOSPITAL	28245	29172	16759	19191	14679	16520	7932	11384	103.3%	114.5%	112.5%	143.5%				
	Total		57202	58932	34879	38290	30293	35236	16343	21505	103.0%	109.8%	116.3%	131.6%				
Sep-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2137	2080	454	475	472	532	0	119	97.3%	104.5%	112.8%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	24208	27604	14308	17278	13993	20283	6794	10406	114.0%	120.8%	144.9%	153.2%				
	RXK10	ROWLEY REGIS HOSPITAL	1274	1472	1216	1382	403	1185	587	756	115.5%	113.6%	294.4%	128.9%				
	RXK01	SANDWELL GENERAL HOSPITAL	27883	32528	16822	23743	14654	20124	7392	15185	116.7%	141.1%	137.3%	205.4%				
	Total		55501	63684	32800	42877	29521	42124	14773	26466	114.7%	130.7%	142.7%	179.2%				
Oct-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2199	2139.917	546.75	548.5	434.75	519	0	28	97.3%	100.3%	119.4%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	25273	27384.5	14779.5	15814.42	14038.5	16711.07	6797	8913.5	108.4%	107.0%	119.0%	131.1%				
	RXK10	ROWLEY REGIS HOSPITAL	3308	3480.067	3886.5	4283.25	1230	1876.5	1590	2006	105.2%	110.2%	152.6%	126.2%				
	RXK01	SANDWELL GENERAL HOSPITAL	31768.25	33296.75	19265.22	21818.3	16182.5	19034.25	8175	11998.83	104.8%	113.3%	117.6%	146.8%				
	Total		62548	66301	38478	42464	31886	38141	16562	22946	106.0%	110.4%	119.6%	138.5%				
Nov-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2082.5	2122.167	569.75	590.9167	490.25	499.75	0	55.75	101.9%	103.7%	101.9%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	26188.75	26959.63	15119	15017.5	14937	16194.5	6939	8142	102.9%	99.3%	108.4%	117.3%				
	RXK10	ROWLEY REGIS HOSPITAL	3040.5	2955.25	3894	3722.75	1306.5	1463	1511.5	1800	97.2%	95.6%	112.0%	119.1%				
	RXK01	SANDWELL GENERAL HOSPITAL	29371	30796.57	18168.5	19839.58	15566	17377.82	7733	11116.5	104.9%	109.2%	111.6%	143.8%				
	Total		60683	62834	37751	39171	32300	35535	16184	21114	103.5%	103.8%	110.0%	130.5%				
Dec-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1963.75	1844.167	554	471.5	518	465.5	0	139.25	93.9%	85.1%	89.9%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	26367.75	26839.52	15860.5	15872.08	15638.5	16717.67	7044	7930	101.8%	100.1%	106.9%	112.6%				
	RXK10	ROWLEY REGIS HOSPITAL	3280	3003	3634.5	3553.5	1262.5	1255.5	1501.5	1622.5	91.6%	97.8%	99.4%	108.1%				
	RXK01	SANDWELL GENERAL HOSPITAL	30676	30848.75	17822	19391.08	16710.5	17467	8177.017	10390.08	100.6%	108.8%	104.5%	127.1%				
	Total		62288	62535	37871	39288	34130	35906	16723	20082	100.4%	103.7%	105.2%	120.1%				
Jan-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2123.25	2227.333	505.5	492.25	582.75	555	129.5	157.5	104.9%	97.4%	95.2%	121.6%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	30328.5	30574.63	15962.5	15937.82	18989.5	20653.42	7731	8767.25	100.8%	99.8%	108.8%	113.4%				
	RXK10	ROWLEY REGIS HOSPITAL	2919	3183.5	3472.5	3411.5	1333	1558.5	1429	1542.25	109.1%	98.2%	116.9%	107.9%				
	RXK01	SANDWELL GENERAL HOSPITAL	29286.5	30702.12	17609.5	19883.43	16561.5	18341	8455	11660.25	104.8%	112.9%	110.7%	137.9%				
			64657	66688	37550	39725	37467	41108	17745	22127	103.1%	105.8%	109.7%	124.7%				
Feb-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1867.25	2053.5	464.5	462	490.25	518	129.5	101.75	110.0%	99.5%	105.7%	78.6%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	27390.25	27677.75	14544.5	14620.48	17409.5	18193.92	6915.5	7414.25	101.0%	100.5%	104.5%	107.2%				
	RXK10	ROWLEY REGIS HOSPITAL	2542	2743.25	3000.5	3185.5	1194.5	1192	1457.5	1407	107.9%	106.2%	99.8%	96.5%				
	RXK01	SANDWELL GENERAL HOSPITAL	25298.5	27136.1	14521.5	16240.82	14720	16798	7292	9867.25	107.3%	111.8%	114.1%	135.3%				
			57098	59611	32531	34509	33814	36702	15795	18790	104.4%	106.1%	108.5%	119.0%				
Mar-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2353.25	2352.417	501.5	447	573.5	565.25	148	139.5	100.0%	89.1%	98.6%	94.3%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	29823.73	30744.15	16727.5	15515.32	18670	21136.23	7507.5	7752	103.1%	92.8%	113.2%	103.3%				
	RXK10	ROWLEY REGIS HOSPITAL	2702.5	3084.9	3546.75	3896.583	1211.5	1717.75	1670.5	2067	114.1%	109.9%	141.8%	123.7%				
	RXK01	SANDWELL GENERAL HOSPITAL	28133.5	30365.28	15989.5	17373.25	15995	20147.07	7760.517	10975.02	107.9%	108.7%	126.0%	141.4%				
			63013	66547	36765	37232	36450	43566	17087	20934	105.6%	101.3%	119.5%	122.5%				
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1502	1941	305.5	396.25	444	536.5	92.5	101.75	129.2%	129.7%	120.8%	110.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				

Apr-15	RXK02	CITY HOSPITAL	30171.5	31776.33	16684	15468.25	18810.5	20221.75	7285.5	8325	105.3%	92.7%	107.5%	114.3%
	RXK10	ROWLEY REGIS HOSPITAL	2614	2568.5	3772	3448.067	1116.5	1351.5	1763	1778	98.3%	91.4%	121.0%	100.9%
	RXK01	SANDWELL GENERAL HOSPITAL	27100	29153.3	15850.25	17460.35	16443.5	18445.28	7508	10431.5	107.6%	110.2%	112.2%	138.9%
			61388	65439	36612	36773	36815	40555	16649	20636	106.6%	100.4%	110.2%	123.9%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2034.5	1941	434	402.25	573.5	527.25	138.75	138.75	95.4%	92.7%	91.9%	100.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
May-15	RXK02	CITY HOSPITAL	32094.5	32675.33	16822.25	16256	19465	21176.25	7493	8437	101.8%	96.6%	108.8%	112.6%
	RXK10	ROWLEY REGIS HOSPITAL	2645.5	2576.067	3508.5	3169.083	1083.5	1475.067	1842.5	2033	97.4%	90.3%	136.1%	110.3%
	RXK01	SANDWELL GENERAL HOSPITAL	26561	27802.15	15591.5	17242.17	16839	17383.17	8199.5	10655	104.7%	110.6%	103.2%	129.9%
			63336	64995	36356	37070	37961	40562	17674	21264	102.6%	102.0%	106.9%	120.3%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2276.25	2172.167	419	426	555	527.25	166.5	184.75	95.4%	101.7%	95.0%	111.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Jun-15	RXK02	CITY HOSPITAL	28309.5	29468.17	15410.18	14755.27	18281	19637.77	6748.5	7504.317	104.1%	95.8%	107.4%	111.2%
	RXK10	ROWLEY REGIS HOSPITAL	2442	2374.75	3676.5	3263	1302.5	1494	1587	1916.5	97.2%	88.8%	114.7%	120.8%
	RXK01	SANDWELL GENERAL HOSPITAL	26826	28578.08	15516.5	17366.28	15139.5	17222.75	8432.5	10183	106.5%	111.9%	113.8%	120.8%
			59854	62593	35022	35811	35278	38882	16935	19789	104.6%	102.3%	110.2%	116.9%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	930	1951.583	465	512.75	589	555	0	166.5	209.8%	110.3%	94.2%	0.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Jul-15	RXK02	CITY HOSPITAL	32069.5	27187.57	13190.5	13134.5	27450.5	19260.02	8199.5	7613.267	84.8%	99.6%	70.2%	92.9%
	RXK10	ROWLEY REGIS HOSPITAL	3208	2495	3565	2970.667	2139	1486.75	2495.5	1923	77.8%	83.3%	69.5%	77.1%
	RXK01	SANDWELL GENERAL HOSPITAL	30178.5	26279.73	15686	15236.02	23885.5	17973.25	11764.5	11337.25	87.1%	97.1%	75.2%	96.4%
			66386	57914	32907	31854	54064	39275	22460	21040	87.2%	96.8%	72.6%	93.7%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	930	806	465	370.75	573	518.25	0	171	86.7%	79.7%	90.4%	0.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Aug-15	RXK02	CITY HOSPITAL	31861.5	24502	13158.25	11459.75	27419.5	18006.17	7843	7162.517	76.9%	87.1%	65.7%	91.3%
	RXK10	ROWLEY REGIS HOSPITAL	3208.5	2431.5	3565	3108.117	2139	1589.75	2495.5	2150.5	75.8%	87.2%	74.3%	86.2%
	RXK01	SANDWELL GENERAL HOSPITAL	29192	24223	14735.5	15146	22765.5	17481.07	11251	11176.75	83.0%	102.8%	76.8%	99.3%
			65192	51963	31924	30085	52897	37595	21590	20661	79.7%	94.2%	71.1%	95.7%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	900	935	450	378.5	555	472	166.5	194.75	103.9%	84.1%	85.0%	117.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Sep-15	RXK02	CITY HOSPITAL	28394	26595.9	11679	13003.83	24495	20277.5	7651	7903	93.7%	111.3%	82.8%	103.3%
	RXK10	ROWLEY REGIS HOSPITAL	3105	2663	3450	3364.5	2070	1881.25	2415	2336	85.8%	97.5%	90.9%	96.7%
	RXK01	SANDWELL GENERAL HOSPITAL	27587	25604	14651	16277.83	21016	18495	11561.5	11814.52	92.8%	111.1%	88.0%	102.2%
			59986	55798	30230	33025	48136	41126	21794	22248	93.0%	109.2%	85.4%	102.1%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	930	969.3333	465	344.75	573.5	536.75	157.25	178.25	104.2%	74.1%	93.6%	113.4%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Oct-15	RXK02	CITY HOSPITAL	30986	34295.28	13485.5	16855.07	26737.5	28120.5	8215	10881.25	110.7%	125.0%	105.2%	132.5%
	RXK10	ROWLEY REGIS HOSPITAL	3208.5	3267.667	3565	3678	2139	2590.25	2495.5	2913.5	101.8%	103.2%	121.1%	116.8%
	RXK01	SANDWELL GENERAL HOSPITAL	27183.5	30355.55	15523.5	21546.75	21761	24224.5	10848	16673.5	111.7%	138.8%	111.3%	153.7%
			62308	68888	33039	42425	51211	55472	21716	30647	110.6%	128.4%	108.3%	141.1%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	435	435	217	191	536	536	157	138	104.2%	74.1%	93.6%	113.4%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Nov-15	RXK02	CITY HOSPITAL	24755	23194	9789	9919	22694	21079	7217	7434	110.7%	125.0%	105.2%	132.5%
	RXK10	ROWLEY REGIS HOSPITAL	2738	2309	1738	1837	1826	1871	1493	1446	101.8%	103.2%	121.1%	116.8%
	RXK01	SANDWELL GENERAL HOSPITAL	24276	23016	12497	12096	20417	19181	10173	9660	111.7%	138.8%	111.3%	153.7%
			52204	48954	24241	24043	45473	42667	19040	18678	93.8%	99.2%	93.8%	98.1%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	450	232	195	573	545	185	148	96.8%	84.1%	95.1%	80.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Dec-15	RXK02	CITY HOSPITAL	28783	27400	12089	11327	27170	24752	9454	8471	95.2%	93.7%	91.1%	89.6%
	RXK10	ROWLEY REGIS HOSPITAL	3044	2561	1975	2027	2030	2007	1689	1586	84.1%	102.6%	98.9%	93.9%
	RXK01	SANDWELL GENERAL HOSPITAL	26109	24203	13225	12669	21872	20396	10342	10095	92.7%	95.8%	93.3%	97.6%
			58401	54614	27521	26218	51645	47700	21670	20300	93.5%	95.3%	92.4%	93.7%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	198	573	564	148	148	100.0%	85.3%	98.4%	100.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Jan-16	RXK02	CITY HOSPITAL	26001	24220	10586	9949	24291	23361	8611	7795	93.2%	94.0%	96.2%	90.5%
	RXK10	ROWLEY REGIS HOSPITAL	2867	2417	1798	1775	1912	1888	1235	1223	84.3%	98.7%	98.7%	99.0%
	RXK01	SANDWELL GENERAL HOSPITAL	25861	24488	12914	12728	21731	20994	10454	10439	94.7%	98.6%	96.6%	99.9%
			55194	51590	25530	24650	48507	46807	20448	19605	93.5%	96.6%	96.5%	95.9%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	420	420	210	195	518	518	148	148	100.0%	92.9%	100.0%	100.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Feb-16	RXK02	CITY HOSPITAL	27047	25992	11249	10768	25705	24916	8501	8412	96.1%	95.7%	96.9%	99.0%

	RXK10	ROWLEY REGIS HOSPITAL	3906	3279	3664	3960	2604	2557	2779	3098	83.9%	108.1%	98.2%	111.5%				
	RXK01	SANDWELL GENERAL HOSPITAL	25483	23052	12166	12244	21532	19958	9856	9788	90.5%	100.6%	92.7%	99.3%				
			56856	52743	27289	27167	50359	47949	21284	21446	92.8%	99.6%	95.2%	100.8%				
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	555	465	277	221	462	573	157	194	83.8%	79.8%	124.0%	123.6%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
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 (BMEC)	450	457	225	206	555	555	148	175	101.6%	91.6%	100.0%	118.2%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
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 (BMEC)	435	435	217	195	536	536	166	185	100.0%	89.9%	100.0%	111.4%	192	5.1	2.0	7.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
May-16	RXK02	CITY HOSPITAL	29134	29287	11975	11748	27549	27239	9115	8696	100.5%	98.1%	98.9%	95.4%	8856	6.4	2.3	8.7
	RXK10	ROWLEY REGIS HOSPITAL	4323	3879	4858	5417	2883	2871	3605	4005	89.7%	111.5%	99.6%	111.1%	2624	2.6	3.6	6.2
	RXK01	SANDWELL GENERAL HOSPITAL	28077	26369	14260	13294	22336	21643	10737	10506	93.9%	93.2%	96.9%	97.8%	9535	5.0	2.5	7.5
			61969	59970	31310	30654	53304	52289	23623	23392	96.8%	97.9%	98.1%	99.0%	21207.00	5.3	2.5	7.8
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	453	225	198	555	555	166	138	100.7%	88.0%	100.0%	83.1%	135	7.5	2.5	10.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jun-16	RXK02	CITY HOSPITAL	28741	27744	12036	11512	27323	25997	9142	8558	96.5%	95.6%	95.1%	93.6%	8704	6.2	2.3	8.5
	RXK10	ROWLEY REGIS HOSPITAL	4144	3873	4656	4953	2790	2801	3495	3805	93.5%	106.4%	100.4%	108.9%	2222	3.0	3.9	6.9
	RXK01	SANDWELL GENERAL HOSPITAL	26756	25382	13609	13418	21064	20441	10916	10982	94.9%	98.6%	97.0%	100.6%	9235	5.0	2.6	7.6
			60091	57452	30526	30081	51732	49794	23719	23483	95.6%	98.5%	96.3%	99.0%	20296			
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	232	573	573	148	148	100.0%	100.0%	100.0%	100.0%	228	4.6	1.7	6.2
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jul-16	RXK02	CITY HOSPITAL	29688	29249	12664	12068	28090	27187	9242	8886	98.5%	95.3%	96.8%	96.1%	9155	6.2	2.3	8.5
	RXK10	ROWLEY REGIS HOSPITAL	4242	3762	5170	5197	3500	3465	3455	3540	88.7%	100.5%	99.0%	102.5%	2178	3.3	4.0	7.3
	RXK01	SANDWELL GENERAL HOSPITAL	27279	25652	14225	14196	21640	20847	11353	11587	94.0%	99.8%	96.3%	102.1%	9872	4.7	2.6	7.3
			61674	59128	32291	31693	53803	52072	24198	24161	95.9%	98.1%	96.8%	99.8%	21433	19	11	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	221	573	573	175	175	100.0%	95.3%	100.0%	100.0%	228	4.6	1.7	6.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Aug-16	RXK02	CITY HOSPITAL	29313	27693	12062	12037	27582	25849	8198	8735	94.5%	99.8%	93.7%	106.6%	9155	5.8	2.3	8.1
	RXK10	ROWLEY REGIS HOSPITAL	3967	3395	4972	4965	3439	3310	3067	3079	85.6%	99.9%	96.2%	100.4%	2178	3.1	3.7	6.8
	RXK01	SANDWELL GENERAL HOSPITAL	25853	25600	20636	14598	21640	20464	11640	12846	99.0%	70.7%	94.6%	110.4%	9872	4.7	2.8	7.4
			59598	57153	37902	31821	53234	50196	23080	24835	95.9%	84.0%	94.3%	107.6%	21433	18	10	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	476	225	195	555	555	157	222	105.8%	86.7%	100.0%	141.4%	174	5.9	2.4	8.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Sep-16	RXK02	CITY HOSPITAL	29457	28063	12304	12574	27112	25549	8197	8677	95.3%	102.2%	94.2%	105.9%	9026	5.9	2.4	8.3
	RXK10	ROWLEY REGIS HOSPITAL	3028	2638	3851	3963	2773	2726	2426	2426	87.1%	102.9%	98.3%	100.0%	1852	2.9	3.4	6.3
	RXK01	SANDWELL GENERAL HOSPITAL	26309	25107	13815	14727	20919	19649	11129	12282	95.4%	106.6%	93.9%	110.4%	9236	4.8	2.9	7.8
			59244	56284	30195	31459	51359	48479	21909	23607	95.0%	104.2%	94.4%	107.8%	20288	20	11	31
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	446	232	217	573	573	157	120	95.9%	93.5%	100.0%	76.4%	144	7.1	2.3	9.4
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Oct-16	RXK02	CITY HOSPITAL	32594	31145	15120	15025	28558	26663	9885	10501	95.6%	99.4%	93.4%	106.2%	9327	6.2	2.7	8.9
	RXK10	ROWLEY REGIS HOSPITAL	2219	2103	2656	2717	2744	1844	2560	2536	94.8%	102.3%	67.2%	99.1%	2262	1.7	2.3	4.1
	RXK01	SANDWELL GENERAL HOSPITAL	28494	27372	14486	16860	22514	21304	12135	13988	96.1%	116.4%	94.6%	115.3%	10266	4.7	3.0	7.7
			63772	61066	32494	34819	54389	50384	24737	27145	95.8%	107.2%	92.6%	109.7%	21999	20	10	30
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	442	225	210	555	545	166	148	98.2%	93.3%	98.2%	89.2%	557	1.8	0.6	2.4
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Nov-16	RXK02	CITY HOSPITAL	31002	30282	13483	13765	27240	25886	8953	9971	97.7%	102.1%	95.0%	111.4%	8630	6.5	2.8	9.3
	RXK10	ROWLEY REGIS HOSPITAL	3382	3220	4072	4197	3874	3257	2981	2957	95.2%	103.1%	84.1%	99.2%	808	8.0	8.9	16.9
	RXK01	SANDWELL GENERAL HOSPITAL	27689	27013	14098	15959	21701	21057	11727	13140	97.6%	113.2%	97.0%	112.0%	7341	6.5	4.0	10.5
			62523	60957	31878	34131	53370	50745	23827	26216	97.5%	107.1%	95.1%	110.0%	17336	23	16	39
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	202	573	573	157	138	100.0%	87.1%	100.0%	87.9%	188	5.5	1.8	7.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Dec-16	RXK02	CITY HOSPITAL	31106	30016	13528	12482	27055	26094	8854	8909	96.5%	92.3%	96.4%	100.6%	8615	6.5	2.5	9.0
	RXK10	ROWLEY REGIS HOSPITAL	3242	3102	3941	4041	3456	2845	2830	2890	95.7%	102.5%	82.3%	102.1%	2679	2.2	2.6	4.8
	RXK01	SANDWELL GENERAL HOSPITAL	28559	27573	14815	15907	22509	21876	12260	13625	96.5%	107.4%	97.2%	111.1%	10387	4.8	2.8	7.6
			63372	61156	32516	32632	53593	51388	24101	25562	96.5%	100.4%	95.9%	106.1%	21869	19	10	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	322	356	217	210	536	536	37	37	110.6%	96.8%	100.0%	100.0%	180	5.0	1.4	6.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jan-17	RXK02	CITY HOSPITAL	31579	31020	13938	13564	27429	26766	8904	9225	98.2%	97.3%	97.6%	103.6%	9215	6.3	2.5	8.7

	RXK10	ROWLEY REGIS HOSPITAL	2924	3101	3578	4062	3168	2880	2614	2998	106.1%	113.5%	90.9%	114.7%	2607	2.3	2.7	5.0
	RXK01	SANDWELL GENERAL HOSPITAL	28919	27969	14877	17262	22491	22021	12307	14590	96.7%	116.0%	97.9%	118.6%	10304	4.9	3.1	7.9
			63744	62446	32610	35098	53624	52203	23862	26850	98.0%	107.6%	97.4%	112.5%	22306	18	10	28
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	270	315	210	191	518	481	0	46	116.7%	91.0%	92.9%	#DIV/0!	175	4.5	1.4	5.9
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Feb-17	RXK02	CITY HOSPITAL	27838	27199	13363	13030	24460	23721	8831	9138	97.7%	97.5%	97.0%	103.5%	8319	6.1	2.7	8.8
	RXK10	ROWLEY REGIS HOSPITAL	2852	2816	3409	3694	3110	2722	2512	2655	98.7%	108.4%	87.5%	105.7%	2242	2.5	2.8	5.3
	RXK01	SANDWELL GENERAL HOSPITAL	26276	25767	13759	15260	19922	19628	12317	13527	98.1%	110.9%	98.5%	109.8%	9359	4.9	3.1	7.9
			57236	56097	30741	32175	48010	46552	23660	25366	98.0%	104.7%	97.0%	107.2%	20095	18	10	28
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1361	1521	945	615	1642	1430	356	525	111.8%	65.1%	87.1%	147.5%	207	14.3	5.5	19.8
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Mar-17	RXK02	CITY HOSPITAL	27241	26683	13748	13163	24777	23662	10047	9645	98.0%	95.7%	95.5%	96.0%	9536	5.3	2.4	7.7
	RXK10	ROWLEY REGIS HOSPITAL	3239	3038	3947	4107	3588	3072	3340	3328	93.8%	104.1%	85.6%	99.6%	2420	2.5	3.1	5.6
	RXK01	SANDWELL GENERAL HOSPITAL	23762	23020	13865	15342	18052	17437	12492	13552	96.9%	110.7%	96.6%	108.5%	9625	4.2	3.0	7.2
			55603	54262	32505	33227	48059	45601	26235	27050	97.6%	102.2%	94.9%	103.1%	21788	26	14	40
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1335	1416	915	648	1590	1541	345	363	106.1%	70.8%	96.9%	105.2%	210	14.1	4.8	18.9
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Apr-17	RXK02	CITY HOSPITAL	28695	27561	13723	13252	26964	24779	9890	9750	96.0%	96.6%	91.9%	98.6%	9329	5.6	2.5	8.1
	RXK10	ROWLEY REGIS HOSPITAL	3144	2958	3855	4022	2820	2460	3885	3897	94.1%	104.3%	87.2%	100.3%	2274	2.4	3.5	5.9
	RXK01	SANDWELL GENERAL HOSPITAL	23021	21873	13713	14464	17400	16747	12336	12769	95.0%	105.5%	96.2%	103.5%	9569	4.0	2.8	6.9
			56195	53808	32206	32386	48774	45527	26456	26779	95.8%	100.6%	93.3%	101.2%	21382	26	14	40
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	292	337	232	217	573	518	0	55	115.4%	93.5%	90.4%	#DIV/0!	238	3.6	1.1	4.7
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
May-17	RXK02	CITY HOSPITAL	30870	31048	14867	13613	28345	27360	10345	10004	100.6%	91.6%	96.5%	96.7%	9915	5.9	2.4	8.3
	RXK10	ROWLEY REGIS HOSPITAL	3254	3078	4397	4186	2914	2536	4014	3919	94.6%	95.2%	87.0%	97.6%	1536	3.7	5.3	8.9
	RXK01	SANDWELL GENERAL HOSPITAL	26141	25145	14245	14637	22440	22611	12412	12946	96.2%	102.8%	100.8%	104.3%	10047	4.8	2.7	7.5
			60557	59608	33741	32653	54272	53025	26771	26924	98.4%	96.8%	97.7%	100.6%	21736	18	12	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	0	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	328	0.0	0.0	0.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jun-17	RXK02	CITY HOSPITAL	32092	31476	15977	14308	29009	27747	11086	11521	98.1%	89.6%	95.6%	103.9%	9390	6.3	2.8	9.1
	RXK10	ROWLEY REGIS HOSPITAL	3157	2937	4381	3949	2825	2476	3890	3867	93.0%	90.1%	87.6%	99.4%	2282	2.4	3.4	5.8
	RXK01	SANDWELL GENERAL HOSPITAL	24642	24373	13973	14438	19970	19498	12336	13033	98.9%	103.3%	97.6%	105.7%	9303	4.7	3.0	7.7
			59891	58786	34331	32695	51804	49721	27312	28421	98.2%	95.2%	96.0%	104.1%	21303	13	9	23
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	0	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0	#DIV/0!	#DIV/0!	#DIV/0!
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jul-17	RXK02	CITY HOSPITAL	30894	29888	14741	13461	28584	26702	9817	10265	96.7%	91.3%	93.4%	104.6%	9579	5.9	2.5	8.4
	RXK10	ROWLEY REGIS HOSPITAL	3075	3000	4281	3966	2850	2490	3915	3879	97.6%	92.6%	87.4%	99.1%	2269	2.4	3.5	5.9
	RXK01	SANDWELL GENERAL HOSPITAL	25308	24971	14711	14847	22287	22588	13274	13555	98.7%	100.9%	101.4%	102.1%	9811	4.8	2.9	7.7
			59277	57859	33733	32274	53721	51780	27006	27699	97.6%	95.7%	96.4%	102.6%	21659	#DIV/0!	#DIV/0!	#DIV/0!
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	97	112	77	72	191	173	0	18	115.4%	93.5%	90.4%	#DIV/0!	189	1.5	0.5	2.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0	#DIV/0!	#DIV/0!	#DIV/0!
3-month Avges	RXK02	CITY HOSPITAL	31285	30804	15195	13794	28646	27270	10416	10597	98.5%	90.8%	95.2%	101.7%	9628	6.0	2.5	8.6
	RXK10	ROWLEY REGIS HOSPITAL	3162	3005	4353	4034	2863	2501	3940	3888	95.0%	92.7%	87.3%	98.7%	2029	2.7	3.9	6.6
	RXK01	SANDWELL GENERAL HOSPITAL	25364	24830	14310	14641	21566	21566	12674	13178	97.9%	102.3%	100.0%	104.0%	9720	4.8	2.9	7.6
	Total	*Latest 3 month average====>*	59908	58751	33935	32541	53266	51509	27030	27681	98.1%	95.9%	96.7%	102.4%	21566	5.1	2.8	7.9

Nurse Fill Rate' (Safer Staffing) data for July 2017

			Day	Day	Day	Day	Night	Night	Night	Night	Day	Day	Night	Night	Care Hours Per Patient Day (CHPPD)				Note
	Main 2 Specialties on each ward	Main 2 Specialties on each ward	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff										
Ward name	Specialty 1	Specialty 2	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/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	
Critical Care - Sandwell	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	2304	2638	288	407	3936	4985	0	23	114.5%	141.3%	126.7%	#DIV/0!	151	50.5	2.8	53.3	
AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3565	3478	1426	1575	3565	3496	1426	1403	97.6%	110.4%	98.1%	98.4%	1034	6.7	2.9	9.6	
Older Persons Assessment Unit (OPAU)	430 - GERIATRIC MEDICINE	430 - GERIATRIC MEDICINE	1426	1339	1069	1058	1069	1058	1069	1000	93.9%	99.0%	99.0%	93.5%	588	4.1	3.5	7.6	New Oct 16
Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	558	450	372	309	1023	803	341	319	80.6%	83.1%	78.5%	93.5%	415	3.0	1.5	4.5	
Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1426	1437	983	1052	954	1023	713	747	100.8%	107.0%	107.2%	104.8%	693	3.5	2.6	6.1	
Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPAEDICS	160 - PLASTIC SURGERY	1782	1638	1679	1713	1069	1058	1575	1667	91.9%	102.0%	99.0%	105.8%	736	3.7	4.6	8.3	
Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1805	1805	1782	1673	1403	1311	1782	1736	100.0%	93.9%	93.4%	97.4%	1038	3.0	3.3	6.3	
Lyndon 5 - Acute Medicine	100 - GENERAL SURGERY	300 - GENERAL MEDICINE									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	Decant
Lyndon Ground - PAU/Adolescents	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	1116	1050	341	341	0	0	1023	704	94.1%	100.0%	#DIV/0!	68.8%	315	3.3	3.3	6.7	
AMU B - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	Closed
Priory 3 - General Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	
Newton 3 - T&O	110 - TRAUMA & ORTHOPAEDICS	430 - GERIATRIC MEDICINE	1702	1748	1426	1592	1069	1069	1069	1713	102.7%	111.6%	100.0%	160.2%	822	3.4	4.0	7.4	
Newton 4 - Stepdown/Stroke/Neurology	314 - REHABILITATION	300 - GENERAL MEDICINE	1426	1408	1069	1040	1426	1403	1069	1081	98.7%	97.3%	98.4%	101.1%	859	3.3	2.5	5.7	
Newton 5 - Haematology	304 - CLINICAL PHYSIOLOGY	300 - GENERAL MEDICINE	713	759	356	322	713	713	356	345	106.5%	90.4%	100.0%	96.9%	398	3.7	1.7	5.4	
Priory 2 - Colorectal/General Surgery	100 - GENERAL SURGERY	100 - GENERAL SURGERY	1782	1736	1069	1046	1069	1058	713	713	97.4%	97.8%	99.0%	100.0%	723	3.9	2.4	6.3	
Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2139	1943	1069	977	2139	1782	1069	1012	90.8%	91.4%	83.3%	94.7%	629	5.9	3.2	9.1	
Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1782	1771	1069	1035	1426	1403	713	724	99.4%	96.8%	98.4%	101.5%	982	3.2	1.8	5.0	
SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1782	1771	713	707	1426	1426	356	368	99.4%	99.2%	100.0%	103.4%	428	7.5	2.5	10.0	See N2
CCS - Critical Care Services - City	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2976	2820	372	354	2728	2464	0	0	94.8%	95.2%	90.3%	#DIV/0!	141	37.5	2.5	40.0	
D5 - Cardiology (Female)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1426	1656	356	373	1069	1299	0	57	116.1%	104.8%	121.5%	#DIV/0!	410	7.2	1.0	8.3	
D11 - Male Older Adult	430 - GERIATRIC MEDICINE	430 - GERIATRIC MEDICINE	1069	1052	1426	1288	1069	1058	713	747	98.4%	90.3%	99.0%	104.8%	627	3.4	3.2	6.6	
D12 - Isolation	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	
D15 - Gastro/Resp/Haem (Male)	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1069	1155	713	667	1069	1046	356	655	108.0%	93.5%	97.8%	184.0%	677	3.3	2.0	5.2	
D16 - (Female)	301 - GASTROENTEROLOGY	340 - RESPIRATORY MEDICINE	1069	1213	713	667	1069	1069	356	713	113.5%	93.5%	100.0%	200.3%	625	3.7	2.2	5.9	
D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	744	726	170	159	682	341	341	297	97.6%	93.5%	50.0%	87.1%	216	4.9	2.1	7.1	
D21 - Male Urology / ENT	101 - UROLOGY	120 - ENT	1196	1184	713	661	713	701	713	690	99.0%	92.7%	98.3%	96.8%	372	5.1	3.6	8.7	
D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1069	1063	1426	1265	1069	1069	713	713	99.4%	88.7%	100.0%	100.0%	639	3.3	3.1	6.4	
D27 - Oncology	502 - GYNAECOLOGY		558	501	396	315	720	660	360	336	89.8%	79.5%	91.7%	93.3%	451	2.6	1.4	4.0	521
AMU 2 & West Midlands Poisons Unit -	300 - GENERAL MEDICINE	305 - CLINICAL PHARMACOLOGY	1782	1742	356	339	1782	1449	356	368	97.8%	95.2%	81.3%	103.4%	502	6.4	1.4	7.8	
Surgical Assesment Unit - City	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	Closed
D43 - Community RTG	318- INTERMEDIATE CARE	430 - GERIATRIC MEDICINE	1380	1265	1380	1334	1035	1023	1035	1035	91.7%	96.7%	98.8%	100.0%	782	2.9	3.0	6.0	
D47 - Geriatric MEDICAL			1230	1063	1207	1075	690	701	690	701	86.4%	89.1%	101.6%	101.6%	568	3.1	3.1	6.2	
D7 - Cardiology (Male)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	2139	2087	356	350	1782	1771	0	34	97.6%	98.3%	99.4%	#DIV/0!	517	7.5	0.7	8.2	
Female Surgical (D17)	101 - UROLOGY	120 - ENT	1069	1006	563	626	989	966	621	632	94.1%	111.2%	97.7%	101.8%	348	5.7	3.6	9.3	
Labour Ward - City	501 - OBSTETRICS	501 - OBSTETRICS	3921	2997	713	741	3921	3139	713	678	76.4%	103.9%	80.1%	95.1%	352	17.4	4.0	21.5	
City Maternity - M1	501 - OBSTETRICS	424- WELL BABIES	1069	1017	713	707	1069	897	356	356	95.1%	99.2%	83.9%	100.0%	459	4.2	2.3	6.5	
City Maternity - M2	501 - OBSTETRICS	424- WELL BABIES	1069	1017	673	644	1069	920	356	368	95.1%	95.7%	86.1%	103.4%	446	4.3	2.3	6.6	
AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	2495	2507	1069	1040	2495	2507	1069	1069	100.5%	97.3%	100.5%	100.0%	729	6.9	2.9	9.8	
Neonatal			2495	2673	713	408	2495	2599	713	414	107.1%	57.2%	104.2%	58.1%	664	7.9	1.2	9.2	
Serenity Birth Centre - City	501 - OBSTETRICS	501 - OBSTETRICS	1069	1144	713	448	1069	1023	356	402	107.0%	62.8%	95.7%	112.9%	54	40.1	15.7	55.9	
Ophthalmology Main Ward - City	130 - OPHTHALMOLOGY	180 - ACCIDENT & EMERGENCY									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	-	#VALUE!	#VALUE!	#VALUE!	
Eliza Tinsley Ward - Community RTG	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	540	531	720	693	720	360	1080	1080	98.3%	96.3%	50.0%	100.0%	629	1.4	2.8	4.2	
Henderson	318- INTERMEDIATE CARE		1035	1029	1581	1437	690	690	1035	1023	99.4%	90.9%	100.0%	98.8%	496	3.5	5.0	8.4	
Leasowes	318- INTERMEDIATE CARE		960	882	1260	1260	720	720	720	720	91.9%	100.0%	100.0%	100.0%	496	3.2	4.0	7.2	
MCCarthy	318- INTERMEDIATE CARE		540	558	720	576	720	720	1080	1056	1	80.0%	100.0%	97.8%	648	2.0	2.5	4.5	
	Trust Totals		**59277**	**57859**	**33733**	**32274**	**53721**	**51780**	**27006**	**27699**	1	95.7%	96.4%	102.6%	21659	**5.1**	**2.8**	**7.8**	

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RXK Sandwell And West Birmingham Hospitals NHS Trust

Period: July_2017-18

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

https://www.swbh.nhs.uk/

Comments

Validation alerts (see control panel)	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name	Only complete sites your organisation is accountable for: Ward name	Main 2 Specialties on each ward: Specialty 1	Specialty 2	Day: Registered midwives/nurses: Total monthly planned staff hours	Day: Registered midwives/nurses: Total monthly actual staff hours	Day: Care Staff: Total monthly planned staff hours	Day: Care Staff: Total monthly actual staff hours	Night: Registered midwives/nurses: Total monthly planned staff hours	Night: Registered midwives/nurses: Total monthly actual staff hours	Night: Care Staff: Total monthly planned staff hours	Night: Care Staff: Total monthly actual staff hours	Day: Average fill rate - registered nurses/midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses/midwives (%)	Night: Average fill rate - care staff (%)	Care Hours Per Patient Day (CHPPD): Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Critical Care - Sandwell	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2304	2638	288	407	3936	4985	0	23	114.5%	141.3%	126.7%	-	151	50.5	2.8	53.3
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3565	3478	1426	1575	3565	3496	1426	1403	97.6%	110.4%	98.1%	98.4%	1034	6.7	2.9	9.6
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Older Persons Assessment U	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1426	1339	1069	1058	1069	1058	1069	1000	93.9%	99.0%	99.0%	93.5%	588	4.1	3.5	7.6
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	558	450	372	309	1023	803	341	319	80.6%	83.1%	78.5%	93.5%	415	3.0	1.5	4.5
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1426	1437	983	1052	954	1023	713	747	100.8%	107.0%	107.2%	104.8%	693	3.5	2.6	6.1
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPAEDICS	160 - PLASTIC SURGERY	1782	1638	1679	1713	1069	1058	1575	1667	91.9%	102.0%	99.0%	105.8%	736	3.7	4.6	8.3
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1805	1805	1782	1673	1403	1311	1782	1736	100.0%	93.9%	93.4%	97.4%	1038	3.0	3.3	6.3
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon Ground - PAU/Adoles	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	1116	1050	341	341	0	0	1023	704	94.1%	100.0%	-	68.8%	315	3.3	3.3	6.7
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 3 - T&O	110 - TRAUMA & ORTHOPAEDICS	430 - GERIATRIC MEDICINE	1702	1748	1426	1592	1069	1069	1069	1713	102.7%	111.6%	100.0%	160.2%	822	3.4	4.0	7.4
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 4 - Stepdown/Stroke/I	314 - REHABILITATION	300 - GENERAL MEDICINE	1426	1408	1069	1040	1426	1403	1069	1081	98.7%	97.3%	98.4%	101.1%	859	3.3	2.5	5.7
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 5 - Haematology	304 - CLINICAL PHYSIOLOGY	300 - GENERAL MEDICINE	713	759	356	322	713	713	356	345	106.5%	90.4%	100.0%	96.9%	398	3.7	1.7	5.4
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 2 - Colorectal/General S	100 - GENERAL SURGERY	100 - GENERAL SURGERY	1782	1736	1069	1046	1069	1058	713	713	97.4%	97.8%	99.0%	100.0%	723	3.9	2.4	6.3
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2139	1943	1069	977	2139	1782	1069	1012	90.8%	91.4%	83.3%	94.7%	629	5.9	3.2	9.1
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1782	1771	1069	1035	1426	1403	713	724	99.4%	96.8%	98.4%	101.5%	982	3.2	1.8	5.0
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1782	1771	713	707	1426	1426	356	368	99.4%	99.2%	100.0%	103.4%	428	7.5	2.5	10.0
	RXK02	CITY HOSPITAL - RXK02	CCS - Critical Care Services -	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2976	2820	372	354	2728	2464	0	0	94.8%	95.2%	90.3%	-	141	37.5	2.5	40.0
	RXK02	CITY HOSPITAL - RXK02	D5 - Cardiology (Female)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1426	1656	356	373	1069	1299	0	57	116.1%	104.8%	121.5%	-	410	7.2	1.0	8.3
	RXK02	CITY HOSPITAL - RXK02	D11 - Male Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1069	1052	1426	1288	1069	1058	713	747	98.4%	90.3%	99.0%	104.8%	627	3.4	3.2	6.6
	RXK02	CITY HOSPITAL - RXK02	D15 - Gastro/Resp/Haem (Ma	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1069	1155	713	667	1069	1046	356	655	108.0%	93.5%	97.8%	184.0%	677	3.3	2.0	5.2
	RXK02	CITY HOSPITAL - RXK02	D16 - (Female)	301 - GASTROENTEROLOGY	340 - RESPIRATORY MEDICINE	1069	1213	713	667	1069	1069	356	713	113.5%	93.5%	100.0%	200.3%	625	3.7	2.2	5.9
	RXK02	CITY HOSPITAL - RXK02	D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	744	726	170	159	682	341	341	297	97.6%	93.5%	50.0%	87.1%	216	4.9	2.1	7.1
	RXK02	CITY HOSPITAL - RXK02	D21 - Male Urology / ENT	101 - UROLOGY	120 - ENT	1196	1184	713	661	713	701	713	690	99.0%	92.7%	98.3%	96.8%	372	5.1	3.6	8.7
	RXK02	CITY HOSPITAL - RXK02	D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1069	1063	1426	1265	1069	1069	713	713	99.4%	88.7%	100.0%	100.0%	639	3.3	3.1	6.4
	RXK02	CITY HOSPITAL - RXK02	D27 - Oncology	502 - GYNAECOLOGY		558	501	396	315	720	660	360	336	89.8%	79.5%	91.7%	93.3%	451	2.6	1.4	4.0
	RXK02	CITY HOSPITAL - RXK02	AMU 2 & West Midlands Pois	300 - GENERAL MEDICINE	305 - CLINICAL PHARMACOLOGY	1782	1742	356	339	1782	1449	356	368	97.8%	95.2%	81.3%	103.4%	502	6.4	1.4	7.8
	RXK02	CITY HOSPITAL - RXK02	D43 - Community RTG	318- INTERMEDIATE CARE	430 - GERIATRIC MEDICINE	1380	1265	1380	1334	1035	1023	1035	1035	91.7%	96.7%	98.8%	100.0%	782	2.9	3.0	6.0
	RXK02	CITY HOSPITAL - RXK02	D47 - Geriatric MEDICAL	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1230	1063	1207	1075	690	701	690	701	86.4%	89.1%	101.6%	101.6%	568	3.1	3.1	6.2
	RXK02	CITY HOSPITAL - RXK02	D7 - Cardiology (Male)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	2139	2087	356	350	1782	1771	0	34	97.6%	98.3%	99.4%	-	517	7.5	0.7	8.2
	RXK02	CITY HOSPITAL - RXK02	Female Surgical Ward	101 - UROLOGY	120 - ENT	1069	1006	563	626	989	966	621	632	94.1%	111.2%	97.7%	101.8%	348	5.7	3.6	9.3
	RXK02	CITY HOSPITAL - RXK02	Labour Ward - City	501 - OBSTETRICS	501 - OBSTETRICS	3921	2997	713	741	3921	3139	713	678	76.4%	103.9%	80.1%	95.1%	352	17.4	4.0	21.5
	RXK02	CITY HOSPITAL - RXK02	City Maternity - 1	501 - OBSTETRICS	424- WELL BABIES	1069	1017	713	707	1069	897	356	356	95.1%	99.2%	83.9%	100.0%	459	4.2	2.3	6.5
	RXK02	CITY HOSPITAL - RXK02	City Maternity - 2	501 - OBSTETRICS	424- WELL BABIES	1069	1017	673	644	1069	920	356	368	95.1%	95.7%	86.1%	103.4%	446	4.3	2.3	6.6
	RXK02	CITY HOSPITAL - RXK02	AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	2495	2507	1069	1040	2495	2507	1069	1069	100.5%	97.3%	100.5%	100.0%	729	6.9	2.9	9.8
	RXK02	CITY HOSPITAL - RXK02	Neonatal	422- NEONATOLOGY		2495	2673	713	408	2495	2599	713	414	107.1%	57.2%	104.2%	58.1%	664	7.9	1.2	9.2
	RXK02	CITY HOSPITAL - RXK02	Serenity Birth Centre - City	501 - OBSTETRICS	501 - OBSTETRICS	1069	1144	713	448	1069	1023	356	402	107.0%	62.8%	95.7%	112.9%	54	40.1	15.7	55.9
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	Eliza Tinsley Ward - Commun	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	540	531	720	693	720	360	1080	1080	98.3%	96.3%	50.0%	100.0%	629	1.4	2.8	4.2
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	Henderson	318- INTERMEDIATE CARE		1035	1029	1581	1437	690	690	1035	1023	99.4%	90.9%	100.0%	98.8%	496	3.5	5.0	8.4
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	Leasowes	318- INTERMEDIATE CARE		960	882	1260	1260	720	720	720	720	91.9%	100.0%	100.0%	100.0%	496	3.2	4.0	7.2
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	McCarthy	318- INTERMEDIATE CARE		540	558	720	576	720	720	1080	1056	103.3%	80.0%	100.0%	97.8%	648	2.0	2.5	4.5

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RXK Sandwell And West Birmingham Hospitals NHS Trust

Period: July_2017-18

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https://www.swbh.nhs.uk/

Comments

Only complete sites your organisation is accountable for

Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	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/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Critical Care - Sandwell	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2304	2638	288	407	3936	4985	0	23	114.5%	141.3%	126.7%	-	151	50.5	2.8	53.3

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RXK Sandwell And West Birmingham Hospitals NHS Trust

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Only complete sites your organisation is accountable for

Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site Name		Specialty 1	Specialty 2	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/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Critical Care - Sandwell	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2304	2638	288	407	3936	4985	0	23	114.5%	141.3%	126.7%	-	151	50.5	2.8	53.3

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RXK Sandwell And West Birmingham Hospitals NHS Trust

Period: July_2017-18

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

https://www.swbh.nhs.uk/

Comments

Validation alerts (see control panel)	Hospital Site Details		Only complete sites your organisation is accountable for	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name	Ward name	Specialty 1	Specialty 2	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
						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								
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Critical Care - Sandwell	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2304	2638	288	407	3936	4985	0	23	114.5%	141.3%	126.7%	-	151	50.5	2.8	53.3
			Total			59277	57859	33733	32274	53721	51780	27006	27699					21659			
RXK01	SANDW	0	0	0	0	0	0	0	0	0	0	0				1	1	1	1	0	
RXK01	SANDW	0	0	0	0	0	0	0	0	0	0	0				0	1	0	0	0	
RXK01	SANDW	0	0	0	0	0	0	0	0	0	0	0				0	0	0	0	0	
RXK01	SANDW	0	0	0	0	0	0	0	0	0	0	0				0	0	0	0	0	

The Black Country and West Birmingham Sustainability & Transformation Partnership

Memorandum of Understanding

Contents

1. Parties

1.1 The parties to the Partnership are the following NHS organisations and Local Authorities, where their governing bodies authorize the signing of this Memorandum of Understanding (MoU):

- Black Country Partnership NHS Foundation Trust
- Dudley Metropolitan Borough Council
- Dudley Group NHS Foundation Trust
- Dudley and Walsall Mental Health Partnership NHS Trust
- NHS Dudley Clinical Commissioning Group
- Sandwell Metropolitan Borough Council
- Birmingham City Council
- Birmingham Community Healthcare NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- NHS Sandwell & West Birmingham Clinical Commissioning Group
- Walsall Metropolitan Borough Council
- Walsall Healthcare NHS Trust
- NHS Walsall Clinical Commissioning Group
- Wolverhampton City Council
- Royal Wolverhampton NHS Trust
- NHS Wolverhampton Clinical Commissioning Group
- West Midlands Ambulance Service NHS Foundation Trust
- NHS England (Specialised Commissioning).

1.2 Organisations listed above that do not sign this MoU but wish to contribute to Partnership discussions will be welcomed as Associate Members. Partnership Board Terms of Reference also allow for wider system partners to be included in Partnership discussions.

1.3 The Partnership recognizes that there are other system partners, not listed above (e.g. Primary Care, Third Sector organisations), and it affirms its intention to work for the benefit of the whole system not simply that of Partner and Associate members. The Terms of Reference for the Partnership Board sets out how wider partners will be engaged, including the patient voice.

1.4 In the event that any of the above organisations is party to a merger or is subject to acquisition, or that a new provider is formed or contracted to provide services within the footprint (e.g. an accountable care organisation), the Partnership Board shall determine whether any additional organisations should be invited to sign this MoU as Partners.

2. Background

2.1 NHS Shared Planning Guidance for 2016/17 – 2020/21 asked every local health and care system to come together to create its own Sustainability and Transformation Plan (STP) for accelerating the implementation of the Five Year Forward View (FYFV). The subsequent 2017 delivery plan, Next Steps on the Five Year Forward View, set out national priorities for implementation and clarified the developing role of STPs.

2.2 The Black Country and West Birmingham footprint was identified as one of the STP footprint areas in which people and organisations would work together to develop robust plans to transform the way that health and care is planned and delivered for the footprint population. The Black Country and West Birmingham partnership represents many different constituent interests (including registered population, resident populations, and populations utilising services and/or working within the geographical area) and that this may change over time. Subject to agreement by the sponsoring group, to allow new members or associate members representing neighbouring population interests to be included within the arrangement.

2.3 The Parties have agreed to work together to enable transformative change and the implementation of the FYFV vision of better health and wellbeing, improved quality of care, and more sustainable services.

2.4 The Parties have collaborated in the development of draft proposals (as set out in Schedule 1) and recognise the need now to develop and implement more detailed plans in key areas.

3. Objective and Intent

3.1 The Objective of this MoU is to provide a mechanism for securing the Parties' agreement and commitment to sustained engagement with, and delivery of, STP plans in order to realise a transformed model of care across The Black Country and West Birmingham.

3.2 The intent of this agreement is to bind the parties to the common purpose of delivering a clinically, socially and financially sustainable health and care system that will improve the health and wellbeing of the population and address inequalities. This requires the Parties to recognise the scale of change required and that its impact may be differential on the Parties. The Partnering Statement is included within Schedule 4.

4. Obligations

4.1 The Parties agree to work collectively to establish the detailed plans and organisational impacts that will achieve the Objectives and Intent. These will incorporate finance, activity and workforce as a minimum, and will be set out in an annual system plan in a format to be agreed.

4.2 The Parties agree that they will comply with the annual system plans that move the system incrementally towards the Objectives and Intent, and that they will actively contribute to reporting performance and progress against the plan both within the Partnership and, through the Partnership, to Regulators.

5. Benefits

5.1 The Parties shall realise the benefits of working collectively by receiving system and regulator support to manage in-year and longer term risks as a whole system, supported by the Parties individually and collectively to the extent that no organisation is deemed to fail individually. Regulator interventions will be aligned to this benefit in order that all parts of the system can release maximum resources to delivery of the intent.

6. Leadership

6.1 Andy Williams will serve as STP Lead.

6.2 The STP Lead's role and remit are set out in Schedule 2.

6.3 The designated STP Lead may change from time to time in accordance with such process as may be agreed by the Partnership in consultation with Regulators.

7. Duration of the MoU

7.1 This MoU will take effect for each party on the date it is signed by that party, following a formal resolution by its governing body.

7.2 The Parties expect the initial duration of the MoU to be for the period of 2017-2021, as a minimum, or otherwise until its termination in accordance with Clause 15.

8. Agreed principles

8.1 The Parties have agreed to work together in a constructive and open manner in accordance with the agreed principles for ways of working and the culture set out in Schedule 3 to achieve the Objective and Intent.

9. Effect of the MoU

9.1 This MoU does not and is not intended to give rise to legally binding commitments between the Parties.

9.2 The MoU does not and is not intended to affect each Party's individual accountability as an independent organisation.

9.3 Despite the lack of legal obligation imposed by this MoU, the Parties:

- have given proper consideration to the terms set out in this MoU; and
- agree to act in good faith to meet the requirements of the MoU.

10. Governance

10.1 The Parties have agreed to establish the Partnership to co-ordinate achievement of the Objective and Intent.

10.2 The Parties have agreed Terms of Reference for the Partnership Board in the form set out in Schedule 4. Terms of Reference describe arrangements for aligned decision making of the Parties which they agree is necessary to achieve the Objective and Intent.

10.3 Each Party will nominate a representative to the Partnership Board and notify the STP Lead of that representative and of a deputy who is authorised to attend in her/his place.

10.4 The Parties agree that the Partnership Board will be responsible for co-ordinating the arrangements set out in this MoU and providing overview and drive for the STP.

10.5 The Partnership Board will meet at least monthly or as otherwise may be required to meet the requirements of the STP.

10.6 The Partnership Board does not have any authority to make binding decisions

on behalf of the Parties. Collective decisions made by the Partnership require ratification by each Party's unitary Board or equivalent.

11. Subsidiarity

11.1 The Parties acknowledge the importance of subsidiarity in terms of The Black Country and West Birmingham's distinct communities.

11.2 The Parties agree that, where appropriate, decisions should be made as close as possible to the people affected by them.

12. Risk management and assurance

12.1 The Parties will develop and maintain a risk register for the STP.

12.2 NHS Commissioners will confirm risk sharing agreements in the light of this MoU.

13. Resources

13.1 The Parties have agreed to commit their own resources to achieve the Objective in accordance with the arrangements set out in Schedule 5.

13.2 Parties also expect that resources currently held by NHS Regulators will also be committed to the work of the STP.

13.3 The STP has an existing Partnership Agreement with The Strategy Unit to provide strategic support and advice, and data and evidence analysis.

13.4 The Parties have further agreed the arrangements set out in Schedule 6 for engaging any additional external resource and advice.

14. Openness and transparency

14.1 The Parties agree that they will work openly and transparently with each other and with other stakeholders, including non-executive directors, governors and elected members of the Parties and other local health and care organisations.

14.2 The Partnership Board will receive plans that demonstrate each Party's compliance with their duties of public involvement to the extent that these

may impact on any other party to this agreement, or be enhanced by the involvement of one or more of the Parties. If there is any ambiguity as to whether the Partnership may require these plans then this should be discussed with the STP Lead.

15. Termination

15.1 Any Party may withdraw from this agreement at any time, following a formal resolution by its governing body, duly notified to the STP Lead who will promptly communicate this notice to other Parties.

15.2 In making such a resolution, the withdrawing Party recognises that it will cease to benefit from any collective agreement or treatment established whilst acting under the agreement, and that it will lose the ability to play a part in Partnership decision-making.

15.3 This agreement is intended to endure for the lifespan of the STP but this collective commitment will be reviewed at least annually to ensure that it remains fit for purpose and meets the needs of the Parties. The Parties will agree whether to extend and/or amend this arrangement according to prevailing circumstances.

16. Dispute resolution

16.1 The Parties will attempt to resolve any dispute between them in respect of this MoU by negotiation in good faith.

16.2 Where Parties are unable to reach agreement, proposals for dispute resolution will be set out by the STP Lead according to the circumstances of the dispute, such that any mediation/arbitration is conducted by one or more of the Parties neutral to the dispute. This may require recourse to external expertise (procured in accordance with Schedule 6) or to intervention by NHS Regulators.

17. General provisions

The Parties agree that this MoU may be varied only with the written agreement of all the Parties.

Signed by the duly authorised representatives of the parties on the dates set out below.

Partner Organisation	Role of Signatory	Signature	Date of Signature
Black Country Partnership NHS Foundation Trust			
Dudley Metropolitan Borough Council			
Dudley Group NHS Foundation Trust			
Dudley and Walsall Mental Health Partnership NHS Trust			
NHS Dudley Clinical Commissioning Group			
Sandwell Metropolitan Borough Council			
Birmingham City Council			
Birmingham Community Healthcare NHS Foundation Trust			
Sandwell and West Birmingham Hospitals NHS Trust			
NHS Sandwell & West Birmingham Clinical Commissioning Group			
Walsall Metropolitan Borough Council			

Partner Organisation	Role of Signatory	Signature	Date of Signature
Walsall Healthcare NHS Trust			
NHS Walsall Clinical Commissioning Group			
Wolverhampton City Council			
Royal Wolverhampton NHS Trust			
NHS Wolverhampton Clinical Commissioning Group			
West Midlands Ambulance Service NHS Foundation Trust			
NHS England – Specialised Commissioning			

[MoU adapted with permission from a template developed for the Devon Success Regime by Hempsons]

Schedule One – Latest STP Submission

Schedule Two – Role and Remit of STP Lead

1 Introduction

The Black Country and West Birmingham STP provides an important opportunity to redefine the future of health and social care locally. There is a collective responsibility to transform care and build delivery and confidence through collaborative effort so that local populations experience services that are of outstanding quality, and are both financially and clinically sustainable.

STP Partner organisations, informed by national guidance, have identified the appointment of an STP Lead as an essential role in supporting the achievement of this goal.

2 What behaviours will the STP Lead need to demonstrate?

The STP Lead (like any leader across the footprint) will need to prioritise and advocate for the needs of The Black Country and West Birmingham population over and above the interests of individual partner organisations. The STP Lead will need to be:

- Organisationally neutral, system leadership focused
- Open, frank and constructive, building good relationships with colleagues and between colleagues
- Engaging of all stakeholders, partners and the public to build a momentum for constructive challenge, constructive dialogue, engagement and consultation
- Committed to build on the positive experiences and services across the patch while pursuing the adoption of best practice and outcomes for all to meet the scale of the challenge faced
- Act and be regarded as fair, balanced and inclusive
- Be an honest broker and mandated by colleague Chief Executives to support and constructively challenge other leaders and Boards to reframe their leadership style and language if necessary to secure agreed STP goals
- Able to explore, through openness and transparency, areas of conflicting views or perceived vested interests of any of the parties.
- Appreciate and integrate the differing requirements, governance and accountabilities involved, supporting all Partners to secure the best outcomes for the STP population while respecting the extant statutory roles of each

organisation

- Demonstrate courage, energy and upmost integrity.

3 What are the requirements of the STP Lead?

This role will require an individual who has the confidence and, therefore, the mandate of existing leaders in the STP, and who possesses the following attributes:

- An experienced and successful executive leader
- Detailed understanding of the regulatory arena and the complexity of health and social care provision
- A wide range of experience working with Boards, and interacting with system partners at local, regional and national levels
- Able to be an efficient, effective, person-centred and future-focused coach of very senior individuals
- Track record of succeeding in a highly challenging environment where tenacity, resilience and humility have been key ingredients for success.
- Able to rapidly secure the confidence of regulatory bodies - credibly balancing the best efforts of local Partners whilst also harnessing external capacity (including relevant resource within Regulators) to drive a new and fully integrated way of working.
- Visible to stakeholders to secure their engagement and confidence to offer and participate in solutions for future models of care
- Able to facilitate and resolve potential material issues of difference in terms of governance and pace of delivery
- A confident public and media spokesperson
- Fluent in the new models of care, national developments, integrated care and the potential for devolution deals across a wide and dispersed geographical patch
- Demonstrable experience of managing local delivery and change under intense national political and media interest.

4 What is the role of the STP Lead?

- To lead Partners in developing and delivering an overall system plan, and in

working towards an acceptable mechanism for managing a single financial control total. This plan will be a compelling platform from which to transform health and care services at pace and scale, securing sustainability within an ambitious timescale.

- To design, lead and drive the overall STP programme. This would include working with all stakeholders and NHS bodies to maximise the potential to deliver excellence, improved health and well-being for populations and communities and integrated and improved care for people.

- To ensure that, where any major service change is proposed, relevant Partners undertake an exemplary approach to engagement and consultation, and that proposals are developed in line with national guidance around the 'five tests' and informed by the Clinical Assurance Framework developed by the West Midlands Clinical Senate.

- To be the lead officer and main point of contact in the footprint for NHS Regulators, and to be the focus of liaison with neighbouring (and national) STPs, working to ensure the appropriate alignment of plans

- To secure from Partners the resources required to develop and deliver the system plan, including the secondment (full or partial) of Partner organisation staff to fulfil STP roles.

- To administer and deploy all STP resources, internally or externally acquired, and to be accountable to Partners for the resource expended.

- To ensure that, although the STP currently has no stand-alone statutory basis, sufficient commitment to, and confidence in, the STP and its leadership is established so as to support the robust and timely delivery of transformation plans. This will include assisting the Partnership to articulate its role on which the collective support is made as being separate from the individual statutory roles and requirements of each organisation represented. As the STP evolves, and subsequent guidance and advice is received, the STP Lead should bring forward proposals for developing the mechanisms for governance and for potential changes to organisational form.

Schedule Three – Agreed Principles

1. Partnership Working Agreement

The Partnership has been established to oversee delivery of the Sustainability and Transformation Plan (STP). This group comprises STP Partner organisations, with associate and other relevant local organisations in attendance at meetings of the Partnership Board.

The following framework sets out the principles that shape how the Partnership shall conduct itself, and agreement to these principles is a pre-requisite to membership of Partnership for organisations that are signatories to the MoU. Other organisations attending the Partnership Board will also be asked to reflect the values set out below.

This agreement is open to statutory bodies responsible for commissioning and/or delivering health and social care services within the defined STP footprint. The organisations eligible for membership, subject to signing up to this agreement, are set out in Appendix 1.

In order that the system may performance manage itself to achieve its objectives, there is a requirement for organisations to give Board/Governing body approval for their organisations to be collectively supported to deliver and to be held to account for that delivery by the system governance arrangements. Whilst their agreement cannot be legally enforced, commitment to this level of mutual accountability is essential, particularly in advance of any challenging circumstances arising.

In order to minimise external intervention, there is considerable advantage to the system of sign-up by regulators to a system-wide plan and accountability arrangements, so that they can have confidence in the system delivering without their intervention. It is therefore proposed that regulators are similarly requested to sign up to a similar commitment.

The organisations therefore agree by their signature to this MoU to the following Partnership Statement:

> *The Partners in The Black Country and West Birmingham STP agree that there is considerable benefit to joint working arrangements that put our patients and service users at the heart of everything we do.*
>
> *We accept that the sustainability challenge is of a scale that will require significant change in order for these to be addressed.*
>
> *Some of the changes may require any of our organisations to enact developments that, whilst demonstrably improving delivery across the*

system, may be suboptimal to a member's organisation. We commit to making such changes where these deliver the STP overall objective of sustainability of the system in the knowledge that none of our organisations will be able to achieve optimal outcomes for patients, service users, carers and families unless the whole system is enabled to function optimally.

We agree to provide the appropriate attendance to support the membership of Partnership, to hold each other to account to deliver our elements of the system plan, and to support and accept support from our fellow Partners to achieve our objectives.

We agree that this function shall be exercised both collectively and by the appointed STP Lead.

2. Partnership Values

The Sustainability and Transformation Plan relationship will be based on:

- Securing beneficial impact for the population of the footprint, and for others accessing footprint services
- Collaborative Leadership & Decision Making
- An inclusive process across the NHS and Local Government
- Engaging clinicians, practitioners, and staff delivering NHS funded care
- Equality of status between all Partner organisations (subject to the respecting of each organisation's differential rights and responsibilities as determined by statute)
- Mutual respect and trust
- Open and transparent communications
- Co-operation and consultation
- A commitment to being positive and constructive
- A willingness to work with and learn from others
- A shared commitment to providing effective and efficient services to the population of The Black Country and West Birmingham
- A shared commitment to deliver parity between mental and physical health care

- A desire to make the best use of resources across the NHS and local government.

3. Partnership Outcomes

- Service delivery will be quality and outcomes focused, prioritising patient/user care and experience by working towards an improvement in health and well-being and a reduction in health inequality.

- The work of the STP needs to be led by health and care clinicians and other professionals, focused on the development of a strategy that targets material improvements in areas of care highlighted in the STP's draft proposals and in NHSE's 2017-21 delivery plan.

- Partner organisations share a common vision and values, whilst understanding the scope of their individual obligations to ensure commissioning ambitions, service delivery and intentions of each of the organisation are accounted for.

- The Model of Care within our system will be transformed to achieve sustainable health and care systems within The Black Country and West Birmingham, mindful also of the impact of plans on neighbouring systems.

- Developing high quality and efficient place-based systems of care will be a prime focus of our work programme. We recognise that the definition of 'place' will differ between services. For the majority of services, 'place' may equate to our four Local Authority areas (each with its own subsidiary 'places' – neighbourhoods/localities of c.30,000-50,000 population) but, for more specialist services, 'place' may be the whole footprint (or even multiple STP footprints) where there is evidence that providing services to larger populations supports the delivery of safe, effective and sustainable care.

- Primary Care provision will play a key role in the design and delivery of the emergent new models of care, and mechanisms to secure the involvement of non- statutory body providers must be developed.

- Our plan will deliver financial and performance improvement from year one.

- Partners recognise that achieving financial sustainability for health and care services in the long term may differentially impact individual STP organisations. Where this results in short term financial pressures for one or more individual organisations, Partners will work together transparently to support the identification and/or implementation of local actions that mitigate short term pressures and that avoid, where possible, the emergence of unsustainable and unplanned long term pressures.

The STP recognizes, however, that it has no direct control over Partner finances but will simply facilitate collaboration between Partners to create whole-system benefit.

4. Partnership Behaviours

- We agree to work collaboratively at pace to successfully develop and deliver a system plan for the STP
- We will identify where it is mutually beneficial to share information to advance an evidenced individual and/or system benefit, and to do so on the basis that the information requested is reasonable for the purpose only, and not excessive. Where information is shared, it is agreed that it will be used for the stated purpose only
- We will demonstrate, through our positive and proactive and inclusive manner, a willingness to make the Partnership succeed
- We will communicate openly about major concerns, issues or opportunities
- We will demonstrate transparent communications in terms of delivery of STP plans and notification of any quality or financial organisational concerns, including mitigation planning
- We will share information , experience and resource, to work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost
- We will adhere to statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, data protection and freedom of information
- We will act in a timely manner, developing robust plans that take full account of governance, assurance, procurement and democratic accountability processes, and will seek to respond promptly to requests for information from such processes
- We will learn from the best practice of Partner organisations and will seek to develop as a Partnership to achieve the full potential of the relationship
- We will work collaboratively on all aspects of our work, seeking to release resource to focus on transformation and adopting an approach based on doing things once together (i.e. one plan for everything we do – trusting others to act on our behalf and on behalf of the system)
- We will publish operational plans and performance data including waiting times, sharing strategic plans, headline contract values and CIP plans

- We agree that challenge will be required in the system and parties will on occasion take different views. All parties agree that where possible we will aim to resolve issues of difference between organisations professionally and privately

- We agree not to take pre-emptive public action on any matter that may result in a public disagreement between Partners

- We agree that the right thing to do is to take costs out of system and therefore we will not engage in activities that primarily aim to transfer deficits

- We will require programme leads to be responsible for assuring and mitigating the commercial conflict of involvement in the wider redesign programmes

- We will develop our workforce to enable people to deliver the objectives requested of them from the STP

- We agree to cascade within our own organisations these values, behaviours and work programmes, leading by example

- We agree to challenge one another in an open and measured manner when there are matters on which we disagree

- To ensure the robust and timely delivery of agreed STP plans, Partners agree to the use of peer review processes within the STP, providing mutual assurance about the effective contribution of each Partner. These processes will adopt an 'open book' approach with confidentiality safeguards where the information to be shared is commercially sensitive.

Appendix 1: Eligible Partnership Organisations

- Black Country Partnership NHS Foundation Trust
- Dudley Metropolitan Borough Council
- Dudley Group NHS Foundation Trust
- Dudley and Walsall Mental Health Partnership NHS Trust
- NHS Dudley Clinical Commissioning Group
- Sandwell Metropolitan Borough Council
- Birmingham City Council
- Birmingham Community Healthcare NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- NHS Sandwell & West Birmingham Clinical Commissioning Group
- Walsall Metropolitan Borough Council
- Walsall Healthcare NHS Trust
- NHS Walsall Clinical Commissioning Group
- Wolverhampton City Council
- Royal Wolverhampton NHS Trust
- NHS Wolverhampton Clinical Commissioning Group
- West Midlands Ambulance Service NHS Foundation Trust
- NHS England (Specialised Commissioning).

Schedule Four – Black Country Partnership Board Terms of Reference

1. Introduction

The Partnership is established in accordance with "Next Steps on the NHS Five Year Forward View" and the MoU between the Partners of The Black Country and West Birmingham STP. These terms of reference set out the membership, remit, duties and responsibilities of the Partnership. The Partnership will review its terms of reference annually.

2. Role:

The purpose of the Partnership is to bring together the statutory providers and commissioners of health and care services in The Black Country and West Birmingham to oversee the development and delivery of plans that will keep people healthier for longer and integrate services around the patients who need them most. To enable this, the Partnership recognizes the need to proactively engage with other significant elements within the local health and social care system, including through their attendance at Partnership Board meetings.

The objectives of the Partnership Board are to:

- Plan services across The Black Country and West Birmingham that are safer and more effective because they link together hospitals so that staff and expertise are shared between them
- Engage front-line clinicians in all settings to drive the real changes to the way care is delivered
- Determine the priorities of the Partnership
- Ensure alignment with Operating Plans
- Ensure that the findings from JSNA inform Partnership plans and strategic objectives
- Identify and ensure the delivery of strategic redesign work streams
- Ensure that Partners fulfil their statutory requirement to consult and engage with patients, public and stakeholders with regard to strategic and local commissioning plans and service changes
- Ensure that the equality and diversity implications of commissioning services and clinical/professional developments are properly considered and acted upon
- Monitor and review commissioning strategies, joint working arrangement, plans and

redesign work streams and their respective implementation.

3. Membership:

The voting members of the Partnership shall be the nominated single representatives of each Partner organisation that is a signatory to this MoU. Additionally, voting rights shall also apply to the STP Lead, the STP Professional Chair and the lay member/non-executive director nominated by the Chairs of NHS provider Trusts with Partner status.

The Partnership Board may agree that non-voting members may be in attendance at its meetings to contribute to its discussions where relevant and appropriate. In particular, the Partnership Board will, as a priority, identify how Primary Care should be represented (e.g. via established Federations of a certain scale or via LMC or RCGP representation). In addition, single representatives of NHSE/NHSI (in their regulatory capacity), Healthwatch, the voluntary sector, the Leadership Centre and The Strategy Unit will normally be in attendance.

Those leadings aspects of the Partnership's work will be invited to attend as required by the STP Lead.

Meetings of the Partnership Board will not normally take place in public since responsibility for engaging with the public and providing opportunities for questions to be raised remains with the Boards of statutory NHS partners and through existing Local Authority mechanisms.

4. Quorum:

The quorum for Partnership Board meetings shall be at least one third of the eligible membership including the following:

- Either the STP Lead or the Professional Chair
- At least one representative from each of the stakeholder groups
    - NHS provider Trusts (acute, community or mental health)
    - Local Authorities
    - NHS Clinical Commissioning Groups
- At least one representative from each of the four Black Country areas (who may be coterminous with the above representatives).

Where members are unable to attend a meeting they must arrange for their named and duly authorised representative to attend in their place.

If a member should be required to leave prior to the conclusion of the meeting, the Chair should confirm whether the meeting is still quorate. If the meeting is no longer quorate, it may continue but any decisions would have to be ratified at the next meeting or, where the Chair judges this would cause undue delay, by email.

Partnership Board decisions may be effected via email – either in the case of inquoracy or other urgent circumstance (at the discretion of the Chair) provided that:

- The Chair sets out the rationale for acting outside of an ordinary meeting;
- Those Partners participating in the email exchange and consenting to the decision would constitute a quorum for a physical meeting;
- The decision is reported to the next meeting and its ratification is minuted; and
- Email responses by Partners are copied to all members of the Partnership Board and form part of the papers for the next meeting of the Partnership.

5. Conflicts of Interest

The Partnership shall establish a register of interests for both voting and associate members.

At the beginning of each meeting, the Chair will ask all Partners and other attendees to declare if they have any conflicts of interest in any matters to be discussed. The Chair will determine how any declared conflicts will be managed during the meeting.

6. Voting:

It is desirable that Partnership Board decisions are made on the basis of a consensus amongst all Partner organisations present at the meeting.

Where it is evident to the Chair that such a consensus does not exist then decisions shall be taken on the basis of a simple majority (indicated by a show of hands). The rationale of those opposing the decision shall be recorded in the minutes.

Where a lack of consensus may adversely impact the delivery of STP plan (or in other cases at the discretion of the STP Lead), the dispute resolution approach set out in the MoU shall be invoked by the STP Lead.

Partnership decisions constitute the consensus or majority view of Partners in relation to the matter in question. They do not and cannot bind the action of Partner organisations' existing governance mechanisms.

In the case of a Local Authority that is a signatory to the MoU, the Partnership recognises

that there may be occasions on which voting on a Partnership decision may be in conflict with an Authority's statutory rights and responsibilities (for example, in relation to public consultation and the right of referral to the Secretary of State). Local Authority Partners shall have the right to determine when such circumstances exist and, in such circumstances, to exempt themselves from a Partnership decision.

7. Chair:

The STP Lead shall serve as the Chair of Partnership meetings. Should the Partnership come to a view that the appointment of an Independent Chair would be beneficial, a proposal will be developed for the approval of all Partners.

8. Secretary:

A named individual will be responsible for supporting the Chair in the management of the Board's business and will be responsible for:

- Preparation of the agenda in conjunction with the Chair
- Circulating the agenda and papers to Partners in advance of the meeting at least 5 working days in advance;
- Minuting the proceedings and resolutions of all meetings of the Partnership Board, including recording the names of those present and in attendance, and details of any conflicts and how they were managed;
- Circulating draft minutes to all members of the Partnership Board within 5 working days;
- Keeping a record of matters arising and issues to be carried forward; and
- Advising the Board on pertinent areas.

9. Frequency and notice of meetings:

Partnership Board meetings will normally take place monthly.

No unscheduled or rescheduled meetings will take place without members having at least one week's notice of the date. The agenda and supporting papers will (save in exceptional circumstances) be circulated to all members at least three working days before the date of the meeting.

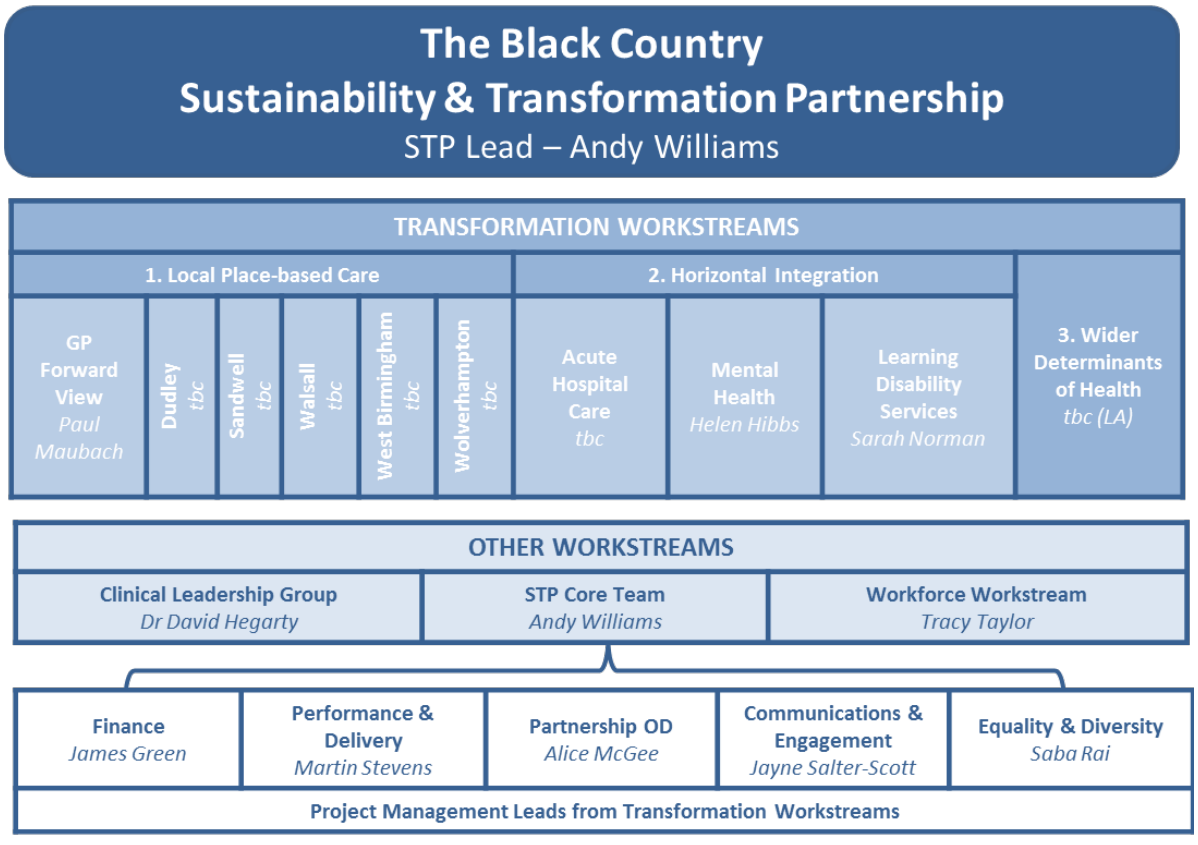
10. Partnership Infrastructure:

In order both to develop plans for consideration by the Partnership and to oversee the

implementation of plans agreed by the Partnership, an appropriate infrastructure needs to be established and resourced. That infrastructure shall be directed by the STP Lead and shall be accountable to the Partnership Board.

The Partnership infrastructure is formed of care-focused Workstreams and function-based Working Groups (see diagram below). The driving force for Partnership Board proposals should be the work of the professionally-led, care-focused Workstreams but those proposals, as they emerge, will need to be reviewed from the perspective of the function-based Working Groups. This is intended to ensure that, by the time proposals are considered by the Partnership Board, they have been well tested. The STP Lead may also draw on additional mechanisms, internal or external to the STP, to assess the appropriateness and robustness of emerging proposals.

Once proposals are approved by the Partnership Board, delivery is to be coordinated by the relevant Workstream, working closely with the affected system Partners.



The role and remit of these groups is summarised below. Groups are responsible for drafting their own detailed terms of reference for approval by the Partnership Board.

Partners recognize that accountability for place-based work sits with local governance mechanisms. Each Partner comes to the Partnership with multiple existing commitments to other bodies and needs to be conscious of this in Partnership discussions.

The role of the Transformation Workstreams is to:

i) Develop proposals for their defined area of care that support delivery of the Five Year Forward View priorities and support the achievement of improved health and wellbeing, better outcomes and experience of care for patients, and the financial sustainability of the STP.

ii) Oversee the delivery of proposals approved by the Partnership Board and all relevant Partners/external authorities.

a) Clinical Leadership Group (CLG)

The role of the CLG is to provide clinical leadership to the Partnership, ensuring that it develops robust proposals that are safe and effective, that align with the evidence base and that are clinically sustainable. The CLG's work will also inform the work of the CCGs' joint committee - the Black Country and West Birmingham Commissioning Board. Specifically, CLG will:

i) Identify priority areas for the STP to consider;

ii) Identify and support a network of clinical champions to provide senior clinical advice to STP Workstreams in developing models of care or other interventions impacting clinical services;

iii) Provide assurance about the proposals developed by Workstreams, including advising on the need for external review of proposals. As part of this, CLG will be guided by, and promote the use by Workstreams, of the Clinical Assurance Framework developed by the West Midlands Clinical Senate;

iv) Ensure that clinical colleagues across The Black Country and West Birmingham (and, where relevant, in wider networks) are kept informed about the work and are engaged in that work as appropriate; and

v) Work with clinical colleagues to support the implementation of STP plans following all necessary approvals.

b) STP Core Team

The co-ordination of STP activities is the responsibility of the STP Lead supported by a Core Team formed of project management leads from the Transformation Workstreams and the leads of the function-based working groups.

c) Workforce Group

The role of the Workforce Group is to:

i) Assure the quality and sustainability of the future workforce implicit or explicit in Workstream proposals.

ii) Ensure that Partner organisations are aware of the workforce matters that may have an impact on them, and organisational actions required.

iii) Make proposals about the more efficient use of the workforce and/or the training and recruitment needs of the STP.

iv) Liaise with educational providers (Health Education England, Universities, Colleges, Schools, Leadership Academy, etc.), regionally and nationally, to influence supply of future workforce capability/skills.

v) Identify and manage workforce related risks.

The Group will liaise closely with the Local Workforce Action Board (LWAB) that has two areas of responsibility detailed within the terms of reference:

a) Supporting STPs across broad range of workforce and HR related activity
b) Local delivery of HEE mandate and strategic priorities affecting STPs

The LWAB role is to:

- Agree the workforce work programme to support STPs
- Oversee implementation of the work programme
- Engage with local and national stakeholders to co-ordinate inputs from both HEE and other STP member organisations.

The LWABs will develop 4 key products as part of the Sustainability and Transformation plan/partnership, these are:

- A comprehensive baseline of the NHS and care workforce within the STP footprint and an overarching assessment of the key issues that the relevant labour markets(s) present. This will describe the workforce case for change.
- A scenario based, high level workforce strategy that sets out the workforce implications of the STP's ambitions in terms of workforce type, numbers and skills, including leadership development
- A workforce transformation plan focused on what is needed to deliver the service ambitions set out in the STP.
- An action plan that proposes the necessary investment in workforce required to support STP delivery, identifying sources of funds to enable its implementation.

d) Finance Group

The role of the Finance Working Group is to:

i) Provide leadership, strategic advice and guidance for the financial delivery of the Sustainability Transformational Plan (STP). This will include the provision of

director level advice and support to the programme.

ii) Ensure that the strategy is fully costed, that its impact on the wider health and social care system is modelled and understood and that it meets the requirements to deliver a financially sustainable health system. This will be set out in a Strategic Financial Framework (StFF).

iii) Provide assurance about the financial sustainability of proposals developed by the Workstreams.

iv) Manage the financial resources committed to the programme by Partners, including the procurement of external advice and support.

e) Performance & Delivery Group

The role of the Performance & Delivery Group is to:

i) Develop systems for monitoring key performance indicators across the STP, as agreed by the Partnership or as otherwise required by regulators, including but not limited to A&E, RTT and Cancer performance. The Group will provide leadership, strategic advice and guidance.

ii) Make regular reports to the Partnership on performance related issues, including regular analysis of activity to plan, providing corrective actions, short-term improvements against quality and performance standards and mitigation where necessary.

iii) Develop and monitor a programme plan for the work of the Partnership, ensuring that the activities of Workstreams and Working Groups are well aligned.

iv) Advise the partnership on progress against the plan, highlighting exceptions and proposing mitigation (in collaboration with the relevant Workstream).

v) Develop and manage a risk register for the Partnership's activities.

The executive lead of the Performance and Delivery Group will act as Programme Director for the STP.

f) Organisational Development Group

The role of the Organisational Development Group is to support the development of the Partnership and its ways of collaborating.

g) Communications & Engagement Group

The role of the Communications & Engagement Group is to:

i) Ensure that Partner activities are coordinated and aligned in relation to the work of the STP, and that Partners discharge their statutory duties in relation to STP proposals;

ii) Advise the Partnership Board and its Workstreams on communication and engagement matters including in relation to media management and public consultation requirements.

h) Equality & Diversity Group

The role of the Equality & Diversity Group is to ensure that equality & diversity considerations are included in the development of STP plans, and to facilitate collaboration between Partners, where appropriate, in the discharge of their statutory duties in relation to STP proposals.

Schedule Five – Resourcing

It is expected that delivery of the STP objectives is seen as the core business of each member organisation, and each will therefore commit in-kind resources to deliver of the STP objectives without recourse for additional resource to the system.

For the Partnership's initial phase, key personnel have been identified as indicated in Section Ten of Schedule Four, above. This includes both the senior leaders sponsoring a Workstream and management personnel who are dedicating an agreed element of their working time to the STP. It is expected that these persons will serve on an in-kind basis pending a review of resourcing in April 2018.

The Partnership Board may, from time to time, agree that system objectives cannot be delivered as described above, and that some additional resourcing is required to be deployed for system benefit. In such circumstances Partner organisations are expected to contribute in a way that is considered fair and proportionate. This will be agreed on a case by case basis as need arises.

Schedule Six – Engaging external resources

Circumstances may arise from time to time whereby the system requires expert external advice or services that are either not available to be sourced from a partner member, or are required for purposes of independence.

Such resources will only be commissioned by agreement of the Partnership Board or by the STP Lead or other officer duly delegated to commission such advice or services.

Where this is the case, to provide the necessary assurances to member organisations regarding value for money and probity, proper procurement process will be followed as set out in the SFIs and SOs of the organisation most appropriate to commission the advice or services.

Schedule Seven – Risk Register

Schedule Eight – STP Programme Plan

Sandwell and West Birmingham Hospitals NHS
NHS Trust

CLINICAL LEADERSHIP EXECUTIVE: SUMMARY NOTE

Date	29th August 2017
Attendees	The Executive Group, Group Triumvirates and Staff Convenor
Key points of discussion relevant to the Board	• **Quality and Safety improvements** The NIV unit will open and be fully operational as a single sure receiver of cases from the start of October. This is another indication of us prioritising quality and reflecting on feedback from incidents. In that context CLE received a paper on the new SI and Never Events process, and Roger briefed us on the medical examiner/judgemental reviewer process within learning from deaths. In creating the executive quality committee to replace current meetings, we aim to give real focus and impetus to our work on the CQC response plan, the safety and quality plans, and other areas of focused attention. The EQC starts meeting in September • **Getting grip on the money** The land sale provides a welcome boost to our cash position, but we are behind on both expenditure reduction and now income generation. The step up in CIP between July and August is almost £1m, rising above that number in October. Our discussion did not create confidence about grip. The sharp deterioration on medical agency in medicine will need to be addressed in coming days, as will the apparent authorisation of surgical WLIs outwith the single sign off process (no COO sign off, no payment). • **Moving forward with Digital** Next month we will devote two thirds of CLE's meeting to EPR. We know we will not deploy in November and are working on plans to deploy instead in March. This rests on a credible plan, and one that learns the lessons from the review of casenote scanning. To that end there are some important workshops in coming days, supported by the improvement team. Mark Reynolds outlined the finalisation process for hardware deployment and the approach through GDOPs to establish our final list of digital champions. • **Future Urgent Care provision** The Urgent Care Centre which will replace the ED at Sandwell in 2019 is an important cross Trust project. Liz Miller outlined the project's work to date and we made important connections with issues like EMRT, ultrasound, primary care development and assessment units like gynae. To make Midland Met work there are a variety of changes we need to make off that site, and the UCC is one. There remains a lack of CCG clarity about Parsonage Street and that is being addressed at the SWB A&E delivery board.

	• **Risk Register refresh** The refresh of the registers from ground to Board level needs to bring with it a focus on (a) specifying the risk, rather than labelled an issue and (b) the mitigating actions and their delivery to time. The RMC and CLE will increasingly be tracking the velocity of our registers and their use as a tool to close out issues, not simply flag them. This is a matter of Board level concern and we need to achieve improvement in Q3-4.
Positive highlights of note	• Opening of the new NIV Unit on 4th September 2017 • New Executive Quality Committee created with inaugural meeting in September 2017 • Improvement of cash position through successful land sale • A cut in agency spend (£2.4m down to £1.4m) • Broad success of the safety plan deployment in driving always events
Matters presented for information or noting	• Casenote scanning review: update • CQC Inspection report: handling approach when received • IPR, including persistent reds • Pathology proposals across Black Country
Decisions made	• EPR deployment moved from November 2017 to March 2018 subject to a credible plan being presented to the CEO.
Matters of concern or key risks to escalate to the Board	• Behind plans for expenditure reduction and now income generation, Group recovery plans being overseen by the Executive • More work to do on Q3 persistent reds delivery trajectory

Toby Lewis, Chief Executive
Chair of the Clinical Leadership Executive
For the meeting of the Trust Board scheduled for 7th September 2017

SWBCLE (09/17) 014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PUBLIC TRUST BOARD

DOCUMENT TITLE:	Trust Risk Registers
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Refeth Mirza, Head of Risk Management
DATE OF MEETING:	7th September 2017

EXECUTIVE SUMMARY:

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

Risks on the Trust Risk Register have been reviewed and updated by Executive Directors.

REPORT RECOMMENDATION:

The Trust Board is recommended to **RECEIVE** and **DISCUSS** the monthly updates on progress with treatment plans from risk owners for risks on 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:

RMC, CLE

TRUST BOARD

Report on Trust Risk Register

1. INTRODUCTION

This report is to provide CLE with an update on the Trust Risk Register (TRR). The report outlines progress in improving the robustness of the Trust's risk management arrangements with a review of the Trust Risk Register.

2. TRUST RISK REGISTER

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

Since the Trust Risk Register (TRR) was reported to the Board at its 3 August 2017 meeting, the newly appointed Head of Risk Management was tasked to review the TRR. Upon review and scrutiny it has been identified that there is a lack of consistency in the risk management process and therefore a refresh of the Risk Register is required. It is evident that the current Risk Register does not provide an accurate position against the progress for the risks. Emphasis needs to be given to actions associated with the risk. Where risks have been identified, actions need to be drawn up and implemented to reduce the risks. Monitoring needs to be proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

Some of the risks already reviewed have changed such that either the risk has altered or actions have been completed so the risk needs to be managed and monitored at a Group or directorate level or it needs reframing to better understand what the current risk is. Examples of these include:

- Unsubstantiated beds
- EPR
- Oncology

The Head of Risk Management will work with risk owners to ensure that risk assessments are completed consistently and there is a clear understanding of the identification, evaluation, ownership, management and reporting of risks and the key responsibilities for risk owners. It is anticipated that this work will be completed in mid-September.

The reviewed Risk Register will be presented to the September Risk Management Committee, Clinical Leadership Executive and October Trust Board, with emphasis on updates to mitigating actions.

In addition to the above, following the review of high impact, low likelihood risks all Clinical Groups/Corporate Directorate risk owners have been asked to review their risk assessments that fall into this category. The Risk Management Team are also working with Clinical Groups, Corporate Directorates risk owners to;

- Ensure all risks are assessed appropriately and are updated with the relevant up to date details and include smart mitigating actions that will reduce severity or likelihood and to include review dates. All high impact risk have now been reviewed and updated. All these risks are now in date with smart mitigating actions.

- Ensure there are no duplicate or incomplete risks on the risk register; this piece of work is underway and is expected to be completed by the end of the month.

- Ensure all high risks which had a high impact (5) and which came out as a risk rating of 15 or above but were not on the Trust Risk Register are reviewed. The Risk Management Team are working with the Risk owners to review these risks as some appear to have duplicates, some are issues and some need challenge around the scoring. There has been a slight delay in completing this piece of work due to annual leave, however it is anticipated that these will be discussed at Risk Management Committee in September.

The Risk Management Team will continue support the maintenance of the risk register and provide guidance to risk owners and teams on how to review risks in a meaningful way.

No new risks are being escalated for CLE to discuss.

3. RECOMMENDATION

The Trust is recommended to **RECEIVE** and **DISCUSS** the monthly updates on progress with treatment plans from risk owners for risks on the Trust Risk Register

Refeth Mirza
Head of Risk Management

23 August 2017

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	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
2272	Live (With Actions)	Emergency And	Accident & Emergency (C)	Quality Of Care	The Trust has un-substantiated beds open due to: _admissions above plan _extended Length of Stay (LOS) above bed plan assumptions _too many Delayed Transfers of Care bed days (DTOC). We are unable to consistently staff the additional beds safely. The Trust has a bed closure programme to close an additional 15 beds in medicine at the City site in 2017. The impact of this would potentially result in overcrowding in ED and a deterioration in time to assessment, diagnosis and treatment, which would result in decreased patient and staff experience, longer ambulance waiting times and will undoubtedly adversely impact on patient outcomes.	5x5=25	Activate business continuity for 10 additional patients in ED: For up to 10 patients additional to ED cubicle capacity - likelihood this occurs 12 hours of the day -Receive patients and starting assessment in the circulating corridor areas of ED -Staffing of the above areas to be put in place utilising block booking of bank / agency. -Equipping area with privacy screens , dynamap and patient trollies to be available -A computer on wheels to be allocated to this team so they can process and document assessment and care. A CAD screen should be installed in the main desk to anticipate incoming ambulances outside of RAM. -2 RAM cubicles to be kept for rotation of WMAS presenting patients through this area for detailed examination etc; 2 majors cubicles would rotate patients from the waiting room dependent on triage scores	5x4=20	Work with WMAS on risk assessment to understand their response to these scenarios- action complete support from On call manager and capacity to support ED cohorting patients in corridor = x1 crew 4 pts Seek social care business continuity response to eradicate all acute delayed transfer of care patients. Plans not available Raise at A&E Delivery Group. Command and control structure with documented continuity plan to manage this scenario. Complete written guidance for both scenarios (a) and (c) Command and control structure to be put in place if plan activated to support ED and live assessment of risk	Rachel Barlow	31/12/2018	17/08/2017	Monthly	Treat

Risks that feature on the Trust Risk Register (TRR) have been escalated and reviewed by management teams through to Clinical Leadership Executive Committee and Trust Board. Trust Board takes the decision whether risks feature on the TRR including approval of requests for risks to be removed from the TRR for them to managed at the relevant Clinical Group / Corporate Directorate.

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
						Queue ambulances on ambulance arrival point x 10 : Ambulances would be held for up to 60 minutes on the ambulance arrival area and remain under the care of the WMAS staff until the patients could be handed over on the ED environment safely. Activate business continuity for 20 additional patients in ED and or patients waiting for 60 minutes on the ambulance arrival area: For up to 20 patients additional to ED cubicle capacity - likelihood estimated to be up to 6 hours a day The approach to mitigate, the ED capacity would need to be expanded. This would be through 2 options: 1)A temporary tent on the ambulance arrival area 2)Expand ED in line with the major incident plan. This would displace adjacent out patients, which would need to be relocated. -Staffing and equipment would need to be in place -Access to patient first IT system to be in place							

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
							Further to the above measures, if ambulance waits persisted and delays to patient assessment exceeded an hour, the Trust would seek to close to further arrivals of urgent care patients: Attendance avoidance would be sought by: Triage all non-majors activity to urgent care centres Divert WMAS to other EDs bed reduction programme in place via medicine GPO to be strengthened through formal patient flow programme reporting to COO							
215	Live (With Actions)	Waiting List	Waiting List Management	Performance	Due to lack of EAB bed, nursing home capacity and waits for domically care there is a deteriorating level of Delayed Transfers of Care (DTOC) bed days which results in an increased demand on acute beds.	4x5=20	Review and update of the ADAPT pathway in progress, with new process to be implemented in September to provide more focused assessments and care planning.	4x4=16	EAB and nursing home capacity remain unmitigated risks. System Resilience partners review of demand and capacity still outstanding. Nursing home and domiciliary care provision is potentially vulnerable across the market place. The system resilience partners considering risk and mitigation as part of A&E delivery group.	Rachel Barlow	30/11/2017	23/08/2017	Quarterly	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	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
666	Monitor	Paediatrics	Lyndon 1	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	4x4=16	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	31/03/2018	22/08/2017	Quarterly	Tolerate
1603	Live (With Actions)	Financial	Financial Management (S)	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	Management controls - Routine cash flow forecasting including rolling 15 month outlook - Routine five year capital programme review & forecast - Routine medium term financial plan update - Routine monitoring of supplier status avoiding any 'on stop' issues	3x5=15	- Deliver operational performance consistent with delivery of financial plan to mitigate further cash erosion - Establish and conclude task & finish programme to resolve significant outstanding debtor and creditor issues - Excellence in working capital management including appropriate creditor stretch, timely debtor recovery and pharmacy	Tony Waite	31/03/2018	01/08/2017	Quarterly	Treat

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
						Independent controls / assurance - Internal audit review of core financial controls - External audit review of trust Use of Resources including financial sustainability - Regulator scrutiny of financial plans		stock reduction - Establish and progress cash generation programme including accelerated programme of surplus asset realisation					
533 Live (With Actions)	Ambulatory	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. NHS Improvement-seconded UHB manager on site at SWBH to try and facilitate communication with UHB clinical team and improve perception of performance.	5x3=15	Recruitment being managed by UHB. Good progress reported for the GI position. UHB SLA has potential to be extended following notice being served however staffing situation is still critical	Roger Stedman	31/10/2017	21/08/2017	Quarterly	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	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
566	Live (With Actions)	Emergency And	Accident & Emergency (S)	Staffing	STAFFING - SENIOR MEDICAL STAFF 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. Robust forward look on rotas through leadership team reliance on locums (37% shifts filled with locums). Registrar vacancy rate 59%. Consultant vacancy rate 35%.	3x5=15	Recruitment ongoing with marketing of new hospital. CESR middle grade training programme to be implemented as a "grow your own" workforce strategy. Development of recruitment strategy	Rachel Barlow	31/03/2018	17/08/2017	Quarterly	Treat
410	Live (With Actions)	Ophthalmology	Outpatients - EYE (S)	Environment - Clinical (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	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	3x4=12	To continue to work with STC design team and Ophthalmology team to ensure design and build of OPD2 is fit for purpose to ensure patient privacy, dignity and associated infection control issues are prioritised in the new build. April 2017 - informed by Jayne Dunn that OPD2 was no longer going to be for ophthalmology and	Rachel Barlow	29/09/2018	22/08/2017	Quarterly	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
					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.				would remain in current area. Raised at RMC May 2017. OPD 2 option has been withdrawn due to lack of funding. Review of plan 7 (David Beale) with the moving of community dental rooms. Plans being drawn up - should be available for consultation mid Sept 2017 - potential for renovation around mid 2018					
121	Live (With Actions)	Maternity_ Health	Maternity 1	Costs Not Planned	There is a risk that due to the unpredictable birth activity and the impact of cross charging from other providers against the AN / PN tariff ,as a result 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.	3x4=12	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	29/12/2017	15/08/2017	Monthly	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	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
221	Live (With Actions)	Informatics	Informatics(C)	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 within the Trust given the fixed time and budgetary constraints. This now focuses on resources to deliver the implementation including business change, training and champions.	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. Project governance including development, approval and tracking to plan.	3x4=12	Embed Informatics implementation and change activities in Group PMOs and production planning Develop and publish implementation checklists and timescales for EPR. Report progress at Digital PMO and Ctte Agree and implement super user and business change approaches. Review and re-establish project governance especially in these areas.	Mark Reynolds	31/10/2017	18/08/2017	Monthly	Treat
114	Live (With Actions)	Human Resources	Human Resources	Cost Improvement Not Met	FINANCE - Excess pay cost Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment reduction of 1400 WTEs, leading to excess pay costs	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.	3x4=12	Implementation of 2nd year of the 16-18 Transformation Plan monitored via TPRS and People Plan Scorecard. Groups required to develop and implement additional CIP plans to address identified CIP shortfall.	Raffaela Goodby	31/07/2018	23/08/2017	Quarterly	Treat

Risk Ref No. / Status / Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
							Groups required to develop workforce plans/ associated savings plans for 18-19 ensuring effective and affordable reconfiguration of services in 2019. Plans to be developed with a view to commencing an open and transparent consultation process in the spring of 2018.					
2642 Live (With Actions) Medical Director	Medical Director's Office (C)	Clinical Results	There is a risk that results not being seen and acknowledged will lead to patients having treatment delayed or omitted.	**3x5=15**	There is results acknowledgment available in CDA only for certain types of investigation. Results acknowledgement is routinely monitored and shows a range of compliance from very poor, in emergency areas, to good in outpatient areas. Policy: Validation Of Imaging Results That Require Skilled Interpretation Policy SWBH/Pt Care/025 Clinical staff are require to keep HCR up to date - Actions related to results are updated in HCR	**2x5=10**	All staff to comply with the updated Management of Clinical Diagnostic Tests policy To review and update Management of Clinical Diagnostic Tests Implementation of EPR in order to allow single point of access for results and audit	Roger Stedman	31/12/2017	27/07/2017	Quarterly	Treat

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
						SOP - Results from Pathology by Telephone (attached)							
228 Live (With Actions)	Informatics	Informatics(C)	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	**3x3=9**	Complete network and desktops refresh. Stabilisation of all aspects of the local IT infrastructure will be completed end March 2017. The replacement of PCs, printers, monitors, etc., and upgrade of the network is conducted in parallel. 80% of the work was completed by December 2016 Establish infrastructure plan and track progress	Mark Reynolds	31/10/2017	18/08/2017	Quarterly	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	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
							Infrastructure work to refresh networks and desktops is underway.							
534	Live (With Actions)	Ambulatory	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.	**3x3=9**	Contingent on start date for GI appointments	Roger Stedman	31/10/2017	21/08/2017	Quarterly	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	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
214	Live (With Actions)	Waiting List	Waiting List Management	Performance	Lack of assurance of standard process impact on 18 week data quality which results in underperformance of access target.	**3x3=9**	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, competency and training. following a bout of 52 week breach patients in Dermatology a process has been implemented where by all clock stops following theatre are automatically removed and a clock stop has to be added following close validation	**3x3=9**	Bespoke training platform for all staff groups developed in line with accredited managers programme Source e-learning module for RTT with a competency sign off for all staff in delivery chain. Decision to be made on the support training product in November. Data quality process to be audited	Rachel Barlow	11/02/2018	23/08/2017	Quarterly	Treat

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
				from cyber attack.		Information security assessment completed and actions underway.		Achieve Cyber Security Essentials The Trust must achieve cyber-security essentials as part of the minimum commitment to security. This will likely form part of our CQC inspections. Restricted Devices Security Controls Implement security controls (VLAN, IPSEC) to stop access to and from restricted devices. Over time this should harden the Trust infrastructure against attack, recognising that securing the physical network is a challenge on the estate.					
1738 Live (With Actions)	Ophthalmology	BMEC Outpatients - Eye	Quality Of Care	There is a risk that children, particularly under 3 years of age, who attend the ED at BMEC with an emergency eye condition, do not receive either timely or appropriate treatment, due to limited availability OOH of specialist paediatric ophthalmologists and/or the availability of a paediatric anaesthetist.	**2x4=8**	Contingency arrangement is for a general ophthalmologist to deal with OOH emergency cases. Agreement with BCH to access paediatric specialists advice. There is a cohort of anaesthetists who are capable of anaesthetising children under 3 who can provide back-up anaesthetic services when required.	**2x4=8**	Actions agreed following a meeting of senior clinicians and Executive Directors, some of which are in progress or completed: Engage with ophthalmology clinical lead at BCH and agree a plan for delivering an on call service. SWBH MD to engage with BCH MD re. joint working (completed). Liaise with commissioners over the funding model for the Paediatric OOH service. Paediatric ophthalmologists from	Roger Stedman	30/11/2018	22/08/2017	Quarterly	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	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
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, raises experience, safety and financial risks.	5x4=20	Overseas recruitment drive (pending) Use of bank staff including block bookings Close working with partners in relation to DTOCs Close monitoring and response as required. Partial control - Bed programme did initially ease the situation but different ways of working not fully implemented as planned.	2x4=8	Contingency bed plan is agreed in October for winter - L5 to be opened in November. Bed programme to ensure robust implementation of EDD planning on admission and implementation of red/green working on wards.	Rachel Barlow	31/12/2017	15/08/2017	Monthly	Treat
325	Live (With Actions)	Informatics	Informatics(C)	IT Software - Clinical System Failure / Issue	There is a risk of a breach of patient or staff confidentiality due to cyber attack which could result in loss of data and/or serious disruption to the operational running of the Trust. This recognises advice from NHS CareCERT and Government about an ongoing threat to UK infrastructure	4x4=16	Prioritised and protected investment for security infrastructure via Infrastructure Stabilisation approved Business Case	2x4=8	Complete rollout of Windows 7. Upgrade servers from version 2003. 287 servers have been moved to Windows Server 2008 and 2012. There are 104 using Windows Server 2003 that need to be migrated. These will be completed by Christmas.	Mark Reynolds	30/12/2017	18/08/2017	Quarterly	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
							Where required patients can be transferred to alternative paediatric ophthalmology services beyond the local area - potentially Great Ormond Street Hospital The expectation of the department is that a general ophthalmologist should be able to treat to the level of a general ophthalmologist and will be able to deal competently with the majority of cases that present at BMEC ED.		around the region to participate in OOH service (for discussion and agreement at a paediatric ophthalmology summit meeting). Clarify with Surgery Group leads what the paediatric anaesthetic resourcing capacity is.					
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. Locum arrangements in place to support workforce plan. Two consultants recruited who will start in 2017.	**2x3=6**	Medical Director of Dudley Group of Hospitals working to create vascular access at Russell's Hall. Some sessions have been arranged at Dudley, and talks are taking place with UHB.	Rachel Barlow	31/12/2017	18/08/2017	Quarterly	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	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
538	Live (With Actions)	Ambulatory	Oncology Medical	Performance	Differential and extended chemotherapy wait times between sites due to staff vacancies results in inequality of service for patients.	**2x4=8**	Monthly monitoring of performance carried out to check that staff recruitment maintains sustainable change. New 2 stop chemotherapy model introduced to equalise waits from beginning of May 2016. New model implemented and improvements being monitored by Cancer Board. Pathway for new patients reviewed, aim 7 days' time to treatment Both units to be staffed to national standard 1:3, ongoing active recruitment to substantive posts, use of bank and where necessary agency to deliver KPI Capacity issues preventing delivery to be escalated to matron Latest report demonstrates good compliance with of 98% trust wide Monthly monitoring of performance carried out to check compliance is sustained.	**1x4=4**	Executive review at peer review in October to confirm if the solution has succeeded in full. Ongoing trust wide support to chemotherapy recruitment Resolution of Oncology uncertainty will aid process .	Rachel Barlow	31/12/2017	23/08/2017	Quarterly	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	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
							Two stop model of chemotherapy deliver continues Ongoing work with pharmacy to address the inequalities in waiting times for patients on the two stop model across the trust							

TRUST BOARD

DOCUMENT TITLE:	Safety Plan progress update
SPONSOR (EXECUTIVE DIRECTOR):	Elaine Newell – Chief Nurse
AUTHOR:	Elaine Newell – Chief Nurse
DATE OF MEETING:	7th September 2017

EXECUTIVE SUMMARY:

This paper provides an early view relating to the impact of the Safety Plan on key outcomes which were established at the outset of the project:

- 100% improved workforce safety compliance.
- Reduction in avoidable harms.
- Improved clinical assessment plans.

The availability of outcome data has proved challenging and will in part be addressed by the launch of Cerner EPR. Whilst early indicators are encouraging it is not yet possible to draw a direct correlation between deployment of the safety plan and improved outcomes as there have been other major pieces of work which have undoubtedly impacted these (consistency of care programme, reduction in use of temporary staff, bed reduction programme, focussed care work etc).

The Trust is now in a unique position where it can confidently provide robust assurance around key patient safety checks.

REPORT RECOMMENDATION:

The Board is asked to note the findings within this report.

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:

Safety Plan

PREVIOUS CONSIDERATION:

Safety Plan – outcome report
Trust Board
7th September 2017

In 2016 SWBH published its 2016/19 Safety and Quality aspirations. The Safety Plan is the Trust's focused and organised commitment to patients and their carer(s) to significantly reduce or ambitiously remove patient avoidable harms, through formalising 'must do' safety-checking actions across the trust. The Trust-wide Safety Plan embeds 10 multidisciplinary evidenced-based clinical standards. More recently, DNA CPR has been included in the 'always' standards required for daily check and completion. The 10 standards detailed below have latterly become part of our current everyday clinical processes upon which the associated Quality Plan can build. The Trust is now in a unique position where it can confidently provide robust assurance around key patient safety checks. Reports generated on a daily basis provide assurance around the number of our patients who are having their safety needs assessed, planned for, implemented and continuously reviewed in real time, as part of routine practice, thus significantly avoiding harms. Measures have also been introduced which ensure that 'missed'checks are addressed within 36 hours. The philosophy and application of a culture of always events is something not widely seen within the NHS and marks a significant and unique step in promoting the absolute value that this Trust places upon the important of safe and high quality care.

	Standard	**Output**
1.	Ten out of Ten – The starting point for safety risk assessment of which care plans are then built upon	A safety checklist made up of **10 sub-standards** that **must b**e completed for every admitted patient within 24 hours
2a.	Pressure Ulcer	A plan of care *is in place* for patients identified to be at a tissue viability risk
2b.	Falls	A plan of care is in place for patients identified to be at a risk of a fall
3.	Infection Control	A plan of care *is in place* for patients identified to be at a risk of a acquiring a HAI or having a HAI on admission to be managed
4.	Observations – Early Warning score (EWS) reporting and management	Monitoring vital signs as clinically required - taking in time appropriate action(s) to prevent an avoidable deterioration in a patient *EWS are recorded (vitalpak or paper)– EWS were acted upon and this is evidenced in the patient's health care records*
5.	Care Plans and signed by Patients and Carers/Family	Nursing care plans *are in place* , individualised; reflecting risks identified (physical , social and psychological) through discussion with patient /carer

6.	Focused care /Johns Campaign	A plan of care *is in place* for patients identified at risk from falls, absconding, self harm, challenging behaviour or acutely unwell to ensure appropriate level of supervision with appropriately skilled HCP and reflecting partnership working with carers.
7.	Antibiotic review every 72 hours	Reduction in inappropriate prescribing of antibiotics - An *assessment has been done and the outcomes are documented* of all patients on IV/oral antibiotics after 72 hours that reflects *appropriate or inappropriate use*
8.	Reduced Omissions	Patient's drugs are prescribed, correctly given and taken within a window that is deemed to be the right prescribed time. That a clinical omission for not giving the drug is recorded in the designated area
9.	Informed Consent	All patients undergoing invasive procedures have been consented in accordance to policy
10.	EDD and home care package	Accurate EDD and 48hr follow up

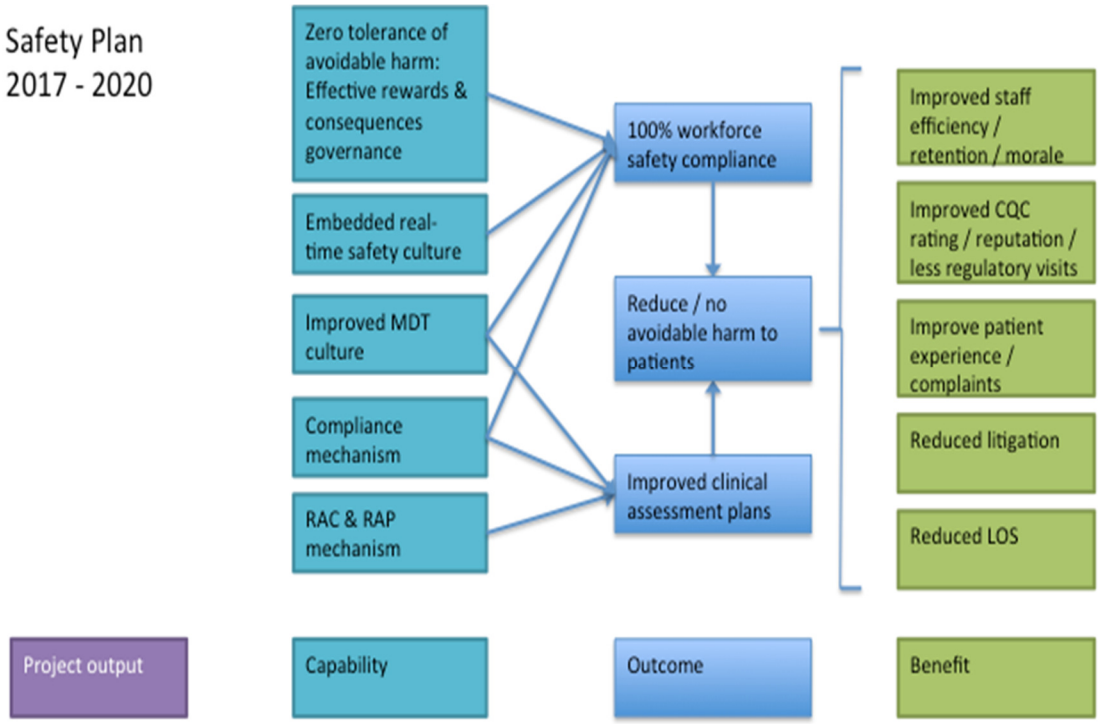
The real success of the safety plan will be determined by a recognisable shift in our safety culture and more tangibly, by clinical outcome measures which demonstrate a reduction in patient harm – specifically avoidable harm. As part of the planned project cycle, PDSA 3 involves reporting outcome data to assess the impact of the safety plan on reducing avoidable harm. In the absence of electronic data capture, this has proved challenging and is predominantly reliant on manual data capture and incident reporting. Outcome data will undoubtedly be more easily reported following introduction of EPR. Recognising the delay to EPR, the project team (and Board colleagues) need to consider whether it is beneficial to utilise time creating additional manual and electronic data capture processes in order to capture the outstanding outcome data ahead of EPR launch.

Cerner EPR will capture 13 of the input measures associated with the safety plan. Change requests have been submitted for the outstanding measures. In developing a reporting strategy for Cerner EPR, it is vital that Safety plan outcomes are also incorporated in order to determine the success of the project going forward.

The benefits outlined in the original project overview document highlighted 3 key areas for improved outcomes:

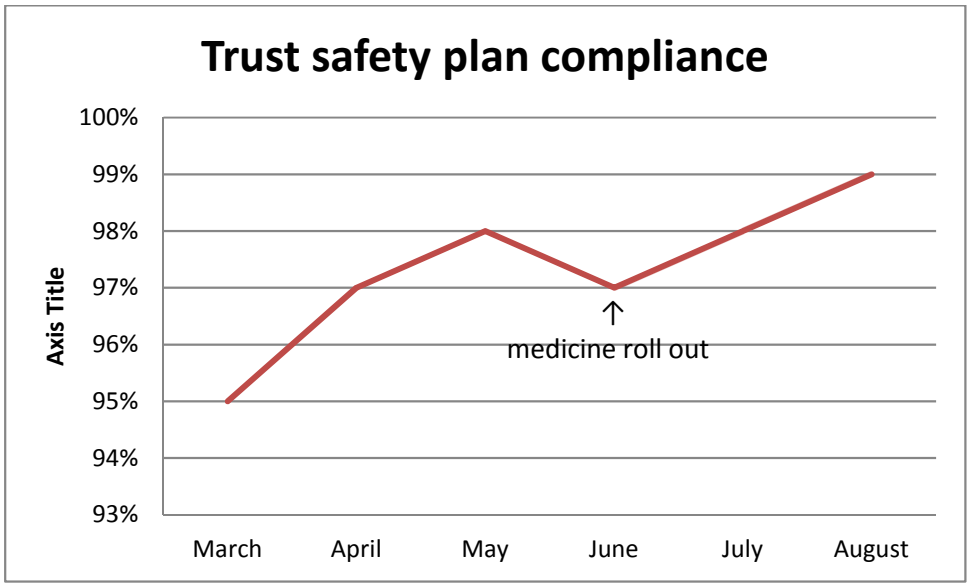
- 100% improved workforce safety compliance.
- Reduction in avoidable harms.
- Improved clinical assessment plans.

Benefit analysis



1. **100% Workforce safety compliance:**

There is a daily senior level focus on ensuring timely and consistent input of data. The initial roll out and subsequent embedding of the safety plan across clinical departments has seen a significant shift in both data input and standard compliance against these 'always' interventions. Average compliance has moved from 95% in March to 99% in August, with 29 wards now consistently achieving compliance rates of >99%. The majority of wards maintain consistent daily data input with focussed improvement required in AMU's and OPAU.



2. **Reduction in avoidable harm to patients:**

The real success of the safety plan will be determined by a recognisable shift in our safety culture and more tangibly, by clinical outcome measures which demonstrate a reduction in patient harm – specifically avoidable harm.

During the period April – July, there appears to have been some reduction in falls, avoidable pressure ulcers, incidents associated with poor patient identification and non-compliance with MCA / DoLs process (Appendix 1). The number of changes to EDD has also shown significant improvement. These have yet to translate to a reduction in Length of Stay. It is not yet possible to draw a direct correlation between deployment of the safety plan and improved outcomes as there have been other major pieces of improvement work which have undoubtedly impacted patient outcomes (consistency of care programme, reduction in use of temporary staff, bed reduction programme, focussed care work etc).

3. **Improved clinical assessments / plans:**

Input data indicates a significant increase in completion of risk assessments relevant to key safety features such as falls / pressure ulcers etc. (consistently >90%, improved from 80%). Over recent weeks, cross specialty peer review has been undertaken to quality assure safety plan inputs and to establish whether the safety plan has prompted an improvement in 'follow on' actions. For example, if a risk assessment has been conducted, has this prompted the appropriate next steps (such as individualised care plan, referral to other agencies etc)? In addition, is the quality of care planning fit for the individual needs of that patient?
The headline results of the peer reviews are summarised as follows:

- Management plans generally well detailed in notes summarising specific interventions relevant to risk assessments
- Care largely carried out in accordance with documented plan however,
- The availability of care plans within records inconsistent.
- Medical documentation requires further attention

These findings are generally consistent with documentation audits completed for the consistency of care project. Whilst evidencing that care has, in the majority of cases been delivered appropriately, these reviews indicate that there is further work to do to improve the quality of documented and individualised care planning in order to realise the benefits associated with the Safety Plan.

Next steps:

1. Further increase local ownership through deployment of the Safety plan at GPO through to ward level.
2. Ensure that output data is reported via EPR and track improvements at ward level through established governance processes.
3. Link quality improvement around clinical assessments and plans with consistency of care 'next steps'.

Conclusion:

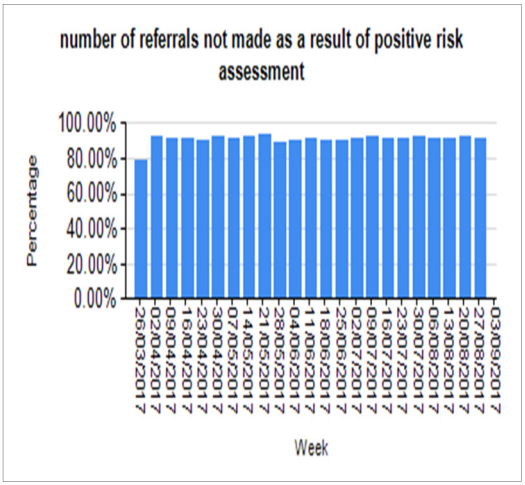
The Trust is now in a unique position where it can confidently provide robust assurance around key patient safety checks, the position relating to compliance having significantly improved over the last 6 months.

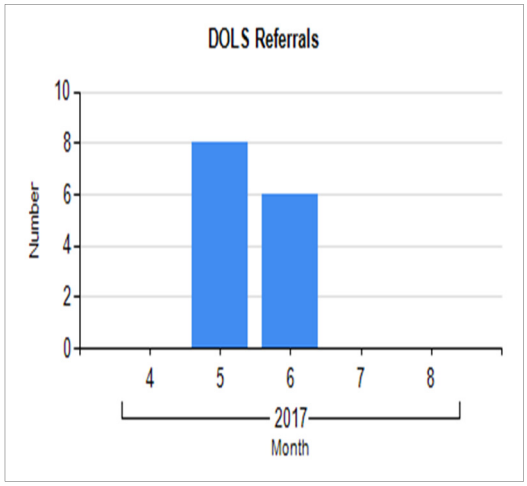
The challenge associated with providing outcome data in advance of EPR should be acknowledged. Although early indicators seem to suggest some improvements in patient outcomes it is too early to establish a direct correlation with the introduction of the safety plan given other major pieces of work which have undoubtedly impacted these.

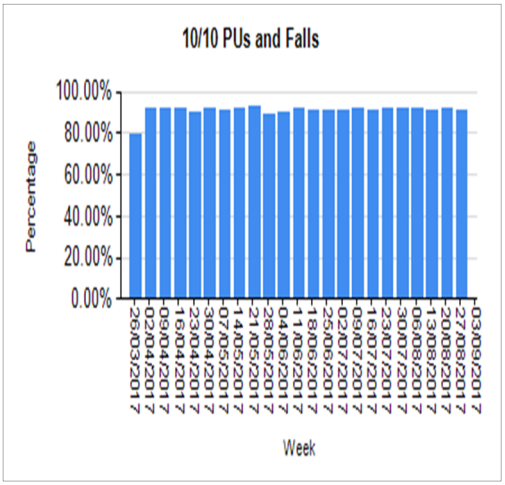
The philosophy and application of a culture of always events is something not widely seen within the NHS and marks a significant and unique step in promoting the absolute value that this Trust places upon the important of safe and high quality care.

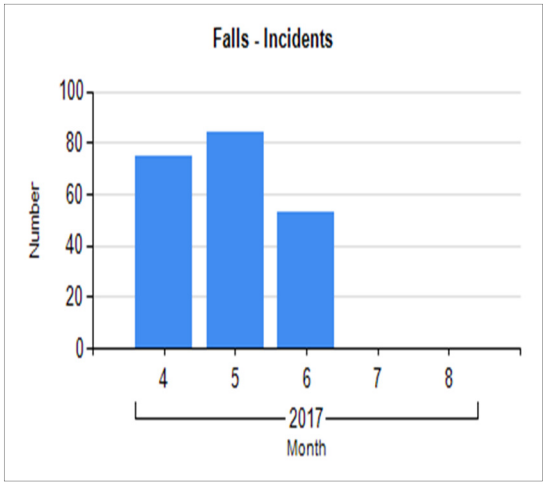
Appendix 1.

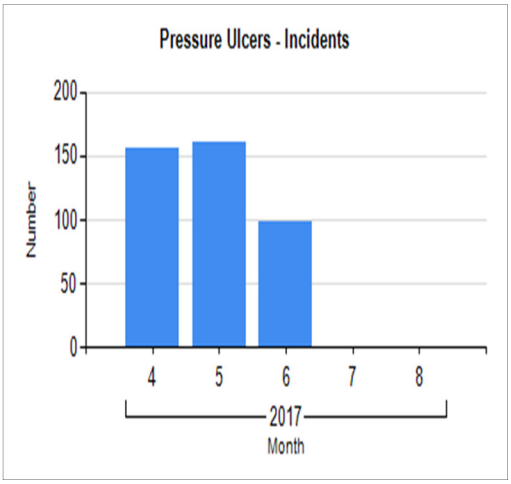
Risk assessments – Dols / failed referral

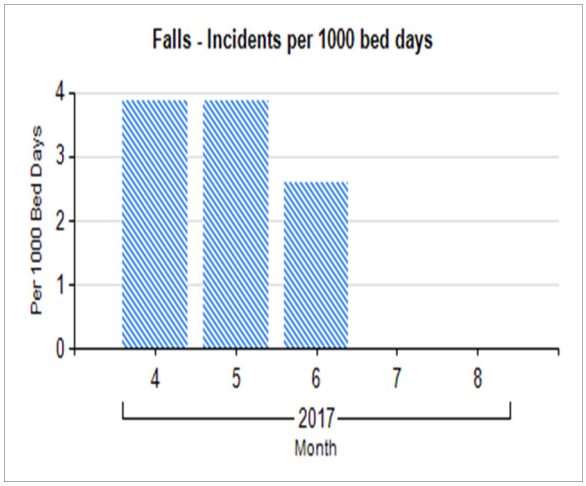


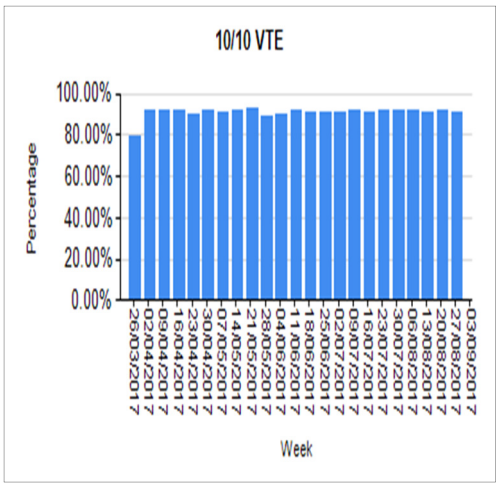








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Percentage
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60.00%
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26/03/2017
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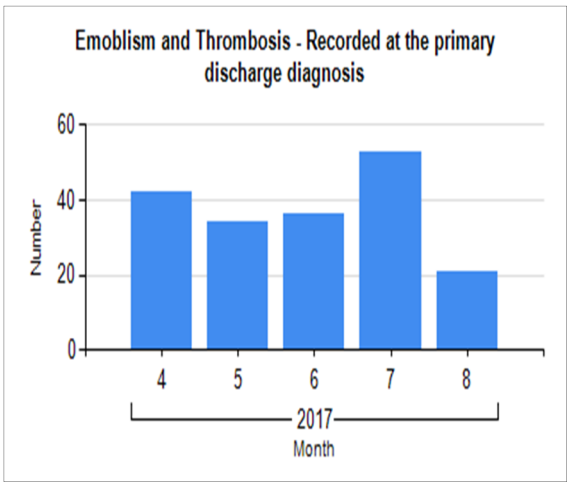
Week


Emoblism and Thrombosis - Recorded at the primary discharge diagnosis
Number
60
40
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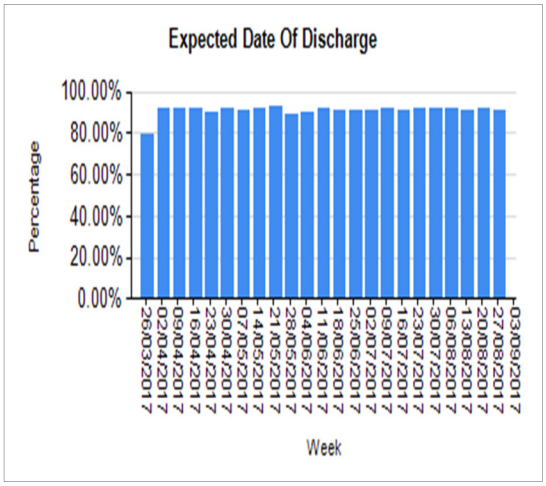
4
5
6
7
8
2017
Month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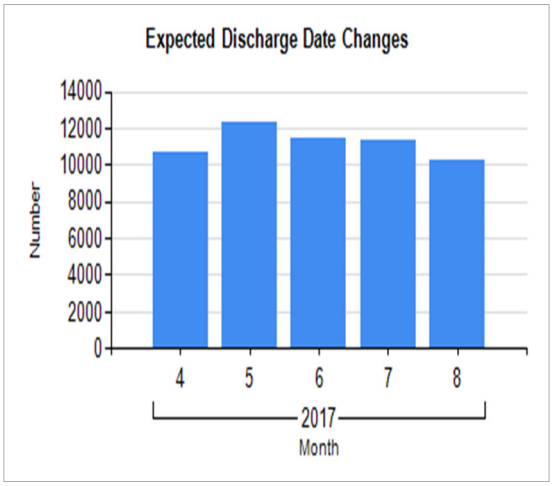
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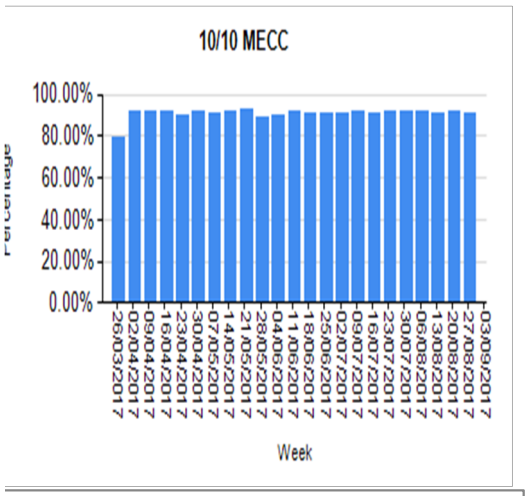
Month


10/10 MECC
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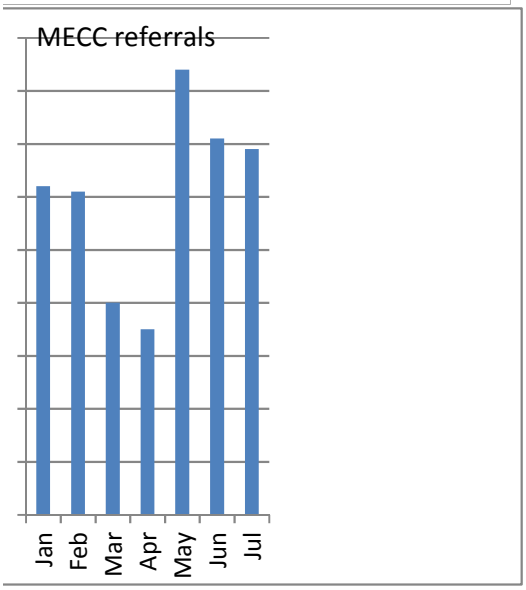
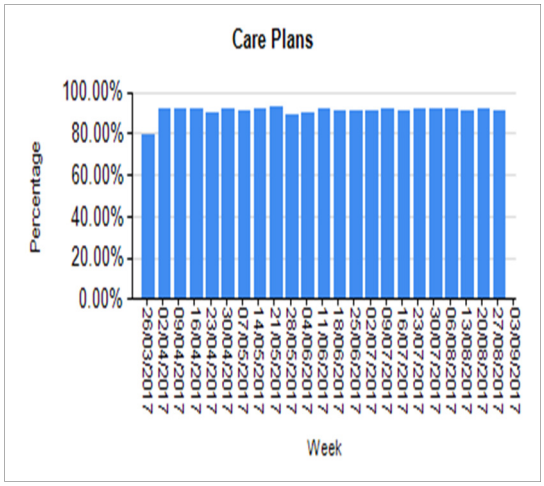

MECC referrals
Jan
Feb
Mar
Apr
May
Jun
Jul


Care Plans
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Percentage
Week

SAFETY PLAN STATS | Numbers

NC Non Compliant Checks that day | Patients Checked | ✓ Compliant for Period | ✘ Not Compliant

>> CONVERT To Ticks/Crosses

>> CONVERT To PERCENTAGES %

SWBTB (09/17) 015a

+ CLICK HERE FOR TRUST LEVEL by INDICATOR	Aug 01 NC	Aug 01 Patients	Aug 02 NC	Aug 02 Patients	Aug 03 NC	Aug 03 Patients	Aug 04 NC	Aug 04 Patients	Aug 05 NC	Aug 05 Patients	Aug 06 NC	Aug 06 Patients	Aug 07 NC	Aug 07 Patients	Aug 08 NC	Aug 08 Patients	Aug 09 NC	Aug 09 Patients	Aug 10 NC	Aug 10 Patients
City - Neonatal Unit	0	1	0	2	0	3	0	1	0	1	0	1	0	0	0	3	0	1	0	1
City AMU 1	0	4	0	8	0	5	0	7	7	7			7	7	0	12	6	5	6	4
City AMU 2	0	2			2	9	2	8	0	4			2	9			1	10	0	4
City D11	0	3	0	2	0	3	0	3	0	4	0	0	0	1	0	0	0	0	0	2
City D15	0	4	0	3	0	5	0	3					1	3	0	5	0	0	0	4
City D16	0	4	0	3	0	0	0	4	0	4	0	0	0	3	11	6	0	4	2	7
City D19	0	2	0	1	0	0	0	3	0	0	0	0	0	0	0	0	0	1	0	0
City D21	0	3	0	5	0	4	3	5	0	3	0	3	0	1	0	0	0	5	0	5
City D26	0	1	0	0	0	2	0	3	0	0	0	1	0	1	0	3	0	3	0	2
City D27	0	2	0	7	0	4	0	2	0	1	0	2	0	2	0	2	0	1	0	4
City D43	0	1	0	4	0	3	0	6	0	1	0	1	0	1	0	3	0	0	9	6
City D47	0	1	0	1	0	0	0	1	0	0	0	0	0	1	0	1	0	1	0	1
City D5	0	3	0	7	0	2	0	4			0	2	1	1	0	4	0	1	2	2
City D7	0	5	0	5	0	3	0	8	0	6			0	6			0	5	0	0
City EGAU			0	1	0	2	0	4					0	1	0	1	0	1	0	0
City Eye Ward	0	1	0	1	0	0	1	2	0	0	0	0	0	0	0	1	0	6	0	2
City Female Surgical Ward	0	2	0	2	6	5	9	4	1	4	0	3	0	2	0	4	3	5	4	4
City M1	0	4	0	6	0	6	0	6	0	4	0	5	0	6	0	6	0	6	0	4
City M2	0	5	1	9	0	10	0	8	0	8	0	10	1	9	0	12	0	3	0	4
Delivery Suite	2	10	1	10	0	7	0	6	1	7	1	5	3	16	1	13	0	5	0	5
LEASOWES	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1
Rowley Eliza Tinsley	0	1	0	1	0	0	0	1	0	2	0	0	0	0	0	1	4	1	1	2
Rowley Henderson	0	1	0	1	0	1	17	3	0	0	1	1	0	1	0	0	0	1	0	0
Rowley McCarthy	0	2	0	0	2	2	1	3	0	1	0	0	0	0	1	1	1	3	0	1
Sandwell AMU A	0	13	0	19	3	25	0	26	21	13	0	11	0	20	0	15			3	23
Sandwell AMU B																				
Sandwell Lyndon 1	0	2	0	3	4	4	0	1	0	1	0	2	0	4	0	2	0	5	0	2
Sandwell Lyndon 2	0	3	0	6	1	5	0	9	0	5	0	9	0	7	0	4	0	7	0	4
Sandwell Lyndon 3	0	3	0	4	0	3	1	4	0	0			0	0	0	3	0	6	0	4
Sandwell Lyndon 4	0	5	0	4	0	4	0	6	1	7	5	4	0	2	2	4	0	3	0	7
Sandwell Lyndon 5					0	0														
Sandwell Lyndon Ground	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sandwell Newton 3	0	2	0	6	0	3	2	6	0	5			1	4	0	1	0	2	0	2
Sandwell Newton 4	0	1	0	2	0	0	0	1	0	0	0	1	0	1	0	1	0	1	0	1
Sandwell Newton 5	0	2	0	2	1	1	0	0	0	1	0	0	0	0	0	2	0	0	0	4
Sandwell OPAU	0	9	0	3	1	5	0	0	0	5	1	2	0	4	1	4	0	3	0	6
Sandwell Priory 2	0	0	0	0	2	3	0	1					1	2	3	6	5	6	1	4
Sandwell Priory 4	0	5					4	5	0	5	0	3	0	2	1	4	1	2	0	5
Sandwell Priory 5			0	3	0	6	0	8	0	6	0	3	0	3	0	2	0	9	0	5
Sandwell SAU	0	7	0	11	0	4	3	4	6	11	0	6	11	7	9	5	0	11	5	15
Total Non Compliant Checks that Day	2	114	2	##	22	139	43	167	37	##	8	75	28	##	29	131	21	124	33	147

+ CLICK HERE FOR TRUST LEVEL by INDICATOR	Aug 11 NC	Aug 11 Patients	Aug 12 NC	Aug 12 Patients	Aug 13 NC	Aug 13 Patients	Aug 14 NC	Aug 14 Patients	Aug 15 NC	Aug 15 Patients	Aug 16 NC	Aug 16 Patients	Aug 17 NC	Aug 17 Patients	Aug 18 NC	Aug 18 Patients	Aug 19 NC	Aug 19 Patients	Aug 20 NC	Aug 20 Patients
City - Neonatal Unit	0	0	0	2	0	3	0	3	0	1	0	3	1	3	0	0	0	1	0	2
City AMU 1	9	12	9	12	7	9	16	14	15	12	15	11			11	7	0	9	0	6
City AMU 2	2	3	0	3	9	10	0	2	0	4	0	4			6	6				
City D11	0	0	0	3	0	1	0	1	0	3	0	1	0	2	0	1	0	0	0	1
City D15	0	2	0	6	0	4	1	3	0	1	0	2	1	3	0	3	0	2	2	2
City D16	0	4	0	6	0	2	0	0	0	0	1	5	0	1	0	3	0	5	0	0
City D19	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
City D21	0	9	0	7	0	2	0	1	2	3	1	5	0	5	0	0	2	4	0	2
City D26	0	1	0	4	0	2	0	1	0	0	0	1	0	4	0	3	0	4	0	1
City D27	0	2	0	4	0	1			0	5	0	3	0	3					1	2
City D43	0	2	0	2	0	1	0	1	0	1	0	2	0	1	0	5	0	1	0	0
City D47	0	0	0	2	0	1	0	0	0	0	0	1	0	5	0	0	0	1	0	0
City D5	0	0	1	1			0	1	0	2	4	4	0	2	0	2	0	0		
City D7	3	5	2	2	0	3	0	4	0	3	1	2	0	5	3	5	0	4	0	3
City EGAU	0	0	0	0	0	0	0	1	0	1			0	2	0	0	0	0	0	0
City Eye Ward	0	3	0	3	0	1	0	1	5	4	0	2	0	2	0	0	0	0	0	0
City Female Surgical Ward	2	2	0	0	5	9	0	0	0	2	13	8	0	2	2	2	4	1	0	2
City M1	0	4	0	4	0	2	0	4	0	4	1	6	0	6	0	7	0	6	0	4
City M2	0	6	0	4	0	3	0	10	0	12	0	9	0	9	0	6	0	12	0	10
Delivery Suite	0	6	0	5	0	3	2	8	2	5	0	9	2	12	0	10	0	8	2	11
LEASOWES	0	2	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	1	0	0
Rowley Eliza Tinsley	0	2	0	2	0	0	0	1	0	2	0	0	0	3	0	0	0	5	0	2
Rowley Henderson	0	0	13	2	5	2	0	0	0	0	0	2	0	0	2	1	0	2	0	1
Rowley McCarthy	1	2	0	3	0	0	1	1	3	3	2	2	0	2	0	3	0	0	0	0
Sandwell AMU A					11	14	2	22	3	22	3	25	1	23	0	26	5	15		
Sandwell AMU B											0	1								
Sandwell Lyndon 1	0	3	0	2	0	1	0	6	0	2	0	0	0	0	0	2	0	2	0	1
Sandwell Lyndon 2	1	10	0	2	0	15	5	4	6	7	8	10	16	9	4	5	0	4	0	3
Sandwell Lyndon 3	0	4	0	2	0	0	0	0	0	2	0	2	3	3	0	3	0	1	0	0
Sandwell Lyndon 4	0	3	0	9	0	3	0	2	0	3	4	3	0	5	8	9	8	10	1	4
Sandwell Lyndon 5																				
Sandwell Lyndon Ground	0	0	2	2	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Sandwell Newton 3	2	5	0	5	0	3	0	5	0	4	0	4	0	1	0	3	3	6	2	5
Sandwell Newton 4	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0
Sandwell Newton 5	0	4			0	3	0	0	0	1	0	0	0	1	0	0			0	0
Sandwell OPAU	0	6					0	4	6	3	0	3	0	2	0	1	0	3	0	3
Sandwell Priory 2	0	0	0	1	0	2	0	0	6	3	4	2	0	0	7	7	0	2	0	0
Sandwell Priory 4	0	5	0	2	13	6	2	3	0	3	7	11	1	5	0	6	0	1	0	2
Sandwell Priory 5	0	5	0	8	0	4	0	5	2	7	0	7	0	3	0	3	0	4	0	4
Sandwell SAU	3	11	7	11	3	11	2	10	4	11	8	14	8	12	3	9	1	5	6	8
Total Non Compliant Checks that Day	23	124	34	122	53	122	31	119	54	137	72	164	33	138	46	138	23	120	14	79

+ CLICK HERE FOR TRUST LEVEL by INDICATOR	Aug 21 NC	Aug 21 Patients	Aug 22 NC	Aug 22 Patients	Aug 23 NC	Aug 23 Patients	Aug 24 NC	Aug 24 Patients	Aug 25 NC	Aug 25 Patients	Aug 26 NC	Aug 26 Patients	Aug 27 NC	Aug 27 Patients	Aug 28 NC	Aug 28 Patients	Aug 29 NC	Aug 29 Patients	Aug 30 NC	Aug 30 Patients	Total Non Compliant Checks	Patients	LAST 4 weeks COMPLIANCE %	Qtr 1	
City - Neonatal Unit	0	1	0	1	0	2	0	3	0	1	0	4	0	1	0	0	0	4	0	2	1	51	99.9	97.1	✘
City AMU 1	0	5	6	9	8	9	0	19	9	7	1	7	7	10			9	12	9	12	157	241	96.6	97.5	✘
City AMU 2	0	10	0	5	2	4	0	4	0	2	7	9	0	6	0	9	0	0	0	4	33	131	98.7	98.4	✘
City D11	0	0	0	3	0	2	0	3	0	0	0	2	0	0	20	1	0	0	0	1	20	43	97.6	95.6	✘
City D15	0	3	1	3	0	5	0	4	0	3	0	5	0	2	0	2	0	0	0	1	6	83	99.6	97.8	✘
City D16	0	1	0	2	19	3	0	2	2	1	1	5	0	0	0	1	0	0			36	76	97.5	93.8	✘
City D19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	4	0	0	0	15	100.0	98.5	✓
City D21	0	6	0	6	0	2	0	2	0	4	0	3	0	1	0	1	0	1	0	5	8	103	99.6	95.7	✘
City D26	0	2	0	3	0	1	0	1	0	3	0	2	0	3	0	2	0	0			0	54	100.0	99.9	✓
City D27	0	0	0	3	1	7	2	2	1	2	0	1	0	0	0	0	0	4	0	4	5	70	99.6	98.1	✘
City D43	0	0	0	3	0	2	0	3	0	2	0	3	0	1	0	2	0	0	0	2	9	60	99.2	99.5	✘
City D47	0	1	0	0	0	1	0	0	0	1	0	0	2	1	0	1	0	1	0	1	2	24	99.6	99.6	✘
City D5	0	1	0	1	0	2	0	1	2	2	0	1	0	3			0	0	0	1	10	50	98.9	96.6	✘
City D7	1	2	0	2	0	7	0	4	0	5	0	6	0	5	0	7	0	4			10	116	99.5	96.2	✘
City EGAU	0	0	0	1	0	1	0	1	0	2	0	2	0	0	0	0	0	4	0	1	0	26	100.0	99.9	✓
City Eye Ward	0	0	0	1	0	1	0	2	0	1	3	4	0	0	0	1	0	2	0	0	9	41	98.8	97.5	✘
City Female Surgical Ward	1	3	1	3	0	0	0	1	0	0	4	4	0	2	0	2	0	3	2	5	57	86	96.5	97.5	✘
City M1	0	7	0	4	0	6	0	4	0	2	1	5	0	5	1	4					3	137	99.9	99.7	✘
City M2	0	6	0	10	0	6	0	6	0	3	0	2	0	5	0	8	1	8			3	213	99.9	100.0	✘
Delivery Suite	1	12	0	14	0	14	10	18	3	19											31	238	99.3	99.7	✘
LEASOWES	0	0	0	1	0	2	0	0	0	0	0	3	0	0	0	1	0	0	0	1	0	17	100.0	99.6	✓
Rowley Eliza Tinsley	0	2	0	2	0	1	0	4	0	0	0	3	0	0	2	3	0	0	0	1	7	42	99.1	92.8	✘
Rowley Henderson	0	0	0	1	0	0	0	1	0	3	0	2	0	2	0	0	0	0	0	1	38	29	93.1	91.7	✘
Rowley McCarthy	0	0	0	1	2	3	0	1	0	2	0	2	0	0	2	3	0	0	0	2	16	43	98.0	99.1	✘
Sandwell AMU A	7	18	2	21	5	19	0	16	2	17	11	18			9	25	1	20	5	21	94	487	99.0	96.1	✘
Sandwell AMU B																					0	1	100.0	0.0	✓
Sandwell Lyndon 1	0	0	0	2	0	2	0	1	0	0	0	3	0	0	0	1	0	1	0	1	4	56	99.6	99.7	✘
Sandwell Lyndon 2	0	5	7	6	0	2	12	9	6	6	0	1	0	5	0	4	7	10	4	18	77	194	97.9	94.8	✘
Sandwell Lyndon 3	0	0	4	4	1	5	1	4	4	5	2	5	0	0	0	0	0	0			16	67	98.7	97.4	✘
Sandwell Lyndon 4	2	4	0	5	4	8	0	4	0	5	0	3	0	2	5	8	0	1	0	1	40	138	98.5	96.5	✘
Sandwell Lyndon 5																					0	0	#NUM!	90.1	✘
Sandwell Lyndon Ground	0	1	0	2	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	1	2	9	98.8	99.6	✘
Sandwell Newton 3	3	3	4	4	0	2	0	3	1	4	2	4	0	3	0	2	1	3			21	100	98.9	97.1	✘
Sandwell Newton 4	0	1	0	1	0	3	0	2	0	1	0	0	0	0	0	0	0	0	0	1	0	21	100.0	97.8	✓
Sandwell Newton 5	0	4	5	1	0	2	0	0	0	0	0	2	0	0			0	1			6	31	99.0	85.5	✘
Sandwell OPAU	3	1	0	2									0	3	1	2	1	7			14	81	99.1	98.3	✘
Sandwell Priory 2	0	2	0	4	0	3	1	2	2	2	0	4	1	3	0	2	2	5	12	4	47	70	96.5	95.9	✘
Sandwell Priory 4	0	6			5	6	0	3	0	7	0	6	0	4	0	4					34	111	98.4	98.9	✘
Sandwell Priory 5	0	2	0	7	0	6	0	6	0	8	0	2	0	2	0	2	0	2	0	5	2	137	99.9	98.0	✘
Sandwell SAU	8	9	1	8	4	5	8	11	0	4	1	3	0	4	0	5	4	7	2	7	107	246	97.7	96.6	✘
Total Non Compliant Checks that Day	26	118	31	146	51	144	34	148	32	125	33	126	10	73	40	105	26	104	34	103				97.1	

A. SAFETY PLAN | TOTAL Compliance (TICK)/SOME Non Compliance (CROSS)

SWBTB (09/17)015b

>> CONVERT To PATIENTS
>> CONVERT To PERCENTAGES %

	Go Live	Aug 01	Aug 02	Aug 03	Aug 04	Aug 05	Aug 06	Aug 07	Aug 08	Aug 09	Aug 10	Aug 11	Aug 12	Aug 13	Aug 14	Aug 15	Aug 16	Aug 17	Aug 18	Aug 19	Aug 20	Aug 21	Aug 22	Aug 23	Aug 24	Aug 25	Aug 26	Aug 27	Aug 28	Aug 29	Aug 30
City - Neonatal Unit		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
City AMU 1	2017-06-01	✓	✓	✓	✓	✗		✗	✓	✗	✗	✗	✗	✗	✗	✗	✗		✗	✓	✓	✓	✗	✗	✓	✗	✗	✗		✗	✗
City AMU 2	2017-06-01	✓		✗	✗	✓		✗		✗	✓	✗	✓	✗	✓	✓	✓		✗			✓	✓	✗	✓	✓	✗	✓	✓	✓	✓
City D11	2017-06-01	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
City D15	2017-06-01	✓	✓	✓	✓			✗	✓	✓	✓	✓	✓	✓	✗	✓	✓	✗	✓	✓	✗	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
City D16	2017-06-01	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✓	✓	✓	
City D19	2017-03-06	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
City D21	2017-03-06	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
City D26	2017-06-01	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
City D27	2017-03-06	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓			✗	✓	✓	✗	✗	✗	✓	✓	✓	✓	✓
City D43	2017-02-06	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
City D47	2017-02-13	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓
City D5	2017-06-01	✓	✓	✓	✓		✓	✗	✓	✓	✗	✓	✗		✓	✓	✗	✓	✓	✓		✓	✓	✓	✓	✗	✓	✓		✓	✓
City D7	2017-06-01	✓	✓	✓	✓	✓		✓		✓	✓	✗	✗	✓	✓	✓	✗	✓	✗	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	
City EGAU	2017-02-06		✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
City Eye Ward	2017-06-01	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
City Female Surgical Ward	2017-03-06	✓	✓	✗	✗	✗	✓	✓	✓	✗	✗	✗	✓	✗	✓	✓	✗	✓	✗	✗	✓	✗	✗	✓	✓	✓	✗	✓	✓	✓	✗
City M1		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗		
City M2		✓	✗	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	
Delivery Suite	2017-06-01	✗	✗	✓	✓	✗	✗	✗	✗	✓	✓	✓	✓	✓	✗	✗	✓	✗	✓	✓	✗	✗	✓	✓	✗	✗					
LEASOWES	2017-03-13	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rowley Eliza Tinsley	2017-03-13	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Rowley Henderson	2017-03-13	✓	✓	✓	✗	✓	✗	✓	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rowley McCarthy	2017-03-13	✓	✓	✗	✗	✓	✓	✓	✗	✗	✓	✗	✓	✓	✗	✗	✗	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✗	✓	✓
Sandwell AMU A	2017-06-01	✓	✓	✗	✓	✗	✓	✓	✓		✗			✗	✗	✗	✗	✗	✓	✗		✗	✗	✗	✓	✗	✗		✗	✗	✗
Sandwell AMU B																	✓														
Sandwell Lyndon 1	2017-03-06	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sandwell Lyndon 2	2017-02-13	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✗	✗	✗	✗	✗	✓	✓	✓	✗	✓	✗	✗	✓	✓	✓	✗	✗
Sandwell Lyndon 3	2017-02-13	✓	✓	✓	✗	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✗	✗	✗	✗	✗	✓	✓	✓	
Sandwell Lyndon 4	2017-06-01	✓	✓	✓	✓	✗	✗	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✗	✓	✗	✓	✓	✓	✓	✗	✓	✓
Sandwell Lyndon 5	2017-06-01			✓																										
Sandwell Lyndon Ground	2017-02-06	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sandwell Newton 3	2017-01-16	✓	✓	✓	✗	✓		✗	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗	✓	✓	✗	✗	✓	✓	✗	
Sandwell Newton 4	2017-06-01	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sandwell Newton 5	2017-06-01	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✗	✓	✓	✓	✓	✓		✓	
Sandwell OPAU	2017-06-01	✓	✓	✗	✓	✓	✗	✓	✗	✓	✓	✓			✓	✗	✓	✓	✓	✓	✓	✗	✓					✓	✗	✗	
Sandwell Priory 2	2017-02-13	✓	✓	✗	✓			✗	✗	✗	✗	✓	✓	✓	✓	✗	✗	✓	✗	✓	✓	✓	✓	✓	✗	✗	✓	✗	✓	✗	✗
Sandwell Priory 4	2017-06-01	✓			✗	✓	✓	✓	✗	✗	✓	✓	✓	✗	✗	✓	✗	✗	✓	✓	✓	✓		✗	✓	✓	✓	✓	✓		
Sandwell Priory 5	2017-06-01		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sandwell SAU	2017-01-16	✓	✓	✓	✗	✗	✓	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✓	✓	✗	✗

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	NHSE Emergency Preparedness Response and Recovery (EPRR)
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Barlow - Chief Operating Officer
AUTHOR:	Caroline Rennalls - Head of Operational Resilience
DATE OF MEETING:	7th September 2017

EXECUTIVE SUMMARY:

The Trust will be **fully compliant** with the annual self-assessment process NHSE EPRR Core Standards.

At the time of writing there is one standard related to the resilience of communication which at the time of writing is red. The mitigating actions of a signed off SOP and complete testing will be presented for sign off at the EPRR Committee on the 8th September and it is anticipated this will be rated as green for our submission. This is a marked improvement from the submission of 2016/17.

The significant progress has been achieved by having **designated managerial and leadership resource** designated to driving the EPRR programme forward within the organisation. The corporate roll out of Business Continuity Management (BCM) strategy alongside training, exercises, unannounced BCM spot checks and sharing learning for internal and external events provide assurance that staff are able to respond to either a critical or major incident with a significant level of robustness. This is further helped by the introduction of EPRR Consultant leads for key specialities such as ED, Trauma, and Critical care. The introductions of definitive roles and responsibilities provide an opportunity to maximise clinical leadership and input into our strategy.

The revision and introduction of a new corporate EPRR Governance structure pulls **together local operations, reporting mechanism and testing plans of ward and department plans into a central repository** where collective lessons for learning can be identified actions and resourced if necessary.

The **training plan** that includes Incident Directors and commanders training, decontamination from Chemical, Biological, Radiological, and Nuclear (CBRN) for our Emergency Departments teams, fire evacuations with the local Fire brigade and table exercises all aim to promote competencies for staff to deploy during an incident. We continue to share learning from actual global events and exercises with other Health and Blue light responders by participating in local forums that focus on EPRR collective working in our conurbation. The underpinning principle being 'we learn more together'.

During 2017/18 we will undertake key activities including a total hospital evacuation, clinical training and simulation for mass casualties in a live exercise to test and revise related polices/plans.

REPORT RECOMMENDATION:

The Trust Board is invited to discuss the compliance standards assessment. The on-going strategy /management of EPRR will continue to sustain full compliance against the NHSE Core standards and National guidance of good practice in 2017/18.

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	**x**	Environmental	x	Communications & Media	x
Business and market share		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:

PREVIOUS CONSIDERATION:

EPRR and BCP previous papers and core compliance submitted annually to Trust Board.

NHS England Core Standards for Emergency preparedness, resilience and response

v5.0

The attached EPRR Core Standards spreadsheet has 6 tabs:

EPRR Core Standards tab: with core standards nos 1 - 37 (green tab)

Governance tab:-with deep dive questions to support the EPRR Governance'deep dive' for EPRR Assurance 2017 -18(blue) tab)

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard: designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards: designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V50. The following changes have been made :

• Inclusion of EPRR Governance questions to support the 'deep dive' for EPRR Assurance 2017-18

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance								
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	• Ensuring accountable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	Rachel Barlow - Chief Operating Officer		Rachel Barlow	
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y		1. Training programmes delivered and scheduled for 17/18 with training records kept in real time 2. live multiagency exercise 7.9.14 & 16.07.2017 with plans for another on 1st October 2017 3. Business Continuity Plan roll out programme completed with review in June 2018 & August 2018. This is supported by a 12 month Business Continuity Management work programme including Table Top exercises to test plans 4. Professional experts include Emergency Planning Officer, Head of Operations and Resilience Management have national Health Emergency Planning Diploma , and Senior Capacity manager have been being trained for Emergency Planning National Diploma with view to put 2 further staff through national diploma. 5. Revised governance structure that reports to Trust Board including BCM, Blast & Ballistics, EPRR Policy & Procedures Group, EPRR for future specifically for transition to Midland Met. CBRN group with ED staff and management team		Philip Stirling	
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y		Comprehensive list of Business Continuity Plans and Business Impact Analysis have been completed for all areas. Major Incident Plan has been taken to Policy and Procedures Group with reviews to Action Cards currently under way.		Caroline Rennalls	
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y		Reports are taken through the EPRR committee and then reported back to Board via AEO/CEO		Rachel Barlow	
Duty to assess risk								
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access);	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	Learning from planned tests and live situations are completed and learniing and risks are brought back to Business Continuity Management group and Report will go to EPRR Group, chaired by AEO.		Phil Holland	
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	• fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure;	Y		Risk Register sits on Trust wide portal with community risk register at the forefront. Specific risks have also been added. Red risks wil be reported to the Trust Board in line with internal governance arrangements		Philip Stirling	
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y				Philip Stirling	
Duty to maintain plans – emergency plans and business continuity plans								
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (Inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	SWBH Major Incident Plan V2 Review date - March 2019		Philip Stirling	
9		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y		SWBH Business Continuity Plan V1 Review date - March 2019		Philip Stirling	
10		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y		CBRN contained within Major Incident Plan V2		Philip Stirling	
11		Severe Weather (heatwave, flooding, snow and cold weather)	Y		SWBH Severe Weather Plan V1 - Review date - November 2018		Philip Stirling	
12		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y		SWBH Influenza Pandemic Preparedness & Response Plan V 1 - Review date November 2018		Philip Stirling	
13		Mass Countermeasures (e.g. mass prophylaxis, or mass vaccination)	Y		No specific Mass Countermeasures in place but would be a reactive process following an Outbreak meeting led by Control of Infection and Occupational Health		Philip Stirling	
14		Mass Casualties	Y		SWBH Mass Casualty Plan V3 - Review Date December 2018		Philip Stirling	
15		Fuel Disruption	Y		SWBH Road Fuel Emergency Plan V1 - Review Date March 2019		Philip Stirling	
16		Surge and Escalation Management (Inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y		Winter Surge Escalation Plan - Conurbation wide (led by CCG)		Philip Stirling	
17		Infectious Disease Outbreak	Y		SWBH Policy for the Management and Control of Outbreaks of Communicable Infections and Serious Infections V5 - Review date December 2017		Philip Stirling	
18		Evacuation	Y		SWBH Hospital Evacuation & Shelter Plan V3 - Review date March 2019		Philip Stirling	
19		Lockdown	Y		SWBH Management of Physical Security Plan V2 - Review March 2019		Philip Stirling	
20		Utilities, IT and Telecommunications Failure	Y		Utilities, IT and communication failure this is included in local Business Continuity Plans in Telecoms and Informatics		Philip Stirling	
21		Excess Deaths/ Mass Fatalities	Y		Black Country Mass Fatalities Plan and SWBH Mortuary Expansion Plan in place		Philip Stirling	
22		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			**Not Applicable to Acute Healthcare Providers**			
23		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			**Not Applicable to Acute Healthcare Providers**			
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	Plans are discussed at Policies Review Group with any amendments being signed off by EPRR Group before being taken to Operational Management Committee to get final approval. All plans are Version controlled and list all contributors and stored on S Drive and Intranet		Philip Stirling	
25	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	• On call Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	24/7 Site team is present on both sites reporting through On-Call structure should an incident occur. There is a 5 tier structure in place within SWBH to Executive level.		Philip Stirling	
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y		Critical Activities will always receive priority and these are outlined in Commander Training within SWBH.		Rachel Barlow	
27	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y		SWBH Policy for Management of Sanctioned Visitors V1 - Review Date July 2018		Rachel Barlow	

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28	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	• Specify who has been consulted on the relevant documents/ plans etc.	Scoping exercises are carried out before Plans are initiated with parties who have a vested interest. Plans and Policies are then taken through the Policy Review Group and signed off at EPRR Group and finally OMC. Eg suppliers and providers are detialed in internal continuity plans.	As the range of our business partners expand (mainly in relation to MMH and managed service contracts) we will consider how we are assured by a wider range of external suppliers continuity plans.	Caroline Rennalls	
29	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold) at the end of an incident.	Y		Hot debriefs are carried out immediately post incident with a cold debrief taking place within 2 weeks post incident. Lessons identified are recorded in the incident report which is taken to EPRR Group and fed back through AEO to Trust Board.		Caroline Rennalls	
Command and Control (C2)								
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	24/7 on call rota in place with Senior Capacity Manager or Clinical Nurse Practitioner taking lead of incident locally until relieved by Tactical Commander on call.		Caroline Rennalls	
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England published competencies are based upon National Occupation Standards .	Y	Training is delivered at the level for which the individual is expected to operate (i.e. operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	Strategic and Tactical Training complete 2017/18		Philip Stirling	
32	Documents identify where and how the emergency or business continuity incident will be managed from, i.e. the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.	Contained within Major Incident Plan and all located with the 4 ICC's		Philip Stirling	
33	Arrangements ensure that decisions are recorded and meetings are minute during an emergency or business continuity incident.		Y		List of trained Loggists available in Trust ICC's		Philip Stirling	
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y		As outlined in SWBH Major Incident Plan and On-Call Training		Philip Stirling	
35	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		CBRN plan is included within Major Incident Plan (MIP) which would be accessed by the Site team or On-call Team. Information for contacting further assistance from Fire or West Midlands Ambulance Service i.e. Hazardous Area Response Team (HART) is included in MIP also.		Philip Stirling	
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		Arrangements are in place to access 24 hour radiation protection supervisor. All ED Nursing staff are trained in the use of RAM Gene for detection purposes.		Philip Stirling	
Duty to communicate with the public								
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	Strategic Comms available 24/7 - led by Incident Director we hosted a Media training day for 12 Strategic Commanders with Social Media and Media training included.		Rachel Barlow	

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38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	Process in place for internal 2 way radios should communications equipment fail. Also the use of Trust mobile phones and conurbation wide High Frequency Radio to communicate with NHS England.	this is rated red as we are in transition of implementing new radios on site. The SOP needs completing and the continuity plan tested to go to green. It is anticiapted this will be rated as green as of the 8th September in time for our submission.	Caroline Rennalls	
Information Sharing – mandatory requirements								
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and include DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supersedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.	Active membership with Local Resilience Forum, Sandwell Resilience Group, Local Health Resilience Forum, Local Health Resilience Partnership		Philip Stirling	
Co-operation								
40	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and membership is quorate. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	Represented at Local Resilience Forum		Philip Stirling	
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y		Attendance at Local Health Resilience Forum and Sandwell Resilience Group		Philip Stirling	
42	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y		The West Midlands Mutual Aid Handbook is used within our Incident Coordination Centres and any updates to this document are fed back to NHS England as owner of the document.		Philip Stirling	
43	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				**Not Applicable to Acute Healthcare Providers**			
44	Arrangements outline the procedure for responding to incidents which affect two or more regions.				**Not Applicable to Acute Healthcare Providers**			
45	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y		The West Midlands Incident Response Plan is available for all Commanders and they are trained in providing NHS England with the appropriate SITREP.		Philip Stirling	
46	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared				**Not Applicable to Acute Healthcare Providers**			
47	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months				**Not Applicable to Acute Healthcare Providers**			
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y		AEO or representative attends Local Health Resilience Partnership		Rachel Barlow	
Training And Exercising								
49	Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • A training needs analysis undertaken within the last 12 months • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs.	Annual tabletop exercise programme has been set up with 1 Tabletop per month focusing on aspects ranging from flood to loss of power. Annual work programme includes all training to be provided to staff relating to Major Incidents, Loggist, Business Continuity, Commander Training (in line with National Occupational Standards) Monthly communications exercises have been scheduled, with		Philip Stirling	
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	• Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidents have been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	All table tops exercises are within the scope of current Business Continuity Plans and will test the function of these. Any lessons identified are ratified and plans are updated to reflect this learning.		Philip Stirling	
51	Demonstrate organisation wide (including on call personnel) appropriate participation in multi-agency exercises		Y		Attendance at Vital Sign (National EPRR Live Ex) Multi Agency Training at City Hospital with WMFS 16.07.2017		Philip Stirling	
52	Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y		Training of Incident Commanders is recorded by Emergency Planning Team. An individual record is also kept in the folders provided to each of the Incident Commanders by the Trust.		Philip Stirling	

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
2017 Deep Dive								
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a public Board/Governing Body meeting for sign off within the last 12 months.	• The organisation has taken the LHRP agreed results of their 2016/17 NHS EPRR assurance process to a public Board meeting or Governing Body, within the last 12 months • The organisations can evidence that the 2016/17 NHS EPRR assurance results Board/Governing Body results have been presented via meeting minutes.	Y	• Organisation's public Board/Governing Body report • Organisation's public website	Execuitve accountable officer identified; Rachel Barlow COO. Last years submission was taken to Trust Board as well as statement published in Annual Report. This years are schedualed to go to the September Trust Board.		Rachel Barlow	31/03/2018
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	• There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report	Y	• Organisation's Annual Report • Organisation's public website	note page 70 of link below https://www.swbh.nhs.uk/wp-content/uploads/2017/02/AR_Partnerships-with-a-purpose-2017-1.pdf		Vanya Rogers	
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	• The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio. • The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR portfolio via their public website and annual report • The Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio is a regular and active member of the Board/Governing Body • The organisation has a formal and established process for keeping the Non-executive Director/Governing Body Representative briefed on the progress of the EPRR work plan outside of Board/Governing Body meetings	Y	• Organisation's Annual Report • Organisation's public Board/Governing Body report • Organisation's public website • Minutes of meetings	Ms Olwen Dutten is the Trusts Non Executive Director who holds EPRR Portfolio		Rachel Barlow	
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	• The organisation has an internal group that meets at least quarterly that agrees the EPRR work priorities and oversees the delivery of the organisation's EPRR function.	Y	• Minutes of meetings	The EPRR Group chaired bythe COO meets monthly and addresses work priorities and oversees the organisations EPRR function. There is an annual work plan that underpins the prioirities of the group.		Rachel Barlow	
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	• The organisation's Accountable Emergency Officer is a regular attendee at the organisation's meeting that provides oversight to the delivery of the EPRR work program. • The organisation's Accountable Emergency Officer has attended at least 50% of these meetings within the last 12 months.	Y	• Minutes of meetings	AEO is chair of EPRR Group Meeting		Rachel Barlow	
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	• The organisation's Accountable Emergency Officer is a regular attendee at Local Health Resilience Partnership meetings • The organisation's Accountable Emergency Officer has attended at least 75% of these meetings within the last 12 months.	Y	• Minutes of meetings	AEO attends or sends nominated other - DCOO or Head of Operational Resilience		Rachel Barlow	

Hazardous materials (HAZMAT) and chemical, biological, radiological and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**		**Evidence of assurance**				
	Preparedness							
53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (Inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	All documents are version controlled and go through a sign off process through the various groups listed previously.		Philip Stirling	
54	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	• Site inspection • IT system screen dump	CBRN plan is contained within the Major Incident Plan. We carry out monthly site inspections and an annual visit from West Midlands Ambulance Service.		Philip Stirling	
55	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	dynamic risk assessments are used within the Emergency Department environment. Risk Assessments have been carried out for staff working within a HAZMAT/CBRN environment with appropriate PPE provided and systems in place for after such an event.		Philip Stirling	
56	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y	• Resource provision / % staff trained and available • Rota / rostering arrangements	All substantive Nursing staff trained within both ED department with Medical staff being incorporated into this years training cycle		Philip Stirling	
57	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	• Provision documented in plan / procedures • Staff awareness	Regional Toxicology service provided by SWBH		Philip Stirling	
	Decontamination Equipment							
58	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	we follow the guidance set out by WMAS and NHS England in relation to the equipment required for decontaminating a patient. The inventory is complete.		Philip Stirling	
59	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Currently green - in liaison with NHS England to reprovide PRPS suits		Philip Stirling	
60	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		The Emergency Planning Officer oversees the equipment with one training lead taking responsibility of this at each Emergency Department		Philip Stirling	
61	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Established in SWBH since September 2016		Philip Stirling	
62	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		we follow NHS England guidance relating to this, utilising out of date suits as training suits		Philip Stirling	
	Training							
63	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		Y		There are 2 training leads in each Emergency Department		Philip Stirling	
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	records are kept in both departments both physically and electronically. The training programme is supported by the Emergency Planning Officer who oversees the exercising programme.		Philip Stirling	
65	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		Y		4 Nursing staff trained to train and Emergency Planning Officer - 5 in total		Philip Stirling	

Hazardous materials (HAZMAT) and chemical, biological, radiological and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**		**Evidence of assurance**				
66	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y		Admin/Front Desk Staff have received training		Philip Stirling	

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		not applicable
E1.1	Liner		not applicable
E1.2	Air inflator pump		not applicable
E1.3	Repair kit		not applicable
E1.2	Tethering equipment		not applicable
	OR: Rigid/ cantilever structure		
E2	Tent shell	SF 15	Sandwell General
	OR: Built structure		
E3	Decontamination unit or room	DC18	City Hospital
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		LED lights on Decontainer, overhead lights at Sandwell
E5	Shower heads		not applicable
E6	Hose connectors and shower heads		x2 at Sandwell, x6 at city
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		in situ
E8	Waste water pump and pipe		in situ
E9	Waste water bladder		in situ
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).		compliant
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		circa 10 cross site
	Ancillary		
E12	A facility to provide privacy and dignity to patients		in situ
E13	Buckets, sponges, cloths and blue roll		in situ
E14	Decontamination liquid (COSHH compliant)		in situ
E15	Entry control board (including clock)		in situ
E16	A means to prevent contamination of the water supply		Water Bowsers in place at both sites
E17	Poly boom (if required by local Fire and Rescue Service)		not applicable
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		in situ
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		in situ
E20	Waste bins		at City only, Sandwell isolate and double bag waste - follow decontamination guidance on intranet
	Disposable gloves		in situ
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		in situ
E22	FFP3 masks		in situ
E23	Cordon tape		in situ
E24	Loud Hailer		in situ
E25	Signage		in situ
E26	Tabards identifying members of the decontamination team		in situ
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		this would be provided by PHE
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		in situ
E29	Hooded paper suits		in situ
E30	Goggles		in situ
E31	FFP3 Masks - for HART personnel only		not applicable
E32	Overshoes & Gloves		in situ

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.			Y													
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.			Y													
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.			Y													
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.			Y													
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.				Y													
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.				Y													
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).			Y													
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.				Y													
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.				Y													
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.				Y													
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.			Y													
19	Organisations ensure that staff view the appropriate NARU training and briefing DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.			Y													

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Orgniations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Orgniations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Orgniations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Orgniations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Orgniations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Orgniations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month. • Orgniations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.			Y												
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.				Y													
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.				Y													
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.				Y													
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.			Y												
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.				Y													
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.			Y													
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.				Y													
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.				Y													
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.				Y													
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).				Y													
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.				Y													
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.				Y													
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.				Y													
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment				Y													
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.				Y													

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Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Learning from Deaths – Policy and implementation
SPONSOR (EXECUTIVE DIRECTOR):	Dr Roger Stedman
AUTHOR:	Dr Roger Stedman, Dr Carol Cobb, Heather Matthews
DATE OF MEETING:	7th September 2017

EXECUTIVE SUMMARY:

This paper outlines the policy and implementation timeline for the Learning From Deaths Plan. A process flow chart outlines (appendix 1) the new approach to reviewing and learning from deaths including:

- The Medical Examiner Role in screening all deaths
- Identification of deaths for special review
- 1st stage structured judgemental review
- 2nd stage structured judgemental review – and referral for SI investigation if warranted
- The Executive Quality Committee at the hub of organisational learning

Implementation includes the recovery of cremation fees in order to fund clinical sessions for the ME role as well as training of a cohort of 1st and 2nd stage structured judgemental reviewers.

The proposals will be shared with the Birmingham and Sandwell coroners.

It is expected the new process for learning from deaths will be fully active by December 2017 – enabling a Q4 report to be submitted with the Trust's 17/18 quality account. A Q3 report will be submitted to NHSI based on the current mortality review profoma.

REPORT RECOMMENDATION:

Review, discuss and accept Learning from Deaths proposal.

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		Workforce	

Comments:

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

PREVIOUS CONSIDERATION:

Quality and Safety Committee – Friday 25th August 2017

Sandwell and West Birmingham Hospitals NHS Trust

Learning from Deaths

Introduction

At SWBH we have been leaders in the national learning from deaths agenda. For over five years deaths have been reviewed at the Trust using an electronic trigger tool methodology. This has identified, through the mortality and quality alerts committee, lessons that can be learnt across the trust. In particular the learning from mortality reviews has driven quality improvement in the following areas: Sepsis, Acute kidney Injury, Recording of DNACPR, and End of Life Care.

The launch of the national Learning from Deaths programme has prompted a re-evaluation of our current methodology to bring it in line with the recommendations of the National Quality Board, National Guidance for Learning from Deaths March 2017. The newly formed Executive Quality Committee will oversee the formation of the new process, commission the Learning from Deaths panel to produce quarterly reports, learning alerts and investigate outlier alerts. It will receive, disseminate and follow up actions identified from the learning.

In particular it has been identified that we can improve the quality and depth of the lessons learnt from mortality review by:

- Screening all deaths and identifying the most appropriate review method
- Involving relatives early in the process to identify issues of concern
- Improving death certification and liaison with the coroner
- Selection of cases for review and not for review
- Having a trained cohort of reviewers to aid consistency of review outcomes
- A method and process for deaths where there are serious care issues requiring investigation
- A robust governance structure that assures the board and regulators that lessons are identified, disseminated and acted upon.

Process for Learning from Deaths.

Appendix 1 shows the flow chart for the process for managing review of deaths. They key points to note are:

Medical Examiner Role -

1) A new function of the 'Medical Examiner' is being created
2) This is a group of doctors that will attend the bereavement office on a daily basis.
3) They will screen all deaths to identify all cases that require review
4) Special cases – Child death, Perinatal deaths, Learning difficulties, Mental Health and Safeguarding concerns will be channelled into a specialist review process
5) Any death meeting the listed criteria will automatically receive a review
6) Any death meeting the criteria for a coroner's referral will receive a review
7) They will liaise with the bereaved families and identify any issues or concerns they have. Where this is the case these will receive a review.

8) Any death where a serious incident has occurred – will be channelled into the SI investigation process
9) They will ensure consistency and quality of death certification, and coding.
10) They will ensure appropriate and good quality referrals to the coroner take place – including the facilitation of rapid release where this is appropriate

Stage 1 review –

1) A larger cohort of health professionals drawn from across the organisation representing all groups and directorates and professions.
2) All trained in the 'Structured Judgmental Review' methodology
3) This process will identify cases that warrant second stage review by the learning from deaths panel
4) Identification of cases of serious concern.
5) Addressing the questions raised by bereaved relatives
6) Applying objective criteria to assess the degree of concern and or avoidability of the death
7) Identifying good practice from which to learn

Stage 2 review –

1) A panel of expert reviewers – 'Learning from Deaths committee'
2) Will review individual cases referred from stage 1
3) Aggregate the learning from all other deaths
4) Monitor mortality statistics, outlier and quality alerts
5) Conduct investigations and cohort reviews into outlier concerns
6) Produce quarterly reports on learning from deaths

Organisational Learning

1) Through the Executive Quality Committee lessons will be disseminated throughout the organisation
2) Actions and quality improvement programmes will be commissioned
3) Assurance will be provided to Trust Board through Quality and Safety committee
4) External stakeholder and regulatory assurance will be provided.

Governance of learning from Deaths

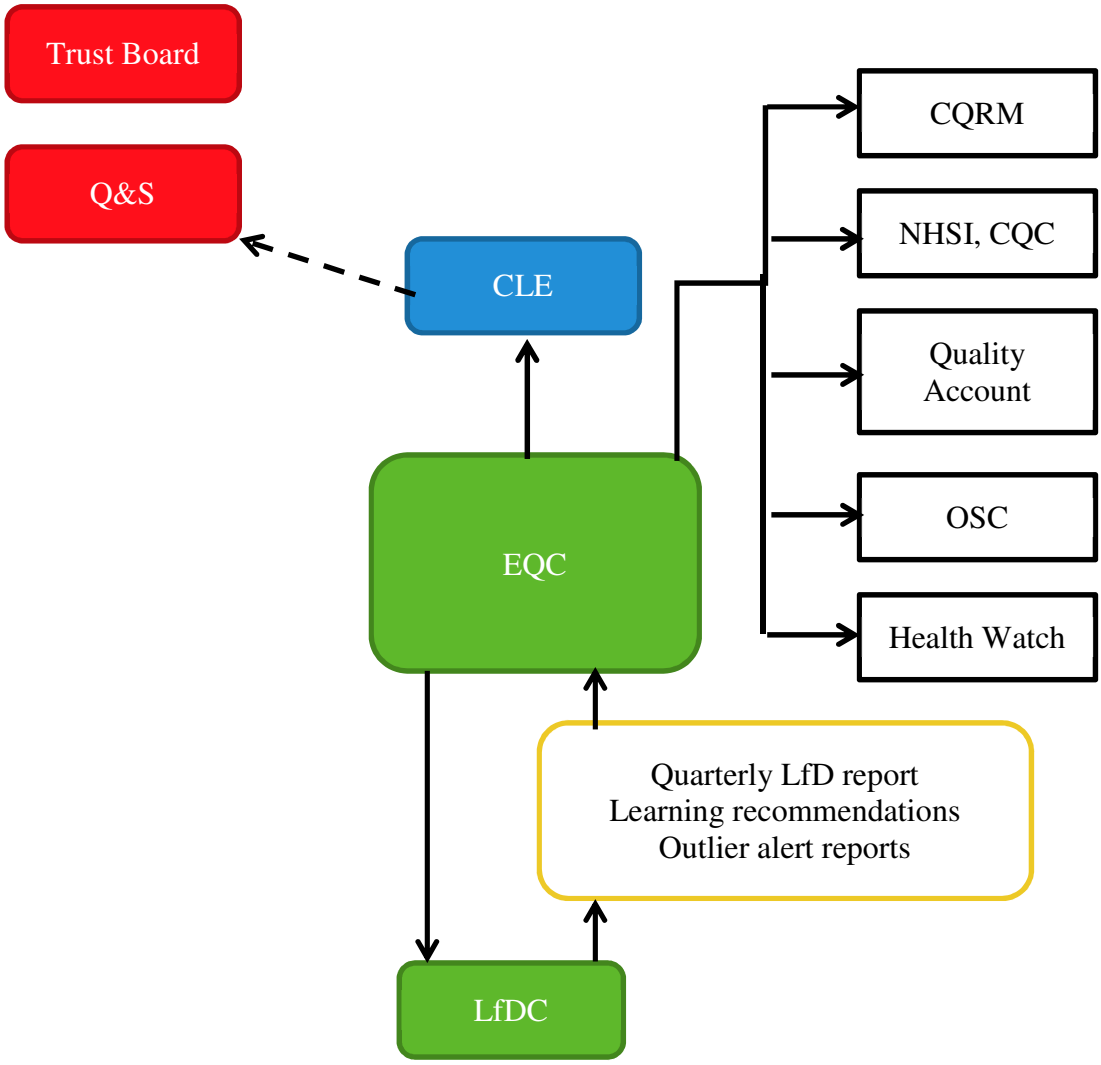
The process of learning from deaths will be directed and governed by the Executive Quality Committee (EQC). This will commission and oversee the programme of work of the Learning from Deaths committee (LfDC). EQC will disseminate learning and incorporate actions into the quality improvement agendas of the clinical groups.

EQC will receive a quarterly report from LfDC summarising the learning outcomes of the LfD process as well as reporting on other activities of the LfDC including review of HSMR, RAMI and response to mortality outlier alerts.

EQC will provide to Q&S committee assurance reports as requested.

EQC will liaise with external stakeholders including CCG, CQC, NHSI, Patient groups, Oversight and scrutiny committees.

An annual report will be submitted as part of the quality account.

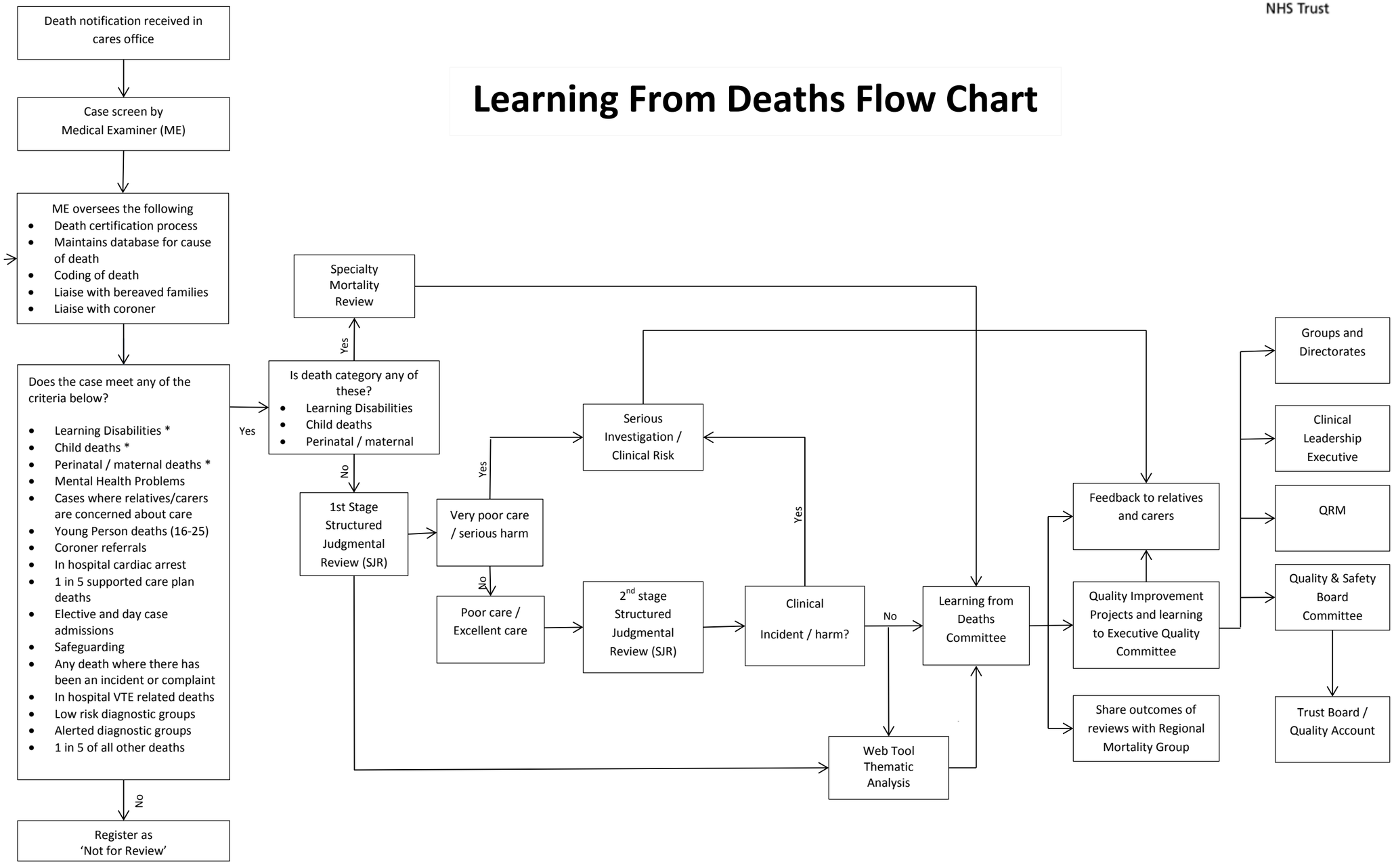


Implementation (see appendix 2)

August 2017	- Learning from deaths Policy (appendix 3)
	- Medical Examiners JD
September	- Advertise and appoint MEs
	- Implement cremation fee recovery
	- Meet coroner
	- Review roles and responsibilities CARES team
October	- Identify SJR reviewers
	- Train SJR reviewers
November	- Q3 report – based on current process
December	- MEs and SJRs in post
	- New LfD process commences
March 2018	- Q4 report to board
April	- Quality account report

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Learning From Deaths Flow Chart



Where EVERYONE Matters

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Learning From Deaths Plan

		2017 / 2018								
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Project Objective	**Lead**									
Outline requirements for Medical Examiner and Chief Medical Examiner Roles and write JDs	CC									
Write revised policy for Learning from Deaths to be published in September	CC									
Advertise, interview and appoint ME roles	RS/CC									
Give notice to LNCC regarding changes to payments for part 1 and part 2 of the crem fees forms	RS									
Meet with coroner to discuss learning from deaths programme										
Review of existing mortality support roles (cares office and CE facilitator) and how they fit into the new framework.	CC/HM									
Identify pool of reviewers	CC/Lead ME									
Train reviewers	CC									
Liaise with funeral directors re the change in payment for crem fees and agree process for payment to the Trust	HM/JD									
Medical Examiners in post	CC									
ME function to start screening process of all deaths	ME									
Implement SJT review process	CC/Lead ME									
Annual report to Trust board on reviews and learning outcomes	CC/RS									
Learning from Deaths data included in Quality Account for 2017/18	CC/RS/HM									

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NHS Trust

Learning From Deaths Assurance Policy

Policy authors	Trust Mortality Lead - Dr. Carol Cobb Head of Clinical Effectiveness – Simon Parker Learning From Deaths: Facilitator-Mumtaz Goolam
Accountable Executive Lead	Medical Director – Dr. Roger Stedman
Approving body	Learning From Deaths Committee
Policy reference	SWBH/XXX/NNN[Assigned by Trust policy-Co-ordinator]

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:

1 - All Medical staff
2 - Nursing & Clinical staff
3 - Group Directorate & Specialty Leadership teams
4 - Risk & Clinical Effectiveness Departments

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:

1 - Executive Team/General/Operational Managers
2 - All healthcare professionals

POLICY APPROVAL DATE
September 2017

POLICY IMPLEMENTATION DATE:
September 2017

DATE POLICY TO BE REVIEWED:
September 2018

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
1.0				New Policy

Learning from Deaths

Key Points

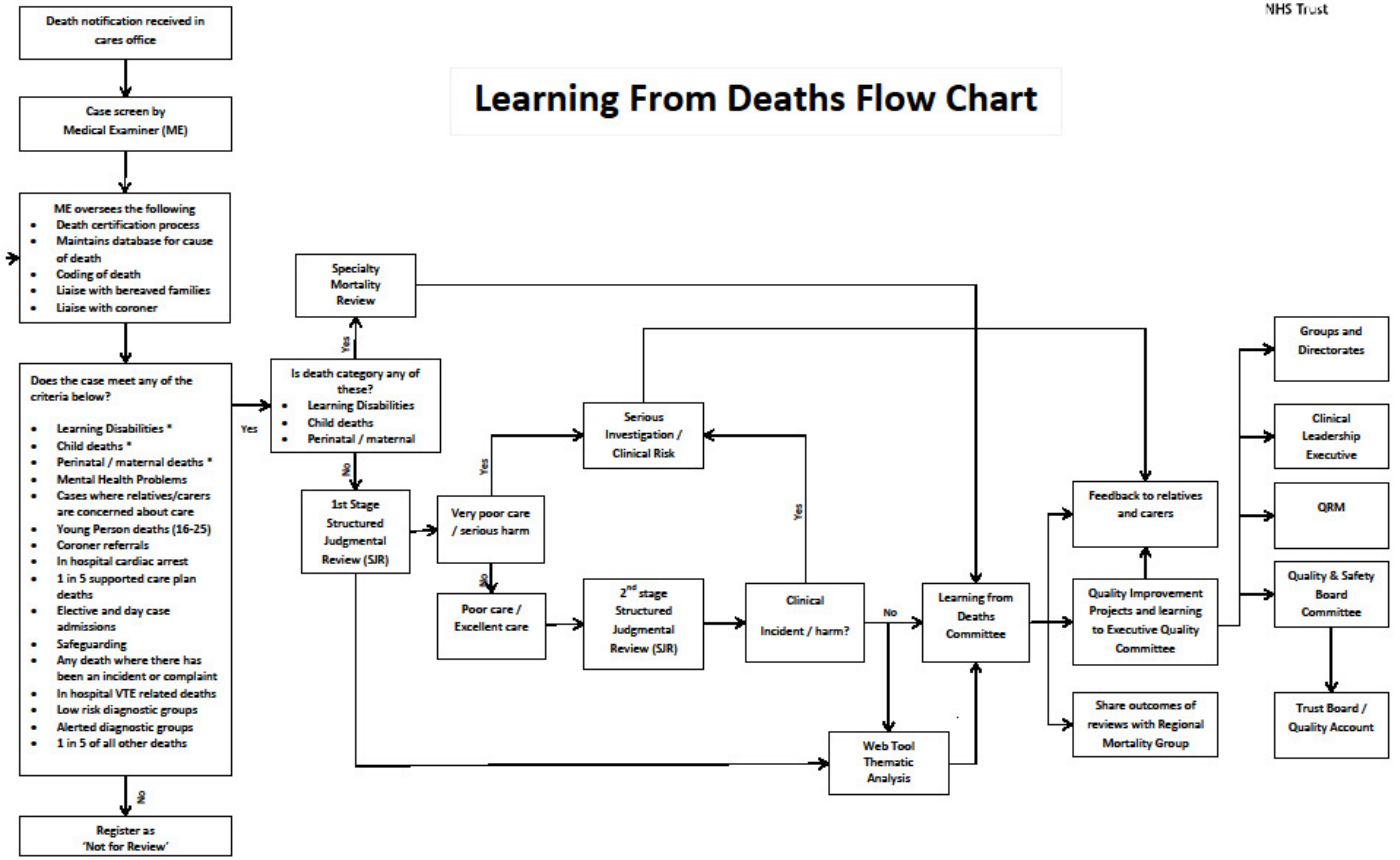
1. Sets out the SWBH Trust Policy for Learning from Deaths in accordance to the National Learning from Deaths Programme launched by the National Quality Board in March 2017.

2. Quality improvement of the present Mortality and Quality Alert programme that safeguards quality of care.

3. The Learning From Deaths Programme includes:
    - Communicating and engaging the relatives and carers of the deceased at all stages in the programme.
    - Monitoring and analysis of national and local mortality data that relate to SWBH NHS Trust
    - Responding to mortality alerts from external and internal investigation.
    - Identifying and screening all deaths occurring under the care of SWBH NHS Trust and establishing which cases require structured review.
    - Analysis and learning from these reviews to implement quality improvement in future patient care.
    - Over sight of the administration effectiveness, quality improvement out puts, sharing and governance of Learning from Deaths Programme in the Trust.
    - Sharing of learning, quality improvement, serious case investigation and examples of excellent care where appropriate relatives and carers, internal and external health care agencies.

Main link/reference:
https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

Learning From Deaths Flow Chart



Learning from Deaths

What does the Policy cover?

1. **Definition of the deaths to be considered by SWBH NHS Trust in the Learning from Deaths Programme.**
    a. All deaths of patients under the care of SWBH NHS Trust to be screened to aid identification of cases for review or referral to Her Majesty's Coroner or notification

    b. Cases will be identified for first and second tier structured review according to
        i. Learning from Deaths Guidance
        ii. Learning from Deaths committee instruction
        iii. Identification by external or internal mortality outlier alerts

2. **Bereavement Officer and Medical Examiner Function & Role**
    a. Bereavement Officer and Medical Examiner will support and engage relatives and carers in the learning from deaths programme from the time of death certification.

    b. Medical staff will be trained, supported and guided in relation to their responsibilities for communicating with bereaved relatives and carers, signing death certificate and cremation forms and communicating with other health care workers and Her Majesty's Coroner.

    c. To ensure accurate and appropriate medical certification of cause of death (MCCD) and clinical coding at the time of a patient's death.

    d. To identify cases for referral to Her Majesty's Coroner, police and disease notification as appropriate

    e. To identify cases for review either by specialty or Learning from Deaths case reviewers.

3. **Communication and Engagement with Relatives and Carers of Deceased Patients**
    a. Information from relatives and carers will guide case review

    b. Relatives and carers will be informed and involved where appropriate regarding the Learning from deaths programme, the relevant case review and learning and quality improvement that results.

4. **Case Review and thematic analysis methods and processes**
    a. Trained multidisciplinary trust staff will use a structured review process and thematic analysis tool to investigate appropriate cases in a 2 tier system.

    b. Excellent, poor and very poor care will be used to identify
        i. cases for escalation and formal case review
        ii. themes identified in care that can inform quality improvement projects

5. Learning, Quality Improvement and Sharing of information

a. Relatives, carers and the public will be made aware of the programme, the process, the learning and resultant quality improvement outcomes

b. Feedback will be provided to relatives and carers about how an individual case is being managed within this programme.

c. All clinical staff will receive regular information about the performance, learning and quality improvement out comes from the programme.

d. All Groups, Directorates and Specialties will share learning from themes identified and the outcomes within their groups

e. All Groups, Directorates and Specialties will share learning, quality improvement and progress with learning from Deaths Committee.

f. Learning, Quality Improvement projects and Quality improvement outcomes resulting from the Learning from Deaths Programme will be shared with local, regional and national agencies as appropriate.

6. Oversight, Monitoring and Governance

a. Learning from Deaths Committee will oversee, monitor and report in accordance with agreed terms of reference

b. An internal and external reporting structure will be defined and monitored.

c. Escalation of any identified problems in care as appropriate

d. External and internal mortality data will be monitored and all alerts and concerns responded to and reported internally and externally as appropriate

e. All Groups, Directorates and Specialties' mortality review performance, morbidity and mortality meeting compliance and quality improvement actions will be monitored

f. The learning from deaths programme will be integrated with the information and Clinical Governance departments and processes.

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

Learning from Deaths

1. Background

Monitoring the mortality statistics of a health care provider can give help indicate the quality and safety of care. External data and internal structured case review and analysis can help identify problems in care as well as excellent practice. Themes in process of care whether problems in care or good care can guide quality improvement in care.

SWBH NHS Trust has had a structured mortality statistics monitoring and case review system in place since 2000. The recently launched National Learning from Deaths guidance from the National Quality Board in march 2017 is a welcome, timely addition to the need to develop our learning From deaths programme. The recommendations in the national Guidance (https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf) complement the present system on which we can build. The focus of the guidance is to engage with relatives and carers of the deceased, to ensure timely, focused structured review of appropriate cases, to identify good and poor care from which we can learn, to identify quality improvement from the learning and implement and share this quality improvement work with the public as well as with health care providers.

The creation of medical examiner role within the bereavement office, engaging with relatives and carers from the time of medical certification of cause of death, timely focused systematic, structured, multidisciplinary mortality review, thematic analysis of excellent as well as poor care and identifying, implementing and sharing quality improvement in care can be achieved through developing our mortality and quality alert approach at SWBH NHS Trust.

The nationally recommended Royal College of Physicians web supported structured judgmental review and thematic analysis tool with its supporting training and assurance network along with medical examiner information and training will develop our systems to achieve national recommendations.

2. Other Policies to which this policy relates to

- The Policy on the Completion of a 'Medical Certificate of the cause of Death'
- Information Governance Policy
- Policy for the Reporting & Managing of Incidents
- Complaints Policy
- Duty of Candor Policy
- Coroners
- Notifiable Diseases
- Child and Infant Deaths
- Perinatal & Maternal Deaths

3. Aims

The aim of this policy is to ensure:

- Support and guidance to relatives and carers of the deceased through the processes following death.
- Engagement of relatives and carers in the processes of leaning from death.
- Systematic, focused, structured patient mortality reviews within SWBH.
- Quality Improvement in patient care results from mortality review and thematic analysis of reviews.
- Learning from Deaths Committee membership and terms of reference established.
- Consistency in group, directorate and specialty morbidity and mortality meetings.
- Integration with clinical and trust Governance processes to ensure escalation of cases of concern identified in mortality review ensure appropriate action is taken.
- Learning and quality improvement work is shared with all clinical staff, Directorate, Group and Corporate teams as well as external health care agencies.
- Internal and external Mortality data, statistics and alerts are monitored, investigated and responded to.
- Reporting structure established

4. Scope

This policy applies to all clinical staff, Group, Directorate & Specialty Leadership teams, Risk & Clinical Effectiveness Departments and Trust executives and Trust Board members.

Implementation of the policy will be supported by managers and administrative staff.

5. Roles and Responsibilities

Chief Executive

Has overall responsibility for ensuring that robust processes are in place for monitoring mortality in accordance with learning from deaths Guidance 2017 on behalf of the Board of Directors of the Trust.

Non-Executive Director – Chair Quality & Safety Committee

Non-Executive Director has responsibility for ensuring a robust system is in place to allow learning from deaths, that the focus is on learning and that published information in relation to learning from deaths is accurate and fair reflection of achievements and challenges.(see appendix B https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf)

Medical Director

Has responsibility for assuring the Board that the mortality monitoring process is functioning correctly. To ensure that arrangements are in place so that all appropriate clinical staff are aware of their responsibilities to contribute to the

process. Provide reports from the Learning from Deaths programme for Executive Quality committee, CLE, Q&S Committee, Trust Board, Quality Account, and external regulatory and stakeholder organisations.

Director of Governance
Have responsibility to support the Learning from Deaths committee through the clinical effectiveness function. Support the dissemination of corporate learning through QIHD and Clinical Group governance structure. Ensure the dissemination of lessons learnt and provide assurance to the organisational governance structures and external regulatory authorities.

Clinical and Group Directorates Triumvirates
Have responsibility to ensure that appropriate multi- disciplinary mortality and morbidity meetings take place in all specialties, that the directorate, or specialty contributes to the case review team and quality improvement resulting from learning from deaths is implemented and monitored.

Learning from Deaths Committee Chair
To ensure:

- Appropriate multidisciplinary representation at monthly meetings
- Oversight and response to internal and external mortality data, statistics and alerts
- Collation of review findings, learning points and actions for quality improvement.
- Leadership and Management of Learning from Deaths Team
- Leadership and Management of medical examiner and case reviewer teams
- Monitor medical examiner team performance
- Monitor appropriate case referral for structured review
- Monitor timeliness and quality of structured mortality reviews and analysis
- Monitor Clinical and Group directorate mortality and quality improvement work
- Reporting learning from deaths performance to Quality & safety committee
- Reporting learning from deaths performance to Trust Board
- Escalation of cases identified as serious incidents
- Integration and reporting through governance processes
- Concerns escalated as appropriate to the Medical Director and Non-executive Director for Learning from Deaths

Learning from Deaths Committee
To ensure:

- Oversight of and response to internal and external mortality data and alerts
- Collation of review findings, thematic analysis , identify learning points and actions for quality improvement
- Monitor implementation of quality improvement projects.
- Monitor medical examiner team performance
- Regular Review and confirmation of cases for referral for review by medical examiners
- Monitor appropriate case referral for structured review
- Monitor timeliness and quality of structured mortality reviews and analysis
- Monitor Clinical and Group directorate mortality and quality improvement work

- Monitor all cases referred for external review or investigation - coroner, police, LeDeR, etc
- Reporting learning from deaths performance to Quality & safety committee
- Reporting learning from deaths performance to Trust Board
- Regular review of reporting structure and templates
- Escalation of cases identified as serious incidents
- Integration and reporting through governance processes
- Sharing of learning and quality improvement outcomes of programme and outcomes internally and externally to appropriate health care agencies.

Mortality and Morbidity (M&M) Meetings

- Each group, directorate and specialty will have regular multidisciplinary M&M meetings chaired by Governance/quality Improvement lead.
- Presentation, analysis and discussion of mortality case reviews, learning and quality improvement actions relevant to group, directorate and specialty
- Sharing of trust wide learning themes and quality improvement projects relating to learning from deaths
- Share actions from any serious incident case reviews.
- The chair of the meeting will be responsible for
    - Report to learning from deaths committee quarterly about learning and quality improvement out comes

Medical Examiners

- To maintain knowledge, skills and legal responsibilities of thefts through CPD, networks and training updates.
- To support and engage relatives and carers in the learning from deaths programme from the time of death certification.
- To ensure Accurate and appropriate MCCD and clinical coding at the time of a patents death.
- To identify cases for referral to coroner, police and disease notification as appropriate
- To identify cases for review according to policy and LfD Committee guidance
- To refer cases for review to appropriate individuals
- To support train and guide junior medical staff through the MCCD and cremation form process, communication with relatives and carers as well as coroner.
- To be an active team member of bereavement office and Learning from deaths Team

Case Reviewer

- To be trained in SJR and use of the web tool provided for this and to keep up to date with developments in process
- To be responsible for thorough object case review and completion of all area of review program
- To pass on cases in which reviewer has contributed to care of the deceased
- To perform case reviews through SWBH mortality review system initially and new SJR process when implemented
- To escalate concerns in patient care immediately
- To feedback to LfD committee any notable cases or cases thought not to have been managed appropriately

All clinical staff

- All clinical staff are required to participate fully in quality improvement work resulting from learning from deaths
- All clinical staff are expected to participate fully in all M&M meetings that are relevant to their practice.

6. Structures & Procedures

Executive Quality Committee

- The executive committee that commissions Learning from Deaths Committee and oversees its programme of work
- Receives regular reports from the Learning from Deaths Committee
- Identifies and disseminates lessons to be learnt from the learning from deaths process
- Holds Clinical Group leadership to account for delivering business process and clinical practice change as a result of lessons learnt from learning from deaths
- Provides reports from Learning from Deaths to Clinical Leadership executive, Quality and Safety Committee, CQRM, Quality Account and NHSI.

Learning from Deaths Committee

a. Membership

- Chair: Medical Director
- LfD Lead
- LfD Facilitator
- Chair Quality & Safety Committee (NED)
- Senior Nurse representative
- Clinical Effectiveness Lead/Governance representative
- Lead Medical Examiner
- Clinical Informatics representative
- Palliative care representative
- LD Lead
- Bereavement Office manager
- Junior Doctors representative
- Medicine Group
- Surgery Group
- 2 x Women's & Children's Group: Women and Paediatric representatives
- Community & Therapies
- Invited members may represent:
    a. Sepsis
    b. VTE
    c. Critical Care
    d. DP&R Committee
    e. Specialties & Directorates

b. Terms of Reference

- Monthly cross site meetings
- Quorate meeting defined as
    a. Chair or deputy
    b. Mortality or MD facilitator

c. Palliative care team
d. Informatics
e. Medical examiner/Bereavement office team
f. Representative from clinical effectiveness,
g. Clinical representation from each of surgical group, medical group, women s and children s group, community group
h. Safeguarding /LD team
i. Public/Carers representative

- Invited members as required and scheduled
- Monitor each of
    a. external and internal mortality statistics,
    b. mortality alerts
    c. bereavement office and ME performance(including rel and carer feedback
    d. incident reporting and escalation of cases
- Responsibilities as listed above
- Quality improvement project identification/priority/actions/ implementation/monitoring
- Auditable/performance measures

c. Bereavement Office Team

- Lead medical Examiner
- Medical Examiners
- Bereavement Officer manager
- Bereavement Office Administrators
- Head of Mortuary

d. Mortality Case Review

- Screening of cases by Medical Examiners
- All deaths will be screened at the time of MCCD
- Relatives and carers will be asked about care of the deceased and to comment on care prior to and during admission
- Relatives and carers will be asked if the deceased has history of Learning Disabilities or significant Mental health problems
- Inform relatives of whether the deceased will or will not be subject to case review and detail the process and feedback they should expect.
-

e. Cases for referral for Structured review

- any individual with a learning disability**
- any individual with significant mental health needs
- any infant or child death**
- any stillbirth or maternal death**
- any young person death age 17-25 years
- any case where another organisation suggests that the Trust should review the care provided to the patient in the past
- any case where a relative or carer has concerns about the care provided during the final illness
- a specified proportion of patients receiving end of life care
- any non-palliative care patient dying in a step down, intermediate care or MFFD bed.

- any patient dying during an admission for Elective or day case care
- any death referred to the coroner or police
- any case where a complaint or clinical incident report is in place before death*
- any death following an in-patient acquired VTE episode*
- any diagnostic group identified as needing investigation as a result of internal or external mortality alert
- some low risk diagnostic groups as defined by LfD Committee e.g. dermatology in patients, ophthalmology in patients
- any diagnostic or care groups suggested by national or regional intelligence.

f. Tier one review

- The above cases will be subject to tier one review
- Trained case reviewers will review referred cases within 10 working days
- Escalate cases for serious incident investigation if not already in place

g. Tier 2 review

- Any tier one case where poor, very poor or excellent care has been identified
- Any case escalated by tier one reviewer
- Escalation to CIU for review for investigation

7. Conducting Mortality Reviews

Sandwell and West Birmingham Hospitals NHS Trust has a dedicated electronic Mortality Review System (MRS) and will develop and implement the new Structured Judgmental Review process and thematic analysis web toll over the next 12-18 months.

The framework for the minimum requirements of a mortality review is set out below:

Components of the Process	Which Deaths	Method and Timing of Review

Component A Individual Case Review	Referred cases as defined in policy	• Mortality review within 10 working days • Complete full review of relevant documents:, EPR and scanned case records • Complete all sections of review proforma • Identify any problems in care and any good or excellent practice, • Complete incident report where appropriate • Inform learning from deaths committee of any incident reported cases
Component B Clinical Team Review	Deaths relating to Specialty	• Case Presentation of relevant deaths at the M&M meeting. • Discuss any concerns with patient care or opportunity for quality improvement • Define actions for clinical team • Complete M&M Template in the Clinical Systems Reporting Tool. • Report quarterly to Group and LfD Committee cases and actions. • Share trust LfD Quality Improvement projects from LfD
Component C Independent Reviews by the Learning From Deaths Committee (LfD Committee)	Tier 2 cases	• MDT 2nd Review of deaths identified from the MRS/Tier 1 review • Mortality performance data by Group/Directorate and identification of trends • Role to commission follow up actions or fuller investigation is required. • At next LfD Committee meeting • Refer for Root Cause Analysis Investigation (RCA) • Identify opportunities and make recommendations for improving the safety and quality of care

Component C External Review Group e.g. Coroner's Inquest, Police, Care Quality Commission, LeDeR Programme,, HSIBoard.	All in-hospital patient deaths identified or initiated for external review. Further scrutiny of care of patient death.	• All external reviews tabled at LfD Committee • Monitor outcomes of investigations and implement recommendations from the review e.g. Coroners Rule 43 reports • Share learning and Quality Improvement implementation

8. Management of Mortality Outliers and Alerts

a. Routine mortality surveillance

Crude mortality, SHMI and HSMR/RAMI rates will be routinely monitored by LfD Committee both at a Trust and at Directorate level. This information will be included in standard reports to Q&S and Trust Board

b. Pro-active review of mortality outliers

Mortality outliers identified from internal surveillance and review of national/CHKS/Dr. Foster data will generate a specialty level case-note analysis and case investigation as appropriate. This will commissioned by LfD Committee through the existing processes and instigated from medical Examiner screening.

c. Reactive review of externally generated mortality outlier alerts

The Medical Director will identify an appropriate clinician to conduct a review and produce a report within the timeframe prescribed by the agency (e.g. Care Quality Commission) publishing the alert or medical director.. The process is supported by the LfD Committee and Information Services. Reports generated as a result of this process will be reviewed at LfD Committee to define actions and reported to Q&S committee and Trust Board.in line with reporting policy.

9. Mortality Review Systems Reporting

- A report from the Mortality Review System or the thematic analysis of structured judgmental review process when in place will be produced by the Clinic Effectiveness Facilitator and presented at the monthly meeting of the LfD Committee
- This will have identified the patient deaths that require Tier 2 MDT review.
- Preventable code and triggered deaths from MRS or poor care very poor or excellent care from SJR process.
- Incident reporting will be identified from MRS or information from CIU
- The lessons learnt as recorded on the Mortality Review System will be used to guide quality improvement and thematic analysis from SJR similarly

10. Non-compliance with the Mortality Review Process

- Individually appointed and trained case reviewers will be expected to comply with training, procedure, timeliness and assurance of MRS and SJR systems.
- Role as case reviewer will be terminated if non-compliance persists despite negotiation, training and support.

11. Consultation

Consultation was undertaken with the Medical Director, the Non-executive Director for Clinical Effectiveness, the Executive team, the Mortality and Quality Alert (MQAC) Committee now Learning from Deaths Committee in order to ascertain the suitability and applicability of content.

12. Auditable Standards/Process for Monitoring Effectiveness

Standard/Process	Monitoring and Audit			
	Method	**By**	**Committee**	**Frequency**
Identification of cases mandated for referral for review at Bereavement Office screening	medical Examiners case referral register	Lead medical Examiner and Chair LfD Committee	LfD Committee	Monthly
Engagement with relatives and carers of deceased patients	relative and carer feedback surveys	bereavement office	LfD Committee	6-12 mthly
Completion of Mortality Reviews through the Mortality Review System or Structured Judgmental Review	Monitoring of number and timeliness of reviews allocated	Head of Performance	LfD Committee	Monthly
LfD Committee Meeting performance	attendance, reports, timeliness of actions	Minutes, action logs and reports	Q&S Committee	Quarterly/ Annually?
Convening of Mortality & Morbidity Meetings	Audit of Directorates/ Specialties quarterly reports to MQuAC Mandatory completion by Directorates of the M&M Template in the Clinical Systems Reporting Tool	Clinical Effectiveness Facilitator	LfD Committee	Quarterly
Feedback on learning from Mortality Reviews	Directorate reports detailing compliance with and outcomes and actions from Mortality and Morbidity review meetings	Individual Directorates	Clinical Effectiveness Committee	Annual

Management of Alerts and Detection of adverse trends	MQuAC minutes and Papers presented at MQuAC Thematic analysis outcomes and Quality Improvement Projects actioned. LfD Reports to Q&S and Board	Clinical Governance Lead	Q&S Committee	Quarterly

13. **Training and Awareness**

Training

- Medical Examiners Role will require training, update, governance and appraisal through Learning from Deaths lead and Medical Examiners Group and Lead.
- Structured Review and Thematic analysis requires training, update, governance and appraisal through Learning from Deaths lead and Medical Examiners Group and Lead.
- Access to, use and interpretation of national mortality data, Mortality monitoring techniques and statistical methods used nationally to monitor mortality for Learning from Deaths Committee and support workers.

Awareness

- All medical staff will be informed of policy and processes at Induction.
- Learning from Deaths national guidance and updates to be shared with all clinical staff.
- Learning and quality Improvement work to be shared with all clinical staff and external agencies as appropriate ; for example LeDeR programme, patient associations, Mental Health services, CCG, NHS West Midlands.
- Reports to Q&S Committee, Trust Board and NHS England/Improvement/NQB as appropriate.
- Quarterly performance report to all clinical staff and appropriate committees.
- Quarterly Newsletter

14. Review

This policy will be reviewed after one year or sooner if either national standards or local requirements necessitates it or Trust practice is amended.

15. Reference Documents and Bibliography

1. Horgan H, Healey F, Neale G, et al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. BMJ Quality and Safety (2012). Doi:10. 1136/bmjqs-2012-001159.

2. Higginson J, Walters R, Fulop N. Mortality and morbidity meetings: an

untapped resource for improving the governance of patient safety? BMJ Quality and Safety (2012). Doi:10.1136/bmjqs-2011-000603.

3. Healthcare Commission, Investigation Into Mid Staffordshire NHS Foundation Trust, March 2009.

4. Department of Health. The Keogh Mortality Review, Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, 2013.

5. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Glossary & Definitions

Avoidable/Preventable – These terms are used interchangeably in the NHS and for the purpose of this policy 'preventable' or 'unpreventable' will be used with reference to whether anything could have been done to change the outcome.

Crude Mortality – This is simply the total number of deaths as a percentage of the total number of spells. Although this is not risk adjusted, it is often a good idea to monitor trends in crude mortality as it can quickly highlight when things are going wrong.

Structured Case Review - A review of the patient death using the Trust Mortality Review Proforma initially and later Royal College of Physicians Structured Judgmental Review and thematic analysis web tool.

Thematic Analysis - Initially analysis of reviewed patient deaths by Mortality Review System Report later through RCP thematic analysis web tool.

Case Investigation - A root cause analysis investigation into appropriate identified cases.

CHKS - Independent company that provides healthcare comparison data and enable healthcare organisation's to benchmark their performance against their peers nationally.

Clinical Systems Reporting Tool (CSRT) - A local database, where audit data pertaining to Mortality and Morbidity is captured and archived, which is accessible on the Trust intranet page.

NHS Digital - Information and technology resource for the health and care system. They are responsible for compiling and monitoring national healthcare data and provide Summary Hospital-level Mortality Indicator (SHMI) on a quarterly basis.

HED - External information and benchmarking system for the provision of various mortality data. The mortality data derived from HED is primarily SHMI (Summary Hospital-level Mortality Indicator), which is usually subject to a slightly longer delay in its availability, due to alignment with data from ONS (Office for National Statistics), as SHMI includes data for deaths which occur within 30 days of discharge from hospital.

Mortality and Morbidity Review Meetings - A mortality and morbidity meeting is where a multi-disciplinary group review and discuss clinical cases, outcome data and related information (e.g. Serious Incidents, Complaints, Dr. Foster/CHKS or other benchmarking data).

Hospital Standardised Mortality Ratio (HSMR) - The HSMR is a method of comparing health care provider 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 of (observed) to (expected) deaths, multiplied conventionally by 100. Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100.

The methodology used to calculate the expected number of in-hospital deaths is

complex. It involves using a range of variables to adjust or standardise the data to reflect the risk or likelihood of death.

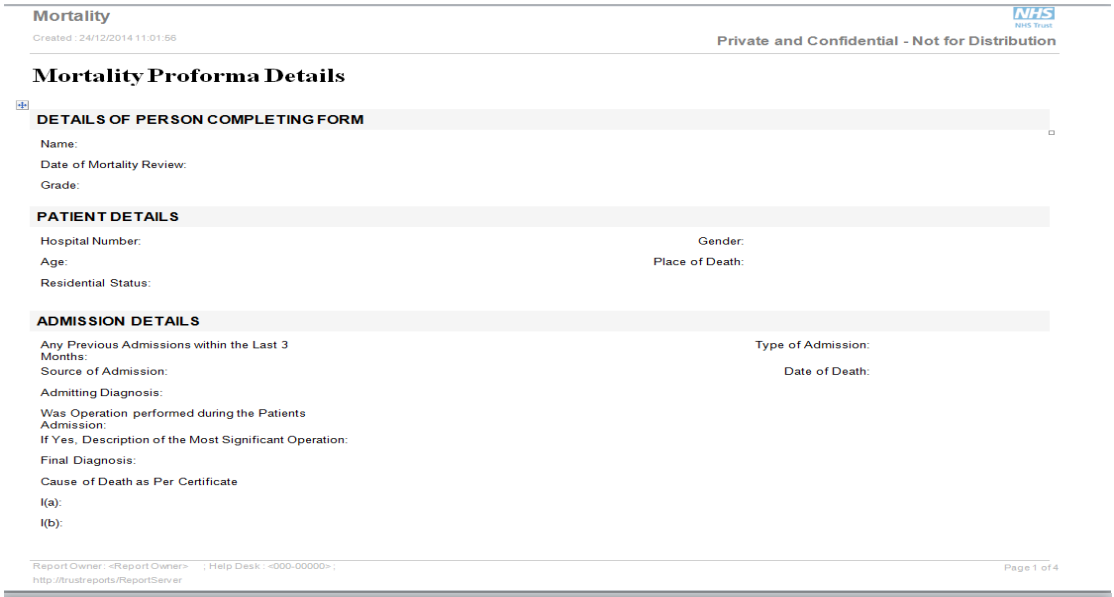
Risk Adjusted Mortality Indicator (RAMI) – This is a methodology developed by CHKS to compute the risk of death for hospital patients on the basis of clinical and hospital characteristic data. It is a ratio of the observed number of deaths to the expected number of deaths that occur within a hospital. A standard logistic regression model is used to estimate the risk of death for each patient. This is done by weighting each patient record with the logistic regression coefficients associated with the corresponding terms in the model, and the intercept term.

Serious Incident (SI) - An accident occurring on NHS premises that resulted in serious injury, and or permanent harm, unexpected or avoidable death (ref to SI policy for further details)

Summary Hospital-level Mortality Indicator (SHMI) - The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider and is the main mortality indicator reported nationally and is supported by the Department of Health. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charlson Comorbidity Index and diagnosis grouping.

Mortality Review Tools

SWBH MRS Proforma – present tool Aug 2017



Mortality

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Private and Confidential - Not for Distribution

Mortality Proforma Details

DETAILS OF PERSON COMPLETING FORM

Name:

Date of Mortality Review:

Grade:

PATIENT DETAILS

Hospital Number:

Gender:

Age:

Place of Death:

Residential Status:

ADMISSION DETAILS

Any Previous Admissions within the Last 3 Months:

Type of Admission:

Source of Admission:

Date of Death:

Admitting Diagnosis:

Was Operation performed during the Patients Admission:

If Yes, Description of the Most Significant Operation:

Final Diagnosis:

Cause of Death as Per Certificate

I(a):

I(b):

Report Owner : <Report Owner> ; Help Desk : <000-00000> ;
http://trustreports/ReportServer

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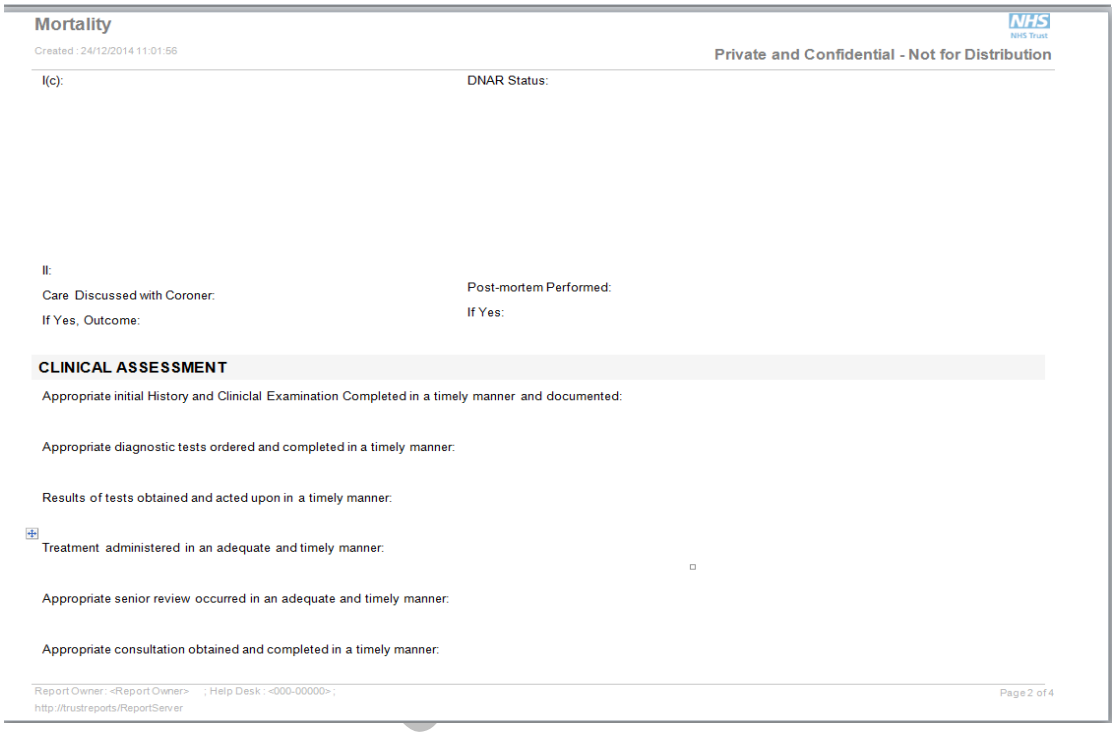


Mortality

Created : 24/12/2014 11:01:56

Private and Confidential - Not for Distribution

I(c):

DNAR Status:

II:

Care Discussed with Coroner:

Post-mortem Performed:

If Yes, Outcome:

If Yes:

CLINICAL ASSESSMENT

Appropriate initial History and Cliniclal Examination Completed in a timely manner and documented:

Appropriate diagnostic tests ordered and completed in a timely manner:

Results of tests obtained and acted upon in a timely manner:

Treatment administered in an adequate and timely manner:

Appropriate senior review occurred in an adequate and timely manner:

Appropriate consultation obtained and completed in a timely manner:

Report Owner : <Report Owner> ; Help Desk : <000-00000> ;
http://trustreports/ReportServer

Page 2 of 4

Reasonable evidence that diagnosis identified supports treatment given:

ONGOING MANAGEMENT

Was ongoing documentation adequate:

Were appropriate investigations ordered and actioned in a timely manner:

Was the Patients reviewed by their parent team on a regular basis:

HOSPITAL ACQUIRED INFECTION

Did Patient develop Hospital acquired infection after admission:

Surgical Site: HAP:

MRSA: CD:

Was DVT Prophylaxis used:

If No, State Reason:

USE OF ITU/HDU RESOURCES

Did Patient receive ITU/HDU Care during admission:

If No, did Patient require ITU/HDU Care:

Was Critical Care available at time of need:

END OF LIFE CARE (if anticipated death)

Functional Status prior to Admissions

Asymptomatic:

Symptomatic but able to do daily routine work:

Bed Bound:

Does daily work with difficulty:

DNAR completed prior to Death:

Adequate Communication with family:

Explain:

Treatment limited prior to death:

Treatment withdrawn prior to death:

CATEGORISATION OF DEATH

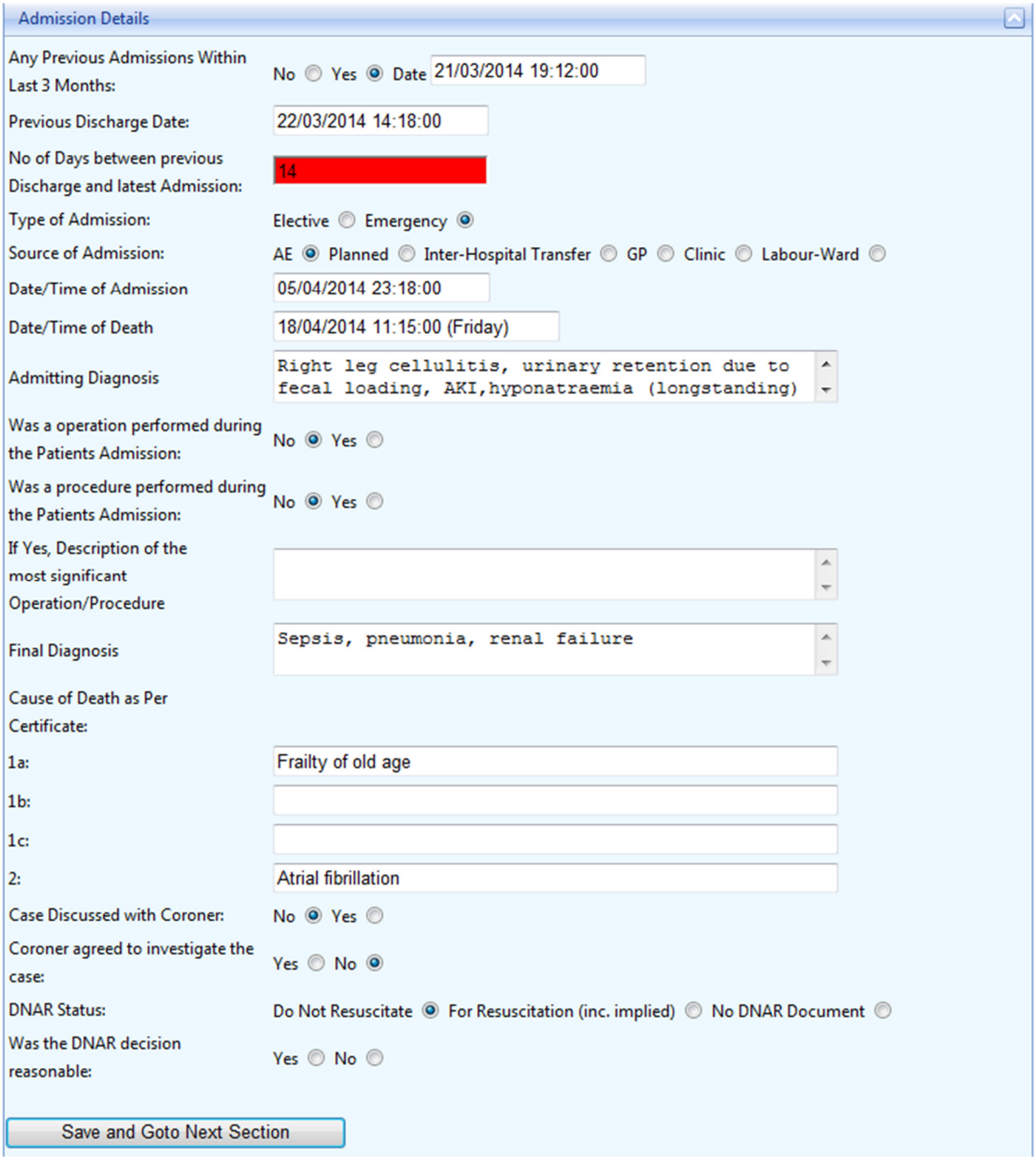
Any other Comments:

Can lessons be learnt:

If Yes, What:

Mortality Review Tools

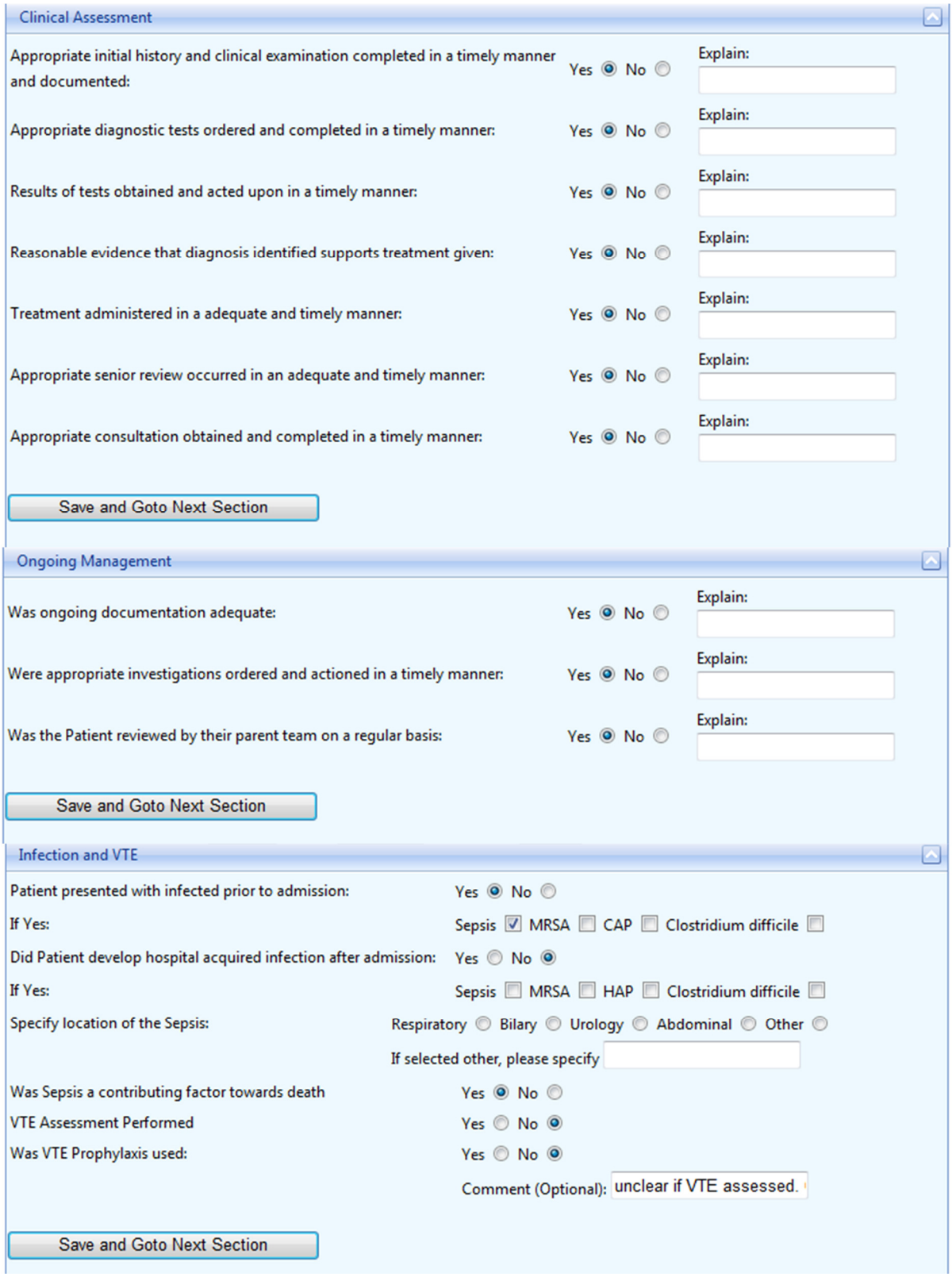
RCP Structured Judgemental Review and thematic analysis tool from 2018

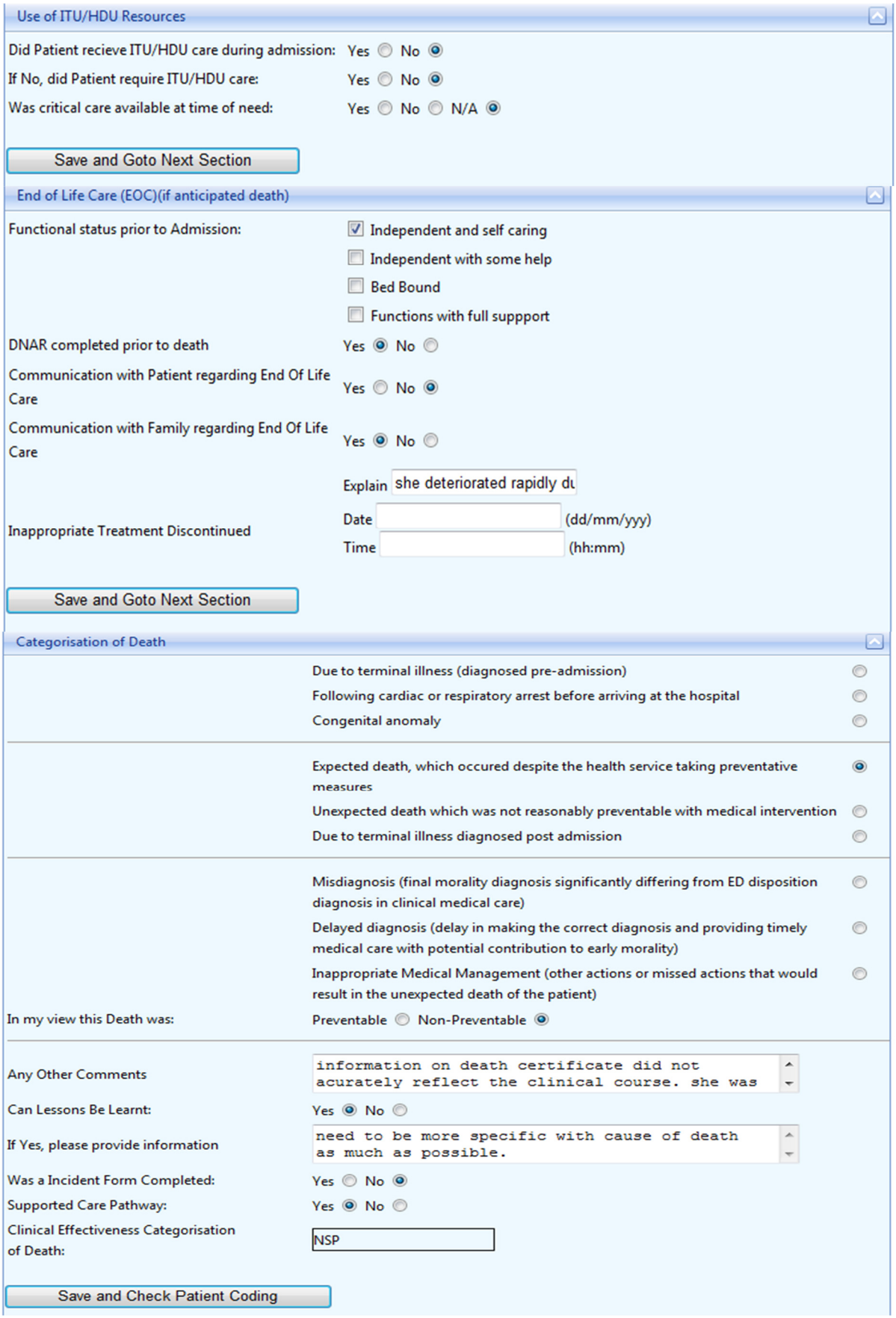


Admission Details

Any Previous Admissions Within Last 3 Months:	No ○ Yes ◉ Date 21/03/2014 19:12:00
Previous Discharge Date:	22/03/2014 14:18:00
No of Days between previous Discharge and latest Admission:	14
Type of Admission:	Elective ○ Emergency ◉
Source of Admission:	AE ◉ Planned ○ Inter-Hospital Transfer ○ GP ○ Clinic ○ Labour-Ward ○
Date/Time of Admission	05/04/2014 23:18:00
Date/Time of Death	18/04/2014 11:15:00 (Friday)
Admitting Diagnosis	Right leg cellulitis, urinary retention due to fecal loading, AKI,hyponatraemia (longstanding)
Was a operation performed during the Patients Admission:	No ◉ Yes ○
Was a procedure performed during the Patients Admission:	No ◉ Yes ○
If Yes, Description of the most significant Operation/Procedure	
Final Diagnosis	Sepsis, pneumonia, renal failure
Cause of Death as Per Certificate:	
1a:	Frailty of old age
1b:	
1c:	
2:	Atrial fibrillation
Case Discussed with Coroner:	No ◉ Yes ○
Coroner agreed to investigate the case:	Yes ○ No ◉
DNAR Status:	Do Not Resuscitate ◉ For Resuscitation (inc. implied) ○ No DNAR Document ○
Was the DNAR decision reasonable:	Yes ○ No ○

Save and Goto Next Section


Clinical Assessment
Appropriate initial history and clinical examination completed in a timely manner and documented:
Yes No
Explain:
Appropriate diagnostic tests ordered and completed in a timely manner:
Yes No
Explain:
Results of tests obtained and acted upon in a timely manner:
Yes No
Explain:
Reasonable evidence that diagnosis identified supports treatment given:
Yes No
Explain:
Treatment administered in a adequate and timely manner:
Yes No
Explain:
Appropriate senior review occurred in an adequate and timely manner:
Yes No
Explain:
Appropriate consultation obtained and completed in a timely manner:
Yes No
Explain:
Save and Goto Next Section
Ongoing Management
Was ongoing documentation adequate:
Yes No
Explain:
Were appropriate investigations ordered and actioned in a timely manner:
Yes No
Explain:
Was the Patient reviewed by their parent team on a regular basis:
Yes No
Explain:
Save and Goto Next Section
Infection and VTE
Patient presented with infected prior to admission:
Yes No
If Yes:
Sepsis MRSA CAP Clostridium difficile
Did Patient develop hospital acquired infection after admission:
Yes No
If Yes:
Sepsis MRSA HAP Clostridium difficile
Specify location of the Sepsis:
Respiratory Bilary Urology Abdominal Other
If selected other, please specify
Was Sepsis a contributing factor towards death
Yes No
VTE Assessment Performed
Yes No
Was VTE Prophylaxis used:
Yes No
Comment (Optional):
unclear if VTE assessed.
Save and Goto Next Section


Use of ITU/HDU Resources
Did Patient recieve ITU/HDU care during admission: Yes No
If No, did Patient require ITU/HDU care: Yes No
Was critical care available at time of need: Yes No N/A
Save and Goto Next Section
End of Life Care (EOC)(if anticipated death)
Functional status prior to Admission:
Independent and self caring
Independent with some help
Bed Bound
Functions with full suppport
DNAR completed prior to death Yes No
Communication with Patient regarding End Of Life Care Yes No
Communication with Family regarding End Of Life Care Yes No
Explain she deteriorated rapidly du
Inappropriate Treatment Discontinued
Date (dd/mm/yyy)
Time (hh:mm)
Save and Goto Next Section
Categorisation of Death
Due to terminal illness (diagnosed pre-admission)
Following cardiac or respiratory arrest before arriving at the hospital
Congenital anomaly
Expected death, which occured despite the health service taking preventative measures
Unexpected death which was not reasonably preventable with medical intervention
Due to terminal illness diagnosed post admission
Misdiagnosis (final morality diagnosis significantly differing from ED disposition diagnosis in clinical medical care)
Delayed diagnosis (delay in making the correct diagnosis and providing timely medical care with potential contribution to early morality)
Inappropriate Medical Management (other actions or missed actions that would result in the unexpected death of the patient)
In my view this Death was: Preventable Non-Preventable
Any Other Comments
information on death certificate did not acurately reflect the clinical course. she was
Can Lessons Be Learnt: Yes No
If Yes, please provide information
need to be more specific with cause of death as much as possible.
Was a Incident Form Completed: Yes No
Supported Care Pathway: Yes No
Clinical Effectiveness Categorisation of Death:
NSP
Save and Check Patient Coding

Statutory Duty of Candour (DoC) Regulations
The statutory Duty of Candour applies where a patient has suffered moderate or severe harm or has died as a result of an incident/event.

The Duty of Candour process must be initiated by the lead clinician (usually consultant or matron) when an incident/event is identified during the actual incident /event or at any stage as part of PALs, complaint, claims or mortality reviews or investigations.

Duty of Candour Regulations came into force 27 November 2014 (ref. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Specialty Mortality Review and Investigation Agendas

- LeDeR programme
- Management of child deaths
- Perinatal and Maternal Deaths
- Cardiac Intervention Audit
- Stroke Audit
- TARN
- ICNARC
- MINAP
- JAG Gastroenterology Mandated Audits

SWBTB (09/17) 018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Public Health Plan
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Toby Lewis, Chief Executive
DATE OF MEETING:	7th September 2017

EXECUTIVE SUMMARY:

The Board has discussed our 2017-2020 public health plan twice and it has also been considered by the board's committee. This paper invites formal approval. The document will then be converted into a glossy document for launch and website use.

In developing the plan we have in particular:

- Reflected on the successes and weaknesses of our 2014-2017 public health plan
- Engaged very actively with the local authority and taken account of their priorities
- Sought to balance a focus on staff and patient wellbeing

From April 2018, in supporting delivery of this plan we will be aided by:

- Our Cerner IT system, which will permit analysis of, and performance management of MECC (making every contact count) questions in all clinical settings
- A dedicated public health plan delivery resource, helping to move this work from a nice to have, to core business

The Trust has led the sector in our prioritisation of and commitment to public health work, and have achieved notable successes around maternal smoking, asthma awareness, apprenticeships, waste recycling and staff wellbeing. MECC and alcohol related admissions were our two weakest areas, whilst staff sickness fell, but is far short of our very ambitious 2.5% target.

REPORT RECOMMENDATION:

To approve the objectives in the plan and support a move to implementation.

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

Accept	Approve the recommendation	Discuss
	X	

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

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

Comments:

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

Part of 2020 vision

PREVIOUS CONSIDERATION:

As in summary

SWBTB (09/17) 018a

The second chapter in our Public Health story

Our 2017 – 2020 Public Health Plan

What is success?

The agreed patient focus is adding 'life to years':

Our 7 priorities and 10 measures

1. Reducing premature infant mortality	(a) Target reduction in infant mortality of 1 per 1000 live births from baseline of 5.5 per 1000 (2013/15). This will be supported by the perinatal mortality target contained in our quality plan.
2 Reducing primary school age obesity	(b) To achieve a year on year reduction in childhood excess weight (0.5% annually) through to 2020. (c) By 2020 achieve a reduction in proportion of children with excess weight in Y6 to not more than 38%.
3. Tackling alcohol related admissions	Sandwell wide public Health target by 2020 is to reduce alcohol related hospital admissions to 697 per 100,000 population. (d) We will achieve our 2014-17 admission avoidance goal of 20%.
4 Reducing isolation in older age	Those at risk of social isolation will receive support from the Sapphire project. (e) By April 2018 a plan will be agreed between the Trust, SMBC and relevant local GP practices about how out of hospital support services are best targeted. This will be delivered.
5. Tackling lifestyle factors for all our patients through MECC	(f) By 2019-20 50% of all SWBH clinical first contacts will include an MECC conversation. (g) The Trust will increase the number of referrals to Sandwell MECC lifestyle hub by 500% against our 2016-17 baseline by 2020.
6. Addressing vaccination rates among local population	(h) Maintain Trust position in top ten flu vaccinators in each year of the plan (i) The Trust will contribute to raising vaccination rates by 10% against the following adult baselines: At risk individuals: 55% coverage Over 65s: 75% coverage
7. Improved access to secondary prevention services	(j) All appropriate pre op and post operative patients will be assessed against MECC and referred for relevant support by 2019-20

The agreed workforce and community focus is wellbeing:

Our 6 priorities and 10 measures

8 Maintaining the Trust's position as a green champion across the region	a) To reduce energy costs by 10% between 2019-20 and 2022-23 through initiatives put in place in 2017-19 b) To reduce our waste costs by 10% against 2016-17 baseline by 2020 through reduced disposal and by selecting more environmentally suitable methods of destruction
9. To reduce instances of mental health absence in our organisation	(c) To agree an industry leading plan to assess and act on mental health among our employees by December 2017, based on promoting positive mental welllbeing at work (d) To cut mental health sick rates by 25% by 2021 against 2016-17 outturn
10. To tackle rates of smoking and alcohol misuse among employees	(e) To go all site smoke free from 2019 and reduce rates of smoking among our employees below 20% by that deadline (f) To provide award winning services to support employees experiencing issues with alcohol and demonstrate high rates of awareness among employees of the risks of alcohol consumption
11.. To increase rates of employee vaccination (over and above flu)	(g) To achieve 15% improvement on baseline data, to be confirmed by December 2017
12.. To act to tackle obesity and weight management issues among employees	(h) To expand take up of existing Trust exercise and weight management schemes to cover over 1000 employees by 2019-20 (this includes dance, sports, cycling, fitness etc) (i) To meet our going green food pledges, including meeting our canteen utilisation commitments of doubling revenues by 2020 (which relies on a 20% growth in customer base)
13. To deliver our employment and procurement promises to local people	(j) To manage our organisation with a commitment to SWB employment and West Midlands purchasing, demonstrated through a 10% growth in both metrics against a 2016-17 baseline by 2020

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Reference Costs and Education & Training – integrated annual submission 2016.17**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite, Finance Director**
AUTHOR:	**Amanda Wharton, Chief Costing & Development Accountant**
DATE OF MEETING:	**7 September 2017**

EXECUTIVE SUMMARY:

The attached report deals with the trust's annual returns for the 2016.17 financial year in respect of Reference Costs and Education and Training income & costs.

The purpose of this report is to request that the Board approve submission of the returns. The Audit Committee has challenged and confirmed the statement of director's responsibilities as being satisfied and recommends to the Board that the returns have been properly compiled and can be appropriately submitted.

The report draws attention to year on year changes in activity and costs and notes that, whilst those costs may continue to be less than might be expected from national norms, they are unlikely to demonstrate significant improvement as measured on a reference cost basis. Consequently, there remains a material opportunity [assessed nationally as £35m based on 2015.16 cost submissions] as measured by the 'New Model Hospital' framework.

The report draws attention to the limitations with data collection and ownership of that data in respect of the education & training return. This is particularly in respect of non-medical activities & costs. The draft return has been signed off as fit for submission by David Carruthers, the trust's Director of Medical Education.

The report records a commitment to on-going development and improvement in costing systems, costing standards and specifically using that information to drive change and improvement in services and outcomes. This is to be encouraged and supported.

REPORT RECOMMENDATION:

That the Board:

1. approve submission of the integrated cost returns

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		Equality and Diversity		Workforce	**X**
Comments:					

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

Excellence in the use of resources

PREVIOUS CONSIDERATION:

Audit Committee – August 2017

INFORMATION

Sandwell and West Birmingham Hospitals NHS Trust

TRUST BOARD

TRUST SUBMISSION OF THE

INTEGRATED COST COLLECTION– 2016/17

7th September 2017

Performance & Costing Team – Finance

Contents

1 Introduction

The outcome of the 16/17 Integrated Cost collection was reported to Audit committee last week, via virtual distribution. It received a positive recommendation in support of the submission.

This year's return, for the first time, integrates Education and Training costs within Reference costs. The submission to NHSi is due on 7th September following a national delay in issuing the reference cost groupers.

This return is the only national mandated collection of cost data for service costs and educational placements in the NHS. It will be used to inform future national tariffs for service, and to support ongoing work to move from the current transitional tariffs for Education and Training, to the development of new Educational tariffs, inform the contract tariff and funding therefore and will form the basis for Model Hospital benchmarking tool.

2 Reference Costs Output - Worksheet Summary

Following the laid out process and NHSi guidance, the summary table below represents the Trust 16/17 Reference costs submission.

The output is structured by individual worksheets, and shows year on year cost and activity movements.

2.1 Reference Costs quantum

Represents the 'relevant' costs that have been used in the return based on prescribed guidance and adjustments (see Appendix 1 for detailed reconciliation statement working back from published statutory accounts to the RC quantum).

- The quantum of costs used for the Reference costs submission has been calculated at **£397.9m**; this quantum has been derived by using the annual statutory accounts expenditure and adjusting it for a number of mandatory exclusions of costs and netting off with income, which are not required for Reference costs purposes (all as per set NHSi guidance, see Appendix 1).
- Bottom line, this year's quantum has increased by £20.9m, reflecting the increase in operating expenses as per audited annual accounts. This represents a year on year expenditure increase of 5.6% and year on year activity increase of 3.2%.
- The increase in activity does not show at the same rate as expenditure, as some of the increase in costs is not directly activity related e.g. premium cost for temporary staffing, CNST costs, bad debt write offs.
- When comparing our 16/17 activity against 15/16 National average unit costs, it predicts that our RC costs are £4m lower than the expected national average (although this is last year's national average). However, between workbook's, there is much variation, which will affect our overall RCI.
- On this basis, we would predict our RCI (Reference Costs Index) to increase from its current 98. However, this depends largely on what other trusts will be submitting.
- RCI's are expected to be published November-December this year.

2.1.1 Non recurrent measures in reported headline deficit 16/17

As Audit Committee will be aware, the Trust's financial position for 2016/17 reflected a number of non-recurrent benefits. An adjustment to the Reference Costs quantum, relating to releases into the I&E, for prior year, have been made to ensure a 'normalised' Reference cost quantum for the 16/17 operating year is submitted.

The scale of this adjustment is £2.5m, 0.006% of the Reference costs quantum and is made up of:

- £1694k GNRI release (Goods Received Not invoiced)
- £800k NHS Property release charges

NHS Improvement

2016-17 reference costs BAU

NHSi validations shows a 'Pass' for Mandatory validation 0% quantum issue and 0 (zero) non-mandatory validation count

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Mandatory validation status: **Pass**

REFC/Recon Quantum: **0%**

Non-mandatory validation count: **0**

Summary totals:

Own Data

Tab Name	Worksheet Name	2015-16 total cost	2015-16 total activity	2016-17 total cost	2016-17 total activity	SWBH 2016-17 Activity x 2015-16 National Average Unit Cost : Expected Costs	2016-17 SWBH vs Expected Cost	% change in cost	% change in activity	Comments
DC	Day cases, ordinary non-elective short stay and regular day and nig	£ 62,560,297	96,528	£73,396,243	89,023	£61,805,900	£11,590,343	17.4%	-7.8%	Improvements in cost allocation at a patient level for drugs and diagnostics, reflect here in the % change in cost from last year
IP	Ordinary electives and ordinary non-electives long stay	£ 100,151,036	39,463	£107,465,055	38,191	£115,773,920	-£8,308,865	7.3%	-3.2%	
OPATT	Outpatient attendances	£ 72,814,332	671,256	£61,764,655	649,564	£68,761,928	-£6,997,272	-15.2%	-3.2%	Decreases in OPATT, also have corresponding increases in OPPROCS for those procedural specialites - Ophthalmology, Dermatology, Gynae and Gastro predomately
OPPROC	Procedures in outpatients	£ 15,271,735	71,891	£20,016,561	75,074	£11,249,205	£8,767,356	31.1%	4.4%	
CMDT	Cancer multi-disciplinary teams	£ 1,337,294	15,068	£1,418,196	13,333	£1,468,930	-£50,734	6.0%	-11.5%	
EM	Emergency medicine	£ 28,697,698	232,623	£26,178,082	232,371	£32,160,179	-£5,982,097	-8.8%	-0.1%	
CR	Chemotherapy and radiotherapy	£ 8,771,385	25,806	£7,744,195	20,704	£16,253,734	-£8,509,539	-11.7%	-19.8%	
CC	Critical care	£ 15,929,691	18,895	£16,676,485	19,299	£18,340,173	-£1,663,688	4.7%	2.1%	
IMAG	Diagnostic imaging	£ 7,261,146	97,276	£8,262,388	102,151	£8,987,753	-£725,365	13.8%	5.0%	
NM	Nuclear Medicine	£ 1,566,135	4,491	£1,425,503	4,425	£1,222,418	£203,085	-9.0%	-1.5%	
HCD	High cost drugs	£ 13,181,791	13,668	£16,630,370	17,464	£14,882,075	£1,748,295	26.2%	27.8%	Methodology improvement. HCD patient level data imported
REHAB	Rehabilitation	£ 1,900,386	6,253	£1,481,864	8,675	£2,861,392	-£1,379,528	-22.0%	38.7%	
SPC	Specialist palliative care	£ 621,284	1,404	£715,669	2,178	£217,800	£497,869	15.2%	55.1%	
RENAL	Renal	£ -	-	£0	-		£0	-	-	
DAD	Direct access diagnostic services	£ 1,621,402	57,152	£1,642,975	58,179	£1,760,549	-£117,574	1.3%	1.8%	
DAP	Direct access pathology	£ 6,918,392	2,802,399	£8,622,831	3,043,626	£5,654,929	£2,967,902	27.0%	8.6%	8% increase in Biochemistry tests performed. Remainder is improvement in patient matching.
MHCC	Mental health care clusters	£ -	-	£0	-		£0	-	-	
MHCCIAPT	Mental health care clusters - Improving Access to Psychological The	£ -	-	£0	-		£0	-	-	
SECUREMH	Secure mental health services	£ -	-	£0	-		£0			
MH	Other mental health	£ -	-	£0	-		£0	-	-	
CHS	Community health services	£ 38,279,452	788,229	£44,313,873	726,601	£40,430,447	£3,883,426	15.8%	-7.8%	New EOL Service and costs
CF	Cystic fibrosis provided solely by a specialist centre	£ 14,565	1	£0	-		£0	-	-	
CFNET	Cystic fibrosis provided under shared care arrangements	£ -	-	£0	-		£0	-	-	
AMB	Ambulance services	£ -	-	£0	-		£0	-	-	
	Totals	**£ 376,898,019**	4,942,403	**£397,754,943**	5,100,874	£401,831,330	-£4,076,387	5.6%	3.2%	
	Total quantum (Own data + Sub-contracted out data)			£397,754,943	5,100,874					Of the £20.9m increase from last year, 82% was pay - Qualified Nursing & Midwifery £5.6m Medical Staffing £4.9m, Scientific Therapeutic and Technical £3m. The non pay was for increase in CNST premium, Bad debt provision, Medical Equipment & Consumables, Drugs & blood products

When using 16/17 activity against 15/16 National average unit cost. Results show we are £4m lower than the National average

3 Limitations to the Reference Costs Collation

There are a number of less material limitations in collating the cost return. However, some limitations are potentially of a bigger impact.

- Job plans specifically play an important part in the accurate apportionment of costs to correct patients and patient types.
- Typically, available job plans data is > 12 months out of date, as there is no central system that captures this information consistently and frequently with the right level of content. This will have impacted in an un-known quantity the allocation of costs between patient types.

Previously this has been a recommendation for improvement for both Reference costs and for Service Line reporting, but the trust still relies on groups collating this manually and individually. The costing team receives this information in-consistently and it does not allow for easy analysis of direct clinical care resource available and hence productivity analysis.

4 What is our Reference Cost used for?

- Traditionally, RC has been mainly used to fee national traffic and education & training funding.
- More recently, the reference costs data has been used to inform the 'Model Hospital' dashboard following the Carter Review. Therefore it will be used to identify potential cost saving opportunities, where our reported unit costs are higher than the expected national average and higher than peers.
- The published 15/16 opportunity was £35.6m.
- We are currently looking to extend our use of NHSi Model Hospital dashboard and identify again, where our 'real' opportunities are at a service level, working with NHSi and peers to understand and review each of the published benchmarks, alongside our own service input and feedback.

5 Reference Cost Self-assessment Quality Checklist

For further assurance, the self-assessment quality checklist has been shown here as an example to provide insight into some of the 'quality checks' performed in the preparation and submission. This by no means is the entire validation and as mentioned in the process overview includes a large number of mandatory and non-mandatory validations.

Self-assessment quality checklist

	Check	Response	Additional information
QC1	Total costs: The reference costs quanta have been fully reconciled to the signed annual accounts through completion of the reconciliation statement workbook in line with guidance	Fully reconciled to within +/- 1% of the signed annual accounts	
QC2	Total activity: The activity information used in the reference costs submissions to report admitted patient care, outpatient attendances and A&E attendances has been fully reconciled to provisional Hospital Episode Statistics and documented	Fully reconciled and documented	
QC3	Sense check: All relevant reference costs unit costs under £5 have been reviewed and are justifiable	All relevant unit costs under £5 reviewed and justified [state reason]	
QC4	Sense check: All relevant reference costs unit costs over £50,000 have been reviewed and are justified	All relevant unit costs over £50,000 reviewed and justified [state reason]	
QC5	Sense check: All BAU reference costs unit cost outliers (defined as unit costs less than one-tenth or more than ten times the previous year's national mean average unit cost) have been reviewed and are justifiable	n/a – no unit cost outliers within the submission	
QC6	Benchmarking: Data has been benchmarked where possible against national data for individual unit costs and for activity volumes	Some but not all cost an activity data within the submission has been benchmarked using another benchmarking process [state]	15/16 submission and National averages have been used as a benchmark. For some area's, the National benchmarking tool has been used as well.
QC7	Data quality: Assurance is obtained over the quality of data for 2016-17	No assurance has been obtained over data quality	Information department provide and reconcile majority of the patient activity for this return against SUS returns. There are a number of other patient information sources that do not report to SUS, and recorded on separate systems or manually.
QC8	Data quality: Assurance is obtained over the reliability of costing and information systems for 2016-17	Assurance has been obtained over costing and information system reliability but not for 2016-17	This is the second year producing the Integrated costing submission from our current costing system, where a thorough review took place in 15-16. There is deemed to be no significant changes for 16-17, therefore no detailed review required.
QC9	Data quality: Where issues have been identified in the work performed on the 2015-16 data and systems, these issues have been resolved to mitigate the risk of inaccuracy in the 2016-17 combined costs collection submission	All exceptions have been resolved and the risk of inaccuracy in the 2016-17 reference costs submission fully mitigated	
QC10	Data quality: All other non-mandatory validations as specified in the guidance and workbooks have been considered and any necessary revisions made	Some non-mandatory validations have been considered and necessary revisions made [specify and state reason]	Some non-mandatory validations are valid and therefore remain as part of the submission

6 Developments and Ongoing Improvements

A number of improvements have happened during the year, the outcomes of which have been incorporated within the Reference costs submission e.g.

- Receiving reliable and consistent patient level data, to allow for more accurate cost apportionment has been part of the ongoing improvement plan for the team.

- In 16/17, patient level data for High Cost drugs and Non High cost drugs, matches drug to the patient, and their associated costs which was a key improvement for this year.
- As well as the continued improvement in matching diagnostic tests or exams to patients, implement a system to be in place to record, and report all Consultant job plans as a minimum at least annually.
- Continual improvement of general ledger cleansing and patient activity recording which in-turn is used for future Integrated cost returns.
- Implement roll-out and use of Service Line reports within the business, alongside NHSi's Model hospital dashboard to aid constructive service discussions around improvements and proposed opportunities for real change, but also this will feed better cost allocations and fine-tuning.
- Implement Costing Transformation Programme (CTP) a national drive to replace reference costs with more detailed PLICS (patient level information costing system)

7 Education and Training worksheet summary

The success of the education and training submission, within the Integrated cost collection is dependent on the production of cost calculations which are underpinned by robust clinical placement information. The requirement of this return is very different, in that it does not fit with the way our placement information is collected and reported within the Trust, or with the quarterly census return submitted as part of the LDA. Therefore, there have been some successes, but there have also been some shortcomings, predominately due to the way this information is used within our own organisation, for its own purposes. This has been communicated to NHSi, and improvements internally continue to meet the National requirement.

7.1 Education and Training process

The use of resources and costing, has been built around a 'model programme' for both Medical and non-medical programmes, rather than on an actual basis. This is not necessarily incorrect, but may show as a variation by cost component to the average when benchmarking is published later this year.

Medical Placements

The number of placement weeks and student/trainee numbers for our doctors in training are based on the recorded information by HEE via our Medical Staffing department, and therefore deemed to be accurate representation of numbers within the Trust. It's not clear if our LDA census return, which requests the required funding, is working from the same source. This is a gap in the recorded processes between departments and must be followed up with both L&D and Medical Staffing. (LDA is the Learning and Development Agreement, summarising our funding schedule from HEE).

Non-medical Placements

The only source that records the number of students and weeks, is the LDA census return. Whilst there is a requirement for Non-medical Education leads to complete the LDA census return quarterly, it's clear this collection is still not being embedded within the Trust, and therefore does have some shortcomings when using this for the Education and Training submission.

7.2 Summary Education and Training Cost Collection – Full year 2016/17

The output is structured into 'Salaried and Non-Salaried' worksheets, indicating by programme and year, a student/trainee count, and cost breakdown by component as per the guidance.

Table 1 below represents the high level Trust summary for Education and Training, comparing Salaried and Non-salaried placement numbers across the two years. This shows a 4.7% reduction in placement hours, with a 13.8% increase in costs. The increase in costs is predominately due to a planned review of the Nursing & Midwifery placement costs, within the Non-salaried worksheet.

NHS Improvement

Organisation name: SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Mandatory validation status: **Pass**

Contents:

Sheet	Description
01a Summary - Salaried	Summary of data entered on relevant 'input' sheet, including total activity and cost figures as well as validation summaries
02a Input - Salaried	**Data entry sheet for SALARIED training programmes, including mandatory validations**
01b Summary - Non-Salaried	Summary of data entered on relevant 'input' sheet, including total activity and cost figures as well as validation summaries
02b Input - Non-Salaried	**Data entry sheet for NON-SALARIED training programmes, including mandatory validations**

Provider Level Data Summary:

Type	Data 2016/17		Data 2015/16		Data variance		Validation Errors	
	Activity (Hours)	Costs (£m)	Activity (Hours)	Costs (£m)	Activity	Costs	Confidence Score	Data input
Salaried	313,572	11.02	400,470	12.47	-21.7%	-11.7%	0	0
Non-Salaried	631,444	12.63	591,260	8.31	6.8%	52.0%	0	0
Total	**945,017**	**23.65**	**991,730**	**20.78**	**-4.7%**	**13.8%**	**0**	**0**

7.3 Learning & Development Funding

The costing submission has been reconciled against the Trusts LDA funding for 16/17 (shown in Appendix 2). The gap between costs (£23.6m) and funding (£18m) is explained clearly as;-

- Trust funded posts
- Overheads
- Fund 50% basic salary for medical

7.3.1 Table 2 – Salaried Costing Collection – Full year 2016/17

Exploding the above high level information, table 2 below reports a 12% reduction in costs and 21% reduction in clinical placement hours, when compared to 15/16. The main reductions have been seen in Obstetrics & Gynaecology and Surgery.

Programme Area	16/17			15/16					
	Total Activity (hours)	Total Activity (FTEs)	Total Costs	Total Activity (hours)	Total Activity (FTEs)	Total Costs	% Change in Cost	% change in Activity (FTE)	% change in Activity (Hours)
	Hours	FTEs	£	Hours	FTEs	£			
Total - Salaried	**313,572**	**310**	**11,019,279**	**400,470**	**392**	**12,473,627**	**-12%**	**-21%**	**-22%**
Acute Care	45,524	47	1,798,877	55,803	56	1,740,254	3%	-16%	-18%
General Practice VTS	0	0	0	1,024	1	21,386	-100%	-100%	-100%
Healthcare Scientist STP	0	0	0	957	1	14,673	-100%	-100%	-100%
Medical (Salaried)	179,416	168	6,057,724	196,849	183	6,003,650	1%	-8%	-9%
Obstetrics & gynaecology	15,593	18	410,291	44,486	45	1,353,655	-70%	-61%	-65%
Ophthalmology	9,461	11	363,493	18,457	21	651,088	-44%	-51%	-49%
Paediatrics	26,523	27	951,994	23,871	24	765,117	24%	14%	11%
Pathology	3,865	5	142,220	1,833	2	105,650	35%	115%	111%
Pharmacy (Salaried)	0	0	0	5,970	5	35,152	-100%	-100%	-100%
Psychiatry	451	0	15,898	1,024	1	33,782	-53%	-56%	-56%
Radiology	11,385	11	387,658	11,233	11	444,619	-13%	2%	1%
Surgery	21,355	24	891,123	38,961	42	1,304,602	-32%	-43%	-45%

7.3.2 Table 3 – Non Salaried Costing Collection – Full Year 2016/17

After the 15/16 submission, a benchmark review for some of those outlier programme area's was carried out, using DH's National dashboard. The focus, for the Trusts educational leads for those programme areas, to understand and review the unique requirements of this return, and directly immerse themselves in capturing, collecting and assisting in costing for their programmes.

The outcome of those reviews, the costs for each Nursing and Midwifery placement, as well as parts of AHP's and Undergraduate have all been revised to produce more robust placement costs, which are comparable both nationally and regionally.

We observe a shift in both costs and placement counts in the table below as an outcome of that more robust work.

Programme Area	16/17		15/16			
	Total Activity	Total Costs	Total Activity	Total Costs	% Change in Cost	% change in Activity (FTE)
	Hours	£	Hours	£		
Total - Non-Salaried	**631,444**	**12,630,226**	**591,260**	**8,310,450**	52%	7%
Allied Health Professionals	11,292	251,649	19,560	69,527	262%	-42%
Dental	0	0	0	0	0%	0%
Dentistry (Non Salaried)	0	0	0	0	0%	0%
Medical (Non Salaried)	163,748	3,904,232	135,318	4,503,240	-13%	21%
Nursing & Midwifery	439,740	8,285,519	420,825	3,737,081	122%	4%
Operating Department Practitioner	3,690	115,191	8,100	218	52814%	-54%
Pharmacy (Non Salaried)	9,375	15,229	5,025	136	11093%	87%
Physician Associate	0	0	0	0	0%	0%
Healthcare Science Practitioner PTP	3,600	58,406	2,433	249	23324%	48%

7.3.3 Education & Training Confidence rating

Providers are asked to rate the confidence in their processes and the quality of assumptions these generate, against each programme. The score ranges from 1-Very low confidence to 5-Very high confidence.

Predominately our score is 2 –Low confidence, with some AHP programmes as 1-Very low confidence, and Nursing and Midwifery which is 3-Moderate confidence. The difference in score reflects 'limited' involvement from Education Leads to 'good' involvement, as well as 'broad assumption's' to cost individual programmes, as opposed to 'reasonable level of underlying data' to allow for decent costing assumptions.

The Director of Medical Education has reviewed and signed off the Education and Training part of the submission, confirming the confidence rating as appropriate. The Director of Finance will sign off the full integrated cost submission.

7.4 Education & Training Recommendations

- For there to be one lead responsible for all educational placements within the Trust, that can oversee the governance for these placements.
- The 3 educational leads currently for Medical, Nursing and Non-medical non-nursing, to ensure cohesive processes in place to inform external returns, currently the quarterly LDA census and the annual Integrated cost submission
- A corporate lead for LDA, to ensure the optimisation of funding from the above outcomes against cost.

8 Statement of director's responsibilities for the 2016/17 combined costs collection

In the production of the annual reference cost return the trust must include a statement of the finance director's responsibilities, in the following form of words: NHS trusts are required pursuant to the Accountability Framework to comply with Monitor's Approved Costing Guidance in the completion of the reference cost return. In preparing the reference cost return the board or relevant sub-committee is required to take steps to satisfy themselves that:

This should be read / reviewed in conjunction with the 'Reference Costs Self-Assessment Quality Checklist' on page 8

Responsibilities	Management Contention	Evidence/ Assurance	Gaps/Action for future improvement
• the reference cost return has been prepared in accordance with Monitor's Approved Costing Guidance, which includes reference cost and education and training guidance	The costing accountant has reviewed and compared the costing guidance including any changes in guidance year on year. Changes have been implemented appropriately and the overall reference cost (RC) return is considered to be materially compliant with the DH Costing Guidance. Departure from guidance has only been made where guidance was vague (Chemotherapy, Physic, CNST Premiums); in these cases an appropriate allocation method was established which follows general, good costing principles. Year on year costing allocation improvements have been applied	14/15 PWC Audit has confirmed the RC costing methodology was materially correct. The costing principles have not deviated from this. The purpose of the audit programme is to provide assurance that reference costs have been prepared in accordance with Monitor's Approved Costing Guidance.	Documentation for some of the processes and allocation principles are in place. Full documentation for all processes would be good practice. As an example;- Where NHSi guidance is weak (Chemo for example), and our own data capture is incomplete.

	including recommendations from the 14/15 PWC (Monitor initiated)		
• the information, data and system underpinning in the reference cost return is reliable and accurate	• All cost and activity data used in the system have been reconciled to SUS validated (HES) returns and Final Statutory Accounts. • Statutory Accounts costs and activity have been used as a starting point and then exclusions have been applied as per set guidance (the 'reconciliation statement' that forms part of the return is an integral element of the audit trail for this reconciliation).	• Audited Statutory Final Accounts and Closed General Ledger for the year of 2016/17. • RC 'Reconciliation Statement' shows as opening position the total costs as per final statutory accounts plus/minus exclusions this deriving a total RC Cost Quantum (App1) . Signed off with Head of Financial Accounts • Exclusions are based on NHSi Costing Guidance. This provides evidence and assurance that correct cost quantum has been used.	Engagement with stakeholders to confirm activity and costing assumptions. This was only achieved in limited cases for this RC round.

	• The costing system (Costmaster – Civica) is subject to annual updates by the supplier in line with national guidance and they are subject to agreement with the Department of Health. An annual health-check / RC update is implemented at the beginning of the costing process to ensure the system is fit for purpose and inclusive of all new guidance and changes as appropriate.	• Where exclusions apply, activity is also excluded as appropriate • The Costmaster supplier provides their own systems guidance for producing RC which complies and complements with the NHSi guidance. • System validation reports are embedded (cannot be changed by us the user) to highlight errors or warnings where incorrect methodology or inappropriate values are being reported (i.e. costs under £5 or over £50k; there is a large number of mandatory and non-mandatory validations). • All are shown on the final 'worklist summary' (page 5, highlighted in green) to demonstrate 0% issues or PASS rates which are entirely awarded by the system and so not influenced by user.	Getting the supplier to provide less time-consuming variance analysis between annual submissions.
• there are proper internal controls over the collection and reporting of the information included in the reference costs, and these controls are subject to review to confirm that they are working effectively in practice	All RC data is imported from known and controlled systems such as the general ledger and information systems. All cost allocation is performed in the costing system rather than outside which would carry a higher error risk.		

• costing teams are appropriately resourced to complete the reference costs return, including the self-assessment quality checklist and validations accurately within the timescales set out in the reference costs guidance.	It is deemed that the costing team is currently under resourced, with plans for recruitment on-going.	• Self-Assessment Quality Checklist • Mandatory and non-Mandatory validation checks embedded in the system have been carried out	
• the content of the reference cost return is not inconsistent with internal and external sources of information including: o board/delegated committee minutes and papers detailing the process for submission the period April 2017 o board/delegated committee minutes and papers detailing the final submission sign off the period April 2017			

The finance director and education lead confirm to the best of their knowledge and belief the board has discharged its responsibilities above and the trust has complied with these requirements in preparing the combined costs collection return. By order of the board

……Date……Finance Director. Print Name: ……**TONY WAITE** ……

……Date……Education Lead. Print Name: ……**Dr DAVID CARRUTHERS**……

9 Matters drawn to the attention of the Audit Committee

- Agree, comment on the proposed Reference Cost submission
- Agree, comment on the proposed Education & Training submission
- Note the limitations stated in the preparation of the submission for both costing parts
- Support the implementation of a robust system to store, record and report all Consultant job plans as a minimum at least annually
- Support the improvement in managing education and training placements
- To note and support the roll-out and use of Service Line reports within the business, alongside NHSi's Model hospital dashboard.
- The 3 educational leads currently for Medical, Nursing and Non-medical non-nursing, to ensure cohesive processes in place to inform external returns, currently the quarterly LDA census and the annual Integrated cost submission. The committee to seek for this to come back to them for assurance.
- To support the establishment of a corporate lead for LDA, to ensure the optimisation of funding from the above outcomes against cost

10 Next steps

1. Management response to NED specific points to October Audit Committee
2. Progress resolution of matters drawn to the attention of the Audit Committee
3. Progress development of reference cost processes through EPR enabled PLICS capabilty and utilising national Costing Transformation Programme resources
4. Report on Trust Reference Cost Index following national publication and utilise consequent 'New Model Hospital' update to progress service & cost improvement opportunity

Appendix 1 - Reconciliation Statement to RC Quantum

Reconciliation of reference costs to the audited annual accounts

Line	Description	Notes: FTs	Notes: NHS Trusts	Reconcile to REFC - BAU (£)
1	**Operating expenses**	1. SOCI Note 3	TRU01 sc100 + sc110	£462,444,193
2	Less: Actual cost of non-NHS private patients			-£172,492
3	Less: Actual cost of non-NHS overseas patients (non-reciprocal)			-£1,100,302
4	Less: Actual cost of other non-NHS patients			-£257,857
5	Less: Total other operating income/costs split into	6. Op Inc (type)	TRU01	
5a	Non-salaried education and training income			-£10,221,702
5b	Salaried education and training income			-£8,917,954
5c	Non-salaried education and training costs			
5d	Salaried education and training costs			
5e	Research and Development income: Centrally funded			-£1,210,890
5f	Research and Development income: Privately funded			
5g	Other			-£22,572,029
6	Adjustments due to Lead Employer arrangements			
7	Add: Not allowable non-contractual income			-£5,296,875
8	Less: Actual cost of centrally funded awards under the Clinical Excellence Awards Scheme			-£926,948
9	Less: Actual funds received for Foundation Trust application			
10	Less: Set up costs for Vanguard sites			
11	Less: PFI/LIFT exclusions			
12	Less: Impairments	7.Op Exp (type)		
12a	New build impairments			
12b	Other impairments			
13	Add: Reversal of impairments	6. Op inc		
13a	New build reversals			
13b	Other reversals			£5,161,026
14	Less: Depreciation related to donated or government granted non-current assets			
15	Add: Donations or government grants received to fund non-current assets		TRU05 sc287 + sc288 + sc300	£62,152
16	[insert full details of additional adjustment]			
17	[insert full details of additional adjustment]			
18	[insert full details of additional adjustment]			
19	[insert full details of additional adjustment]			
20	[insert full details of additional adjustment]			
21	Less: Adjustment for provider-to-provider agreements			-£1,506,307
22	Add: Income received from other providers for maternity pathways			
23	Less: Payments made to other providers for maternity pathways			-£6,027,749
24	Profit or loss on sale of of assets where proceeds not used for patient care			
25	Other gains or losses	Part year FTs only	TRU01 sc160	
26	Less: Finance income (FTs) or investment revenue (NHS trusts)	1.SOCI Note 8	TRU01 sc150	-£65,706
27	Add: Finance expenses financial liabilities (FTs) or finance costs (NHS trusts)	1.SOCI Note 9	TRU01 sc170	£2,145,974
28	Add: PDC dividends payable	1.SOCI	TRU01 sc190	£5,117,000
29	Add: Finance expenses - unwinding of discount			£45,407
30	**Less: Services excluded from reference costs**			
30a	Ambulance trusts - specified services			
30b	Cystic fibrosis drugs			
30c	Discrete external aids and appliances			-£2,348,555
30d	Health promotion programmes: Contraception and sexual health			
30e	Health promotion programmes: Oral health promotion			
30f	Health promotion programmes: Stop smoking education programme			
30g	Health promotion programmes: Substance misuse			
30h	Health promotion programmes: Weight management			
30i	Health promotion programmes: Other health promotion programme			
30j	Home delivery of drugs and supplies: administration and associated costs			-£92,500
30k	Home delivery of drugs and supplies: drugs, supplies and associated costs			-£5,928,031
30l	Hospital travel costs scheme			-£60,419
30m	In vitro fertilisation (IVF) drugs			
30n	Learning disability services			
30o	Local Improvement Finance Trust (LIFT) and Private Finance Initiative (PFI) set up costs			
30p	Mental health trusts - specified services			
30q	Named providers - specified services			
30r	NHS continuing healthcare, NHS-funded nursing care and excluded intermediate care for individuals aged 18 or over			-£2,811,548
30s	NHS continuing healthcare, NHS-funded nursing care for children			
30t	Patient transport services (PTS)			-£2,752,678
30u	Pooled or unified budgets			-£22,876
30v	Primary medical services			
30w	Prison health services			
30x	Screening programmes			-£4,950,482
30y	Specified hosted services			
31	Total Sub-contracted out from REFC-BAU			
32	**Total reference costs submission quantum (sum lines 1 to 25)**			**£397,731,852**

Appendix 2 – Learning & Development Agreement Funding Summary

Health Education England working across West Midlands
2016-17 Learning & Development Agreement Funding Summary

Provider: Sandwell and West Birmingham Hospitals NHS Trust

Area	Tariff / Non Tariff	Funding Type	Indicative Q1 Annual Allocation £	Q2 Annual Allocation (Refresh) £	Schedule Q1 £	Schedule Q2 £	Schedule Q3 £	Schedule Q4 £	Total £
Non Medical	Tariff	Non Medical Tariff Funding	*1,070,556*	1,077,456	249,916	374,808	203,388	249,344	1,077,456
	Tariff	Additional Payment for Non Medical Placement (2%)		21,812	5,059	7,588	4,117	5,048	21,812
	Non Tariff	Placement Transition (from 27 weeks to 37 weeks)	*275,399*	413,099	103,275	103,275	103,275	103,275	413,099
	Non Tariff	RTP Placement						5,500	5,500
	Non Tariff	Non Medical Salary Replacement	*1,252,490*	1,686,420	399,902	416,160	447,262	423,097	1,686,420
	Non Tariff	Learning Beyond Registration	*118,705*	287,479	71,223	47,482	168,774		287,479
Undergraduate Medical & Dental	Tariff	Undergraduate Medical Tariff Funding	*4,398,803*	4,088,200	443,531	735,599	1,341,640	1,567,431	4,088,200
	Tariff	Additional Payment for Undergraduate Medical Placement (2%)		83,395	9,048	15,005	27,368	31,974	83,395
	Non Tariff	Undergraduate Medical for Dental Funding	*56,134*	56,134	0	18,711	18,711	18,712	56,134
Postgraduate Medical & Dental	Tariff	Postgraduate Medical Tariff Funding	*9,545,461*	9,545,461	2,386,365	2,386,365	2,386,365	2,386,365	9,545,461
	Tariff	Additional Payment for Postgraduate Medical & Dental Placement (2%)		75,354	18,838	18,838	18,838	18,838	75,354
	Non Tariff	Postgraduate Non Tariff Training Posts	*854,085*	854,085	219,990	213,521	210,287	210,287	854,085
	Non Tariff	Postgraduate Medical Less Than Full Time Training Top Up: Slot Share	*33,659*	33,659	6,170	5,553	8,639	13,296	33,659
	Non Tariff	Postgraduate Medical Less Than Full Time Training Top Up: Part Time Fu	*91,122*	91,122	26,337	29,454	21,643	13,687	91,122
	Non Tariff	Coordinated Postgraduate Medical Study Leave	*-70,110*	(70,110)	(17,528)	(17,528)	(17,528)	(17,528)	(70,110)
	Non Tariff	Postgraduate Medical Non Tariff Non Pay Funding	*26,324*	26,324	8,081	6,081	6,081	6,081	26,324
	Non Tariff	Postgraduate Dental Education	*16,131*	16,131	4,033	4,033	4,033	4,032	16,131
	Non Tariff	Staff and Associate Specialist Doctors	*5,000*	5,000	0	5,000	0	0	5,000
	Non Tariff	National Institute for Health Research Funding	*90,480*	98,531	31,874	24,633	23,685	18,339	98,531
Other	Tariff	Tariff Transition Plan	*-545,574*	(545,574)	(136,394)	(136,394)	(136,394)	(136,394)	(545,574)
	Non Tariff	Widening Participation: Apprenticeships, Foundation Degree		47,600	12,900	20,200	12,000	2,500	47,600
	Non Tariff	Additional Funding		69,482	0	5,800	0	63,682	69,482
		Total	***17,218,664***	**17,961,061**	**3,842,622**	**4,284,186**	**4,852,186**	**4,987,567**	**17,966,561**
Indicative Schedule		Invoice No.			*1167978*	*1169338 & 1170182*	*1170183*		
		Amount Paid			4,476,205	3,492,200	4,720,470		12,688,875
		Total Outstanding			**-633,583**	**791,986**	**131,716**	**4,987,567**	**5,277,686**

16/17

Actual funded received	**18,031,561**
Excluded from E&T Cost return:-	
Widening Participation: Apprenticeships	(47,600)
Staff and Associate Specialist Doctors	(5,000)
National Institute for Health Research Funding	(98,531)
Non Medical Salary Replacements (All)	(1,686,420)
LDA Funding Reconciliation Value	**16,194,010**
Salaried Submission	11,019,279
Non-Salaried Submission (Undergrad & Non-Medical)	12,630,226
E&T Cost Submission	**23,649,505**
Variance to funding	**7,455,495**
Main Variance reasons;-	
Trust Funded Posts (@ midpoint)	*3,619,100*
Overheads	*1,012,453*
Funded 50% of Salary. 100% cost in submission	*2,572,996*
	7,204,549

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Dermatology Never Event
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Allison Binns, Deputy Director of Governance
DATE OF MEETING:	7 September 2017

EXECUTIVE SUMMARY:

This report provides the Board with an update on the investigation into the most recent Never Event which occurred in Dermatology Theatres in August 2017.

The investigation has been carried out in line with the recent changes which have been made to strengthen the Serious Incident (SI) process, which includes Never Events, ensuring that investigations are timely (concluded within 50 working days), ensuring more patient/relative involvement and developing one or two SMART actions to get to the root cause.

The robustness of the Trust's response to learning lessons both locally and across clinical directorates and Clinical Groups remains a challenge. Following identification of actions to mitigate the issues arising from this latest Never Event we will instigate a campaign to learn from it across the Trust. To inform this, members of the corporate Governance function are talking to private organisations to understand how they share learning, ensuring this is understood by all staff and becomes the 'norm'. This will assist us in developing a robust, inclusive and assured method of communicating required safety changes to staff.

REPORT RECOMMENDATION:

The Board is recommended to RECEIVE and NOTE the update on Never Event investigation progress.

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

Accept	Approve the recommendation	Discuss
	✓	✓

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

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

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

Safe High Quality Care

PREVIOUS CONSIDERATION:

Never Event notification is circulated.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 7 September 2017

Never Event in Dermatology: Briefing

1. On 3 August 2017 in the Dermatology Outpatient theatre the wrong patient had a biopsy carried out on his left cheek. This is defined as a Never Event.

2. As soon as the incident was identified it was reported to the specialty lead who met with the team members involved to understand what had taken place. She then met the patient and explained what had happened and offered an apology. As English is not the patient's first language, a further meeting was arranged with an interpreter present for the following week, and at the same time the suture in his cheek was to be removed.

3. The staff members involved were asked to provide statements, the incident was reported on the Trust's system and an internal investigation initiated. The three staff members directly involved in the incident were interviewed individually, as was the specialty lead. The patient did not attend for the follow up meeting as he had moved to Bristol; however he was interviewed over the telephone. The patient's healthcare records were reviewed.

4. A week following the incident a meeting of those within the Dermatology Department who worked in the theatre suite was convened to discuss the processes for safely operating on patients. Discussions were held around the use of open questions when identifying a patient and completion of the WHO checklist.

5. The team immediately introduced a system whereby those patients attending for theatre had a wristband placed which contained their details.

6. Two key findings from the staff interviews are:

a. No one used the positive patient identification (PPI) method to check that they had the right patient; and
b. The WHO checklist is carried out by an individual and not the team

7. PPI was a key factor in previous Never Events, with the most recent being in Ophthalmology in November 2016. The root cause of this incident was failure to carry out PPI, although in that incident the patient names were extremely similar, other identifying factors however were not. In this incident neither of the two patients had the same or similar identifiers except their middle name.

8. In 2013, following a serious incident, a short video on the importance of PPI was made and distributed to staff via Trust mobile telephones. Following the Never Event in November 2016 this was reissued. Careful consideration needs to be given now to the action(s) required to prevent further incidents where PPI is the root cause.

9. The three staff members involved recognise the error made in not correctly identifying the patient prior to carrying out the intervention. The Governance Department will use the Incident Decision Tree to advise the line managers concerned of the appropriate processes to follow and any sanctions or consequences to be applied. This process will be initiated by the end of September. This will be done through the Governance function to ensure proportionality and consistency of application across all professions.

10. SMART actions will now be identified, applied to the local team in Dermatology and monitored intensively for 3 months at which time a report will be presented to the new Executive Quality Committee and then the Board Quality and Safety Committee in December. At the same time the incident will be shared across all Clinical Groups and the actions applied with an assurance process that all applicable staff have understood and will follow the stated requirements for improving patient safety.

Allison Binns
Deputy Director of Governance

31 August 2017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC MEETING MINUTES

Venue: Training Room 2, Archer Ward, Rowley Regis Hospital **Date:** 3rd August 2017, 0930 – 1300h

Members Present:		**In Attendance:**	
Mr R Samuda, Chair	(RS)	Mrs C Rickards, Unison	(CR)
Ms. O. Dutton, Non-Executive Director	(OD)	Ms. D Talbot	(DT)
Mr H Kang, Non-Executive Director	(HK)		
Cllr W Zaffar, Non-Executive Director	(WZ)		
Mr M Hoare, Non-Executive Director	(MH)	**Board Support**	
Prof K Thomas, Non-Executive Director	(KT)	Mrs E Quinn	(EQ)
Ms. M Perry, Non-Executive Director	(MP)		
Mr T Lewis, Chief Executive	(TL)		
Dr R Stedman, Medical Director	(RSt)		
Mr T Waite, Finance Director	(TW)		
Miss K Dhami, Director of Governance	(KD)		
Mrs R Goodby, Director of OD	(RG)		
Ms R Barlow, Chief Operating Officer	(RB)		

Minutes	**Reference**
1. Welcome, apologies and declaration of interests	**Verbal**
Apologies were received from Ms Newell. The members present did not have any interests to disclose.	
2. Patient Story	**Presentation**
The Board heard from staff member Linda Parkes, End of Life Care Facilitator on behalf of a patient that had been diagnosed with a cerebral tumour in June 2017. The patient was noted to be a Dudley resident, registered with a Sandwell and West Birmingham CCG G.P. Due to a late diagnosis and the patient generally deteriorating due to disease progression, there had been a fast referral by the ward to Palliative Care Services for symptom control and support. A summary of events was shared with the Board as follows: On the 2nd July, the patient's wife called the Connected Palliative Care (CPC) Hub, as she was concerned that her husband had had multiple falls within a 48 hour period. The G.P. had excluded an infection as the cause. The nurse from the Urgent Response Team (URT) visited to provide support and identified that the family was finding it difficult to manage the patient's personal care needs. The preferred place of care was at home, so a package of care was agreed. A CHC Fast Track was completed but sent to Dudley CCG in error. The patient was visited by a Palliative Care CNS the following day. The URT commenced personal care calls every morning and evening until the care package was in place, as Dudley Fast Response Team had no capacity. On the 6th July, the CPC Hub noticed that the CHC fast track referral had been sent to the wrong CCG. The fast track document was therefore urgently sent to SWBCCG CHC Team. Equipment needs were identified by the URT and were requested via the District Nurses, as at the time, the URT did not have direct access to the Dudley equipment store. On the 11th July, the CHC team reported difficulty finding a Care Agency due to the geographical area. A potential package of care was therefore planned to commence on 19th July 2017. The patient continued to deteriorate, with	

incontinence being the main problem. The URT increased visits up to four times a day in order to meet the needs of the patient and to maintain support for his wife.

On the 19th July, the care package did not commence as planned due to miscommunication between the care agency and the CHC Team. The Hub rang the patient's wife to apologise for the error. The URT continued to provide four calls a day and the CHC team confirmed a package of care was to commence on the morning of 22nd July.

Currently, the patient remains at home with all care needs met and his wife feels well supported. The patient has continued to deteriorate due to disease progression, with a probable prognosis of weeks.

The Board noted that the challenges were issues with geographical cross- boundaries, funding and availability of carers, keeping the patient in his preferred place of care without a package of care in place and the challenge for the URT to continue to visit patients in crisis whilst maintaining the care of this patient.

The successes highlighted in this instance were noted to be that a hospital admission had been prevented, with the patient being able to remain in his preferred place of care, the team went the extra mile to ensure that the patient and his wife's needs were met and that they felt supported at home.

The learning/actions were noted to be the importance of keeping the family informed, teams to be aware of CCG/CHC boundaries for the CHC funded care, Connected Palliative Care is arranging for the URT to access Dudley equipment store and the URT Team Leader and the District Nurse Team Leader have agreed that personal care is not the remit of either team.

Members of the Board praised the team for exceeding the expectations of their remit. Ms Barlow suggested that a meeting with the Social Services team and Caroline Rennalls in relation to cross-boundary working would be beneficial. Ms Barlow agreed to arrange to put Caroline Rennalls in touch to make the necessary arrangements.

ACTION:

- **To arrange a meeting with Social Services and Caroline Rennalls in relation to cross-boundary working.**

3. Questions from the public	**Verbal**

An enquiry was made from a member of the public who provided part-time volunteer services at Rowley Regis Hospital. He was concerned about cost pressures on the Trust surrounding the number of wheelchair-bound inpatients that had been in hospital for some months and had been unable to return home due to issues in relation to securing ground floor accommodation. Ms Barlow confirmed that this cost pressure was not sustainable but that work was currently on-going with social care teams in terms of patients that are medically fit for discharge. Mr Lewis highlighted that a Housing Adjustment Team was in place however, active consideration was underway in terms of ensuring the relevant regulations/permissions were in place.

Mr Bill Hodgetts of Healthwatch highlighted the case of a 92 year-old patient at City Hospital that had been informed that there was a three month waiting list for 'Assist'.

4. Chair's opening comments	**Verbal**

Mr Samuda thanked all those involved with the recent Midland Met Topping-Out Ceremony and shared the positive comments he had received about involving so many young people and the presence of the West Midlands Mayor, Andy Street.

Mr Samuda reported that the Sandwell sustainability work with GE Healthcare to review the viability of future commissioning plans was on-going and was almost completed. A report from the collaborative process was expected over the next month.

5a. Audit & Risk Management Committee	**TABLED SWBTB (08/17) 001**

Ms Perry reported on the following:

Q1 Legal Services Update - the Trust receives a higher number of employer and public liability claims than both the national and member type average. A thorough review is to be undertaken of all employer/public liability claims to identify any themes/trends. This will be reported at the next Committee meeting in October.

Overseas Visitors - the figures in relation to the identification of overseas visitors demonstrate good progress. Further work is being undertaken in relation to pre-payment for treatment and the taking of deposits, and is expected to be reported to the October meeting.

External Audit - colleagues from Grant Thornton, the Trust's newly appointed external audit provider were in attendance. The external audit plan is being pulled together, with a report expected in November. A verbal update on the Trust's emerging risks will be reported at the next meeting in October, with a focus on financial stability.

Internal Audit Progress Report **–** the Internal Audit Plan had had a good start to the year. There were a high number of audit recommendations outstanding, although arrangements were in place for Mr Hussain and Ms Dhami to meet on a monthly basis to proactively identify any due actions to be closed. This would also be a monthly item at the Performance Management Committee (PMC). Safeguarding Adults training was identified as an area of concern, for which the Trust had received a Safeguarding training performance notice from the CCG. This is being picked up at PMC and will be noted at Quality & Safety Committee. Mrs Goodby reported that the Trust had since met the trajectory in relation to training for Safeguarding Adults.

LCFS Progress Report - good progress was being made against the 2017/18 counter fraud work plan.

The Board received and noted the minutes of the Audit and Risk Management Committee meeting held on 24th May.

5b. Quality & Safety Committee	**TABLED SWBTB (08 /17) 002**

Ms Dutton reported on the following:

DNACPR Progress Report - a weekly audit programme of DNACPR forms and recording of information on eBMS had commenced for a selection of wards at City and Sandwell Hospitals. The Committee had noted the actions taken in response to concerns raised regarding the accuracy of DNACPR information, in particular the recording of a patient's DNACPR status in eBMS.

DoLS Progress Report - the committee noted the actions taken in response to further concerns raised regarding the lack of progress in undertaking appropriate and timely DoLs Assessment and referrals. In order to achieve the agreed improvement trajectory, a further 5 assessments per day would be required over a 9 week period.

CQC Outlier Alert Relating to Puerperal Sepsis - the committee had noted the CQC outlier alert relating to an increase in reported cases of puerperal sepsis within 42 days of delivery for the period of July to November 2016. A response was required by the CQC by 10th August.

Mr Lewis reported that the investigation into perinatal mortality was now planned to report at the end of September, rather than the end of August as originally planned. This was due to the non-availability of the reviewer. The outcome of the investigation is to be reported at the September Board and Quality and Safety meetings.

Mr. Lewis drew attention to the recent T&O Safety summit. He confirmed that the outcome would be tracked by Q&S.

The Board received and noted the minutes of the Quality and Safety Committee meeting held on 30th June.

5c. Finance and Investment Committee	**TABLED SWBTB (08/17) 003**

Mr Hoare reported on the following:

Q1 – headline performance after STF is reported is £235k adverse to plan. This reflects Quarter 1 failure of the A&E waiting times performance element of STF.
Data challenge – the Trust remains in dialogue with commissioners in respect of data and other challenges to the income position. Mr Lewis reported that the data challenge risk was for £36m, although he was confident that the Trust would win most of the challenges due to robust procedures in the plan. Meetings had been scheduled between himself and the CCG leadership, together with a separate meeting between Mr Samuda and the CCG leadership.
Financial Improvement Programme – a new level of scrutiny to the delivery of financial controls totals had been implemented. This was to be supported by a tiered structure of scrutiny and support at Directorate, Group and Executive level.

The Board received and noted the minutes of the Finance and Investment Committee meeting held on 30th June.

6. Chief Executive's Report	**SWBTB (08/17) 004**

Mr. Lewis highlighted the following matters from his report:

Never Events – at the last Board meeting, it was agreed that the processes behind the Trust's Never Event governance and Serious Incident reporting practice would be re-examined. The emerging conclusions formed the proposal that:

- Investigations are undertaken over a 50 working day period, meaning that final reports into the Board will be submitted in detail slightly more slowly than presently;
- Formal training of a revised list of lead investigators is undertaken, equipping them with the knowledge to conduct not simply root cause analysis training but better development of action plans and project management;
- Each incident in practice gives rise to two action plans. One specific to the incident under investigation, and a second aimed at identifying and tackling similar or related risks across the wider organisation;
- The tracking of delivery of both Serious Incidents and Never Event action plans moves to the central Governance team and is routinely reported to the Board's Quality and Safety committee, and to the new streamlined Executive Quality Committee which will support CLE.

Work had not yet concluded around defining the circumstances under which such investigations would give rise to conduct action against an individual employee. It was recognised that we want a culture of learning and insight, but also one of responsibility and accountability. This work will be brought back to the Board in September alongside the wider "consequences" paper, which covers rewards and remedies for individuals, teams and directorates.

Casenote scanning – this would be covered further in the Private Board session. The process was currently being reviewed, however, the majority of clinicians were now working with electronic notes. Displaced Medical Records' staff had been successfully redeployed.

Oncology Services – the risks were highlighted in relation to the future delivery, associated with the perceived uncertainty over solid tumour oncology service provision. NHS Improvement had taken lead role in brokering a continued service and there was optimism of a successful outcome.

7. Pathology Proposal	**SWBTB (08/17) 005**

Mr Samuda introduced the item and highlighted the national issues in relation to Pathology Services. He stressed that the Trust was keen to protect the highly valued SWBH service due to its unique nature in terms of the work undertaken.

Mr Lewis reported that this item was also being presented for discussion at the Board meetings at Dudley Group Foundation Trust, Walsall Healthcare NHS Trust and Royal Wolverhampton Trust. He summarised that the Black Country Pathology Transitional Management Team had met to discuss the opportunities that could be realised by creating a single managed Pathology service from the four Trust services. It was made clear that there is not an option to 'do nothing', as there is a national instruction to effect change. It was stressed, however, that the proposal must meet the Trust's, patients' and strategic interests.

The Board was asked to consider the Outline Business Case (OBC), and approve the recommendations to:

- Establish a Black Country Pathology Service, which will be equitably and jointly owned by all 4 Trusts;
- Commence a transition phase to create a Black Country Pathology Service based on a single hub / Emergency Service Laboratory (ESL) model that is expected to be fully operational by end of 2018;
- Begin the process of recruiting BCP Clinical and Operational Director roles that will drive this work forward;
- Commit to enabling expenditure for the next period of activity as defined in the OBC;
- Produce a detailed Target Operating Model (TOM) and Full Business Case (FBC) that will be completed in time for consideration at Trust Board meetings in October 2017.

The Board discussed presentational risks, implementation risks and clinical risks. Issues in relation to the Microbiology service were discussed and it was stressed that the ESL must be right for the new Midland Metropolitan Hospital in this respect. The Board was conscious that the SWBH Pathology service undertakes unique work streams that the other

Trusts do not do and this should be borne in mind when incentivised. The importance that the proposal should work commercially was stressed.

Mr Kang queried how the business would be allocated. Mr Waite explained that the individual organisations would retain their existing business contracts until such time that they expire. Upon renewal, the contracts will form part of the new hub. There was a general discussion around stranded costs and how they might flow through, as this issue does not yet form part of the OBC. The need to understand any exit arrangements was also highlighted.

Mr Samuda queried the consistency of equipment and I.T. and how this would be funded. Mr Lewis commented that the costs were not yet clear enough and stressed the importance of this before the Full Business Case is agreed.

Mrs Rickards informed the Board that the staff in the Pathology service recognised the need for change but felt that their views had not been considered when drawing up the OBC. Mr Lewis explained that the next twelve weeks would be around staff engagement in relation to the implementation of the service, with Walsall being the preferred location due to the available physical space. It was noted that SWBH does not have this available space.

Dr Stedman stressed the importance of the need for clarity within the OBC in relation to samples, specifically how complex samples would be turned around within one hour. He informed the Board that arrangements were being made to visit other areas where this model is in operation.

Mr Samuda summarised that this change was being brought about as a response to national policy. There was no option to 'do nothing'. The concerns raised by the Executive and the Non-Executive Directors were recognised. It was also recognised that SWBH was in a different position to the other Trusts there was more work to be done in terms of finance and service support. This was to be discussed further in the subsequent Private Board session.

8. NHSE Emergency Preparedness, Response and Recovery Core Standards	**SWBTB (08/17) 006**

Ms Barlow updated the Board in relation to the assessment of core standards as set out by NHS England (NHSE). The Trust is expected to submit to NHSE the portfolio of required documentation by 15th September 2017. The areas of assessment this year were noted to include:

- EPRR Core Standards
- Training and exercising
- Governance
- Duty to assess risk
- Duty to maintain plans and Business continuity
- Command and control
- Duty to community care with the public
- Information sharing/cooperation

- Governance
- HAZMAT CBRN Core Standards (decontamination)
- HAZMAT CBRN - Equipment List

The assessment data will be presented to the Board at its next meeting in September, prior to submission to NHSE.

Ms Barlow proposed that a Non-Executive Director be involved in the process to act as a critical friend/sponsor. Mr Samuda agreed to the proposition and asked Ms Barlow to put together a short job specification.

ACTION:

- **Ms Barlow to draw up a role specification for a NED sponsor.**

9. Staff Inclusion and Diversity Pledges progress report	**SWBTB (08/17) 007**

Mrs Goodby presented the report that that sets out the agreed 'Inclusion and Diversity' pledges that were agreed earlier in the year and the progress to date. The areas where progress was lacking were noted to be in relation to developing a robust WRES action plan and a focussed approach to BME Leadership Development. These areas would be addressed in the coming quarter.

Mr Lewis congratulated Mrs Goodby and the team on the significant progress that had been made. He felt it was important that a specific item on disability was added.

ACTION:

- Exec disability sponsor Miss Dhami to add pledge.

10. Trust Risk Register	**SWBTB (08/17) 008**

Miss Dhami asked the Board to note a new risk in relation to the lack of assurance that patients' test results have been seen/acted upon. The risk of this could mean that patients' treatment could potentially be delayed or omitted. It was noted that existing controls were in place, however, there may be a need for those controls to be strengthened. Miss Dhami asked the Board to consider whether this risk should stay on the Trust Risk Register or if it was content for it to be managed locally. Mr Lewis stressed that this was a corporate risk and should therefore remain on the Trust Risk Register.

Miss Dhami reported that the Trust Risk Register was under review and was to be refreshed. This exercise would pick up any overdue actions.

11. Integrated Performance Report	**SWBTB (08/17) 009**

Mr Waite summarised the key areas of the report. The areas of concern were noted to be the Mortality reviews (which, at 50%, remained significantly below the 90% standard) and Sepsis [CQUIN] where performance is required to be addressed.

Mortality reviews - Dr Stedman reported that although his team had been looking at learning from deaths, a more focussed approach to the reviews will need to take place to catch up. This will be in place by December.

Sepsis - Dr Stedman reported that the CQUIN definition had changed this year and now has a broader scope. He acknowledged that there was work to do to bring up to performance and manage focus effectively. Mr Lewis informed the Board that this would be tracked via the Performance Management Committee.

Ms Dutton queried the data for the cancellations of elective operations. Ms Barlow reported that improvement work was being led, with good results being seen. The Trust was expected to be back on trajectory for September. A report in this respect will be presented at the September Board meeting.

12. Persistent Reds	**SWBTB (08/17) 010**

Mr Waite summarised and presented the IPR indicators where performance during the last year was consistently below targets. It was noted that the summary included a management assessment of relative priority for remediation and the proposed timescale for the remediation. The next steps were noted to be the development of specific milestone plans for delivery and month on month trajectories against which performance can be monitored and reported. Oversight and assurance is to be provided via routine consideration of the Quality and Safety Committee. The Board were asked to challenge and confirm the assessment of priority and timescale for remediation of performance in respect the persistent red indicators.

After challenge, Mrs Goodby agreedto bring forward the recovery plan for return to work interviews to Quarter 3.

Professor Thomas raised a query in relation to the indicator for falls. Ms Talbot reported that the falls data was being examined with a view to identifying preventable measures. The Trust was noted to be benchmarked well nationally and that this would be a regular item on the Quality and Safety agenda.

13. Financial Performance: P03 June 2017	**SWBTB (08/17) 011**

Mr Waite summarised that this item had already been covered elsewhere on the agenda and would be discussed further in the Private Board session.

14. CIP Delivery: Q1	**SWBTB (08/17) 012**

Ms Barlow reported the implementation of a renewed grip and control approach to the delivery of the CIP and explained how this would be tracked via a series of gateways. The main areas of under-delivery/focus were noted to be in relation to:

- Bed reduction schemes - of the three Bed Reduction schemes, the overall under-delivery in Medicine is £307,161 for the period. Oversight and scrutiny of the Bed Base Work stream will fall under the Urgent Care Board and be manged through the Medicine and Surgery GPOs. 75% of the planned bed closures are now complete. The remaining 16 beds scheduled for closure in Medicine are due to be closed in August. Surgery bed closures are on track for September, with 10 scheduled to close at the City Hospital site in August.

- Procurement - £73,387 of under-delivery lies in six separate procurement schemes, one for each clinical group. Oversight and Scrutiny of the Procurement Work stream will take place at the Operational Leaders Meeting (OLM) and full in year recovery is expected.

- Owed Hours - the rostering of shifts to pay back owed hours is covered in two schemes which are showing an under-delivery totalling £60,000. This is mainly due to an over-estimation of the size of the opportunity identified and is further complicated by less than ideal quality being input into ESR so that "owed hours" are not being coded correctly. Work is underway to resolve both issues and new schemes will need to be identified to cover the anticipated shortfall.

Ms Dutton raised a query in terms of how the system for 'owed hours' worked. Mrs Goodby explained that there should be no more than ten hours owed by either party (staff member/Trust) and that there is a three month window in which to redeem these hours. It is expected that the owed hours are used in the most effective way to remove the need to use agency staff. Mrs Goodby agreed to circulate a note to the Board in relation to CIP under-delivery for owed hours.

Mr Kang and Mr Waite had a discussion around the need for the Executive to be assured of the grip and control in relation to procurement. It was noted that the National Procurement Strategy was behind plan in delivery nationally. Mr Lewis stressed the importance of the non-pay CIP.

ACTION:

- **Mrs Goodby to circulate a note to the Board in relation to CIP under-delivery for owed hours.**

15. Production Plan forecast	**SWBTB (08/17) 013**

Ms Barlow presented the production plan and reported a strengthened and sustainable position. The forecast for Quarter 2, together with indicative forecasting for each quarter for the remainder of the year was summarised. It was noted that there was governance and oversight in place to ensure ongoing delivery of the production plan. The August position was forecasted to provide surplus to the current plan.

16. Nurse Recruitment update and retention: progress update	**SWBTB (08/17) 014**

Mrs Goodby presented the report that provides an update on the position in relation to Nurse and HCA recruitment and retention of staff. She reported that the Trust is ahead of trajectory for the recruitment of HCAs and Band 5 Nurses and on target for midwives and other posts. The Board noted that the Trust had reduced nursing turnover by its target of 3% for the period March 2016 – March 2017. The target for the coming year was to maintain this reduction (11.7%) and further reduce this by 1% (10.7%). This reduction in turnover is included in the Board's recruitment trajectory.

Mr Kang asked Mrs Goodby if there had been any feedback in terms of retaining staff. Mrs Goodby reported that the initiative to apply to move between wards was highly profiled around the Trust, with 42 applications having been received so far, equating to retained staff that may have otherwise left the Trust. The initiative could also highlight any worry wards. The process was being managed by the Chief Nurse.
Mr Hoare enquired about the trajectory for reducing vacancies for Band 5 and Band 6 nurses. Mrs Goodby reported that the Trust was planning to hold a series of recruitment events and would make the assumption that 50% of job offers made would convert to staff in substantive posts and was satisfied that this would underpin the trajectory.

Mrs Rickards enquired if there would be a route cause analysis to establish the reasons for those staff wishing to transfer wards, as this could suggest a potential problem within particular ward environments. Mrs Goodby reassured Mrs Rickards that this potential issue had been borne in mind and that work was underway in this respect. It was noted that there were 'quick wins' where possible, however, some issues may require resolution over a longer period.

17. Emergency Department scorecard	**SWBTB (08/17) 015**

Ms Barlow reported that the Emergency Department scorecard tracks a set of data related to patient activity, clinical and professional standards. The A&E improvement plan is designed to improve the 4 hour performance to 90% by September. A single integrated scorecard is expected to be available by the end of August. The Board noted that good progress had been made against the month and matched the national position. There was good engagement through the ED leadership team. BMEC had impacted on performance by 2% due to changes in urgent care pathways.

Mrs Goodby enquired how staff performance was examined. Ms Barlow explained that this was a new process, however, feedback was shared with each member of staff.

18. Complaints Report: Q1	**SWBTB (08/17) 016**

Ms Dhami presented the report that sets out the details of Complaints and PALS enquiries received between April and June 2017. It was noted that during this period, the complaints activity had decreased, with 98% of complaints received since April 2017 being managed within their target date. It was noted that there had been a reduction in complaints about appointments during Quarter 1. There were 35 complaints from 2016/17 that were overdue a response and would be finalised by the end of September.

The experience of patients from the BME community where the experience results in a formal complaint was discussed. Miss Dhami reported that there were no explanations/themes. Karen Wood, Head of PALS and Complaints was linking in with the BME network in this respect.

Mr Lewis asked whether the process for insisting upon changes was sufficiently robust. Miss Dhami expressed confidence that she had the authority to insist on improvement and that the new Executive Quality Committee would provide a locus for that emphasis.

19. Application of the Trust Seal	**SWBTB (08/17) 018**

The Trust Board was asked to approve the affixation of the Trust Seal to the Settlement Deed for Unit 3, Church Lane.

The Trust Board approved the application of the Trust seal.

AGREEMENT:

- The use of the Trust seal was agreed for the documentation regarding the Settlement Deed for Unit 3, Church Lane.

20. Minutes of the previous meeting and action log – 6th July 2017	**SWBTB (08/17) 018** **SWBTB (08/17) 019**

The minutes of the 6th July 2017 were agreed as an accurate record of the meeting.

It was noted that there had been a reduction in complaints about appointments during Quarter 1.

Action Log

2: STP Governance - this should be re-opened and added to the September agenda.

11: Learning Disabilities - An update is expected at the September meeting.
14: Smoking Cessation – this is to remain on the action log as a recurring item until resolved.

21. Any other business	**Verbal**

There were no other items of business.

22. Date and time of next meeting	**Verbal**

The next public Trust Board will be held on 7th September 2017 starting at 09.30am in the Anne Gibson Board Room, City Hospital.

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SWBTB (08/17) 023

Public Trust Board

Action Log following meeting held on 3rd August 2017

	Action	Assigned to	Due Date	Status
From Meeting held on 3rd August 2017:				
1)	Patient Story: End of Life Care. Social Services and Caroline Rennalls to discuss cross-boundary working.	Rachel Barlow	September 2017	Open
2)	NHSE Emergency Preparedness – draw up role specification for NED sponsor.	Rachel Barlow	September 2017	Closed On the agenda
3)	Staff Inclusion and Diversity pledges. A disability pledge to be included.	Kam Dhami	September 2017	Open
4)	CIP Delivery: Q1 – circulate note to the Board in relation to CIP under-delivery for owed hours.	Raffaela Goodby	September2017	Open
From Meeting held on 6th July 2017:				
1)	Patient Story: Interpreting – follow up on actions and the service as noted in the Trust Board including the use of translation ear pieces, a cohort of staff who can be called upon to assist in translating and obtaining intel on the model used by Birmingham Community Trusts.	Elaine Newell	September 2017	Open
2)	STP Governance. A note on the impact of the residents in West Birmingham	Toby Lewis	September 2017	Closed On the agenda
3)	An assurance report on Perinatal Mortality to be provided to the September Trust Board following its presentation to the Quality & Safety Committee	Elaine Newell	~~September 2017~~ October 2017	Open

	Action	Assigned to	Due Date	Status
4)	Business continuity: update including the audit key risks	Rachel Barlow	September 2017	Closed On the agenda
5)	Safety Plan outcome data to be provided to the Trust Board.	Elaine Newell	September 2017	Closed On the agenda
6)	Integrated Performance Review: An update to be provided on cancelled operations within ophthalmology	Rachel Barlow	July 2017	Closed On the agenda
7)	Learning Disabilities – update the September meeting on the advisory service with the Black Country Partnership	Toby Lewis	September 2017	Open
8)	Smoking cessation: matter to be resolved and reported to Trust Board.	Toby Lewis	Monthly verbal progress report until resolved	Open