Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION AGENDA

Venue: Handsworth Association of Schools, Welford School, Welford Road, Handsworth, Birmingham. B20 2BL

Date: 6th July 2017 from 09:30h to 13:15h

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
Prof K Thomas	(KT)	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

Board Support:

Ms R Fuller	(RF)

Time	Item	Title	Reference Number	Lead
0930h **0931h**	**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.* <u>New declaration by Raffaela Goodby</u>: • Director (Trustee) of Sandwell Multi Academy Trust	Verbal	**Chair**
	3.	**Patient Story**	Presentation	**EN**
0940h	**4.**	**Questions from members of the public**	Verbal	**Chair**
0945h	**5.**	**Chair's opening comments**	Verbal	**Chair**
		UPDATES FROM THE BOARD COMMITTEES		
0950h	**6a**	To: (a) receive the update of the **Major Projects Authority Committee** meeting held on 23rd June 2017 (b) receive the minutes of the **Major Projects Authority Committee** meeting held on 28th April 2017	SWBTB (07/17) 002 SWBTB (07/17) 003	**MH**

Time	Item	Title	Reference Number	Lead
0955h	6b	To: (a) receive the update of the **People & OD Committee** meeting held on 26th June 2017 (b) receive the minutes of the **Workforce & OD Committee** meeting held on 17th March 2017	SWBTB (07/17) 004 SWBTB (07/17) 005	**HK**
1000h	6c	To: (c) receive the update of the **Quality and Safety Committee** meeting held on 30th June 2017 (d) receive the minutes of the **Quality and Safety Committee** meeting held on 26th May 2017	Tabled SWBTB (07/17) 006	**OD**
1005h	6d	To: (a) receive the update of the **Finance & Investment Committee** meeting held on 30th June 2017 (b) receive the minutes of the **Finance & Investment** meeting held on 31st May 2017	Tabled SWBTB (07/17) 007	**MP**
	MATTERS FOR APPROVAL OR DISCUSSION			
1010h	**7.**	**Chief Executive's Report**	SWBTB (07/17) 008	**TL**
1025h	**8.**	**13 week plan**	SWBTB (07/17) 009	**TL**
1035h	**9.**	**Business continuity: Board review of operational plans**	SWBTB (07/17) 010	**RB**
1100h	**10.**	**Trust Risk Register**	SWBTB (07/17) 011	**KD**
1110h	**11.**	**DNACPR and DoLS**	SWBTB (07/17) 012	**RST**
1130h	**12.**	**2016/17 Never Events actions: status**	SWBTB (07/17) 013	**KD**
1140h	**13.**	**Never Event: Update**	SWBTB (07/17) 014	**RST**
1155h	**14.**	**Consistency of Care Programme: progress report**	SWBTB (07/17) 015	**KD**
1205h	**15.**	**Safety Plan: progress report**	SWBTB (07/17) 016	**EN**
1215h	**16.**	**Annual Report on the Implementation of Medical Appraisal**	SWBTB (07/17) 017	**RST**
1220h	**17.**	**Patient stories to the Board – wider learning**	SWBTB (07/17) 018	**EN**
1230h	**18.**	**Production Plan: June position**	SWBTB (07/17) 019	**RB**
1240h	**19.**	**Integrated Performance Report**	SWBTB (07/17) 020	**TW**
1255h	**20.**	**Finance Report: PO2 May**	SWBTB (07/17) 021	**TW**
	21.	**Application of the Trust Seal**	SWBTB (07/17) 022	**KD**
	UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS			
1310h	**22.**	**Minutes of the previous meeting and action log** (a) To approve the minutes of the meeting held on 1st June 2017 as a true and accurate records of discussions (b) Update on actions from previous meetings (action log)	SWBTB (07/17) 023 SWBTB (07/17) 024	**Chair** **KD**

Time	Item	Title	Reference Number	Lead
		MATTERS FOR INFORMATION		
	23.	**Any other business**	Verbal	**All**
	24.	**Details of next meeting** The next public Trust Board meeting will be held on **3rd August 2017 starting at 09:30am** in Training Room 2, Archer Ward, Rowley Regis Hospital		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MAJOR PROJECTS AUTHORITY SUMMRY	
Date	23rd June 2017
Attendees	Mr Toby Lewis, Mr Tony Waite, Mrs Raffaela Goodby, Mr Alan Kenny, Mr Mike Hoare (Chair), Dr Stedman and Mr Mark Reynolds
Apologies	Apologies were received from Mr Samuda, Mr Waite and Ms Barlow Mr Hoare was chairing the meeting Mr Samuda's behalf
Key points of discussion relevant to the Board	Taper Relief - Trust has secured £22.3million of taper relief to be received over a 4 year period (2016-2020), and has been successful in recovering the £3.0m income profiled to 2016/17. The finance team are working to secure an appropriate taper relief for 17/18. Distribution strategy specification - DHL proposition has been received and is now proceeding. Revised Charter Manager timescale - Timescales have been amended and all managers will be up to level 1 standard in 5 key models by Q4. E-Docs go live decision update - Case note scanning project went live on 20th June. User feedback has been good. However issues have arisen relating to the external providers interlinking with each other. People Plan - Scorecard Programme - Scorecard programme was approved by the committee. BTC draft design - Mr Kenny went through the plans in detail. Work is commencing to reallocate fracture clinic and therapy services into the BTC.
Positive highlights of note	Committee congratulated Mrs Goodby and her team for winning at the HPMA awards for health & wellbeing
Matters of concern or key risks to escalate to the Board	• Tape Relief update • Distribution strategy • CDA – EPR status • Summary of homeless project
Matters presented for information or noting	
Decisions made	
Actions agreed	As above

Mike Hoare
CHAIR OF THE MAJOR PROJECTS AUTHORITY MEETING
For the meeting of the Trust Board scheduled for 6th July 2017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Major Projects Authority Committee Minutes

Venue Anne Gibson Committee Room, City Hospital **Date** 28th April 2017 1230-1400

Members Present:		**In attendance:**	
Mr Mike Hoare	Non-Executive Director (Chair)	Mr Dean Harris	Deputy Chief Informatics Officer
Mr Toby Lewis	Chief Executive	Miss Claire Wilson	Executive Assistant
Mr Alan Kenny	Director of Estates and New Hospital		
Mr Tony Waite	Director of Finance and Performance Management		
Dr Roger Stedman	Medical Director		
Ms Rachel Barlow	Chief Operating Officer		
Ms Raffaela Goodby	Director of OD		

Minutes	**Paper Reference**
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 Reynolds. The members present did not have any interests to declare.	
2. Minutes of the previous meeting	**SWBMPA (04/17) 002**
The minutes of the previous meeting held on 24th February 2017 were agreed as a true record.	
3. Matters arising (action log)	**SWBMPA (04/17) 003**
Mr Waite described the work being done on taper relief. He noted the desire of committee members to confirm the non-discretionary items and therefore to be able to make choices about the balance of available funds. He undertook to have a finalised version ready for the July meeting. Mr Lewis accepted that the land sales committee had yet to meet and that the action to organise this sat with him. The committee has been constituted by the Board and would meet to advise the Board on a final decision in relation to Infirmary Wharf.	
3.1 Distribution strategy for Midland Met	**Verbal**
Mr Waite explained that work has been undertaken and a plan is in place working backwards from October 2018. There is a 12 month implementation plan which is currently on track and that we are due to receive a proposal from DHL next week in their capacity as NHS supply chain key partner. Mr Lewis asked about the DHL proposition. Mr Waite explained they are planning to separate out the diagnosis and development including an optional appraisal.	

Mr Hoare asked if the timelines aligned with the savings that need to be met within MMH. Mr Waite agreed that was necessary but clarified they have not identified what the actual savings opportunity would be. Mr Lewis asked that by the next meeting they have an update on the diagnosis and development phase.

Action:

- update on diagnosis and development phase for distribution strategy (TW)

3.2 Governance of land sales	**Verbal**

Item not discussed because covered under matters arising.

4. Capital plan for the estate **4.1 Equipment funding**	**SWBMPA (04/17) 004**

Mr Kenny noted that he had been asked to look at alternative ways for funding as it is unlikely to be achievable through charitable sources. The plan for the funding and the plan for the charity was not aligned. Mr Hoare challenged the data for the reduction in the overall need. Mr Waite explained the figures and agreed to rectify the data to show where the impact is by funding stream. Mrs Goodby asked for clarity around the comments in the paper about reducing the burden on charitable funds. She explained that her understanding was it relates to identifying what was appropriate to be sourced from charitable funds and that the burden was the expectation to use charitable funds money.

Dr Stedman explained they have been through the medical equipment list. Mr Hoare asked if there were any clinical safety issues. Dr Stedman explained he considered the arrangements acceptable, with the removed items either being deferred or obviated.

Mr Lewis asked about the asset register and what information is being recorded. Dr Stedman stated that he has seen the register and that it states by year when the replacement are due.

Action:

Data in current position table to be rectified to show where the impact is on the funding stream (TW)

4.2 STC design sign off	**SWBMPA (04/17) 005**

Mr Kenny explained that meetings have been held throughout March and April with representatives from each of the Trust's Clinical Groups, Directorates & Specialty services and NHP & Estates managers. The meetings have enabled service needs to be confirmed, schedules of accommodation to be prepared and designs and layouts to be developed. Where necessary designs have been further developed and been re-issued for final comments. This interactive process will continue during April and May to enable designs to be signed off.

Action:

STC and BTC phase plans to be presented at next meeting to ensure no staff are left 'homeless' (AK)

5. People plan **5.1 2017-18 delivery milestones**	**SWBMPA (04/17) 006**

Mrs Goodby explained the People Plan is one of the Trust's enabling strategies (along with Estates and Digital) that will support SWBH to deliver the 2020 Vision. The People Plan development process has included the development of a balanced scorecard that outlines the KPI's the People Plan will achieve. The key performance indicators (KPIs) are mapped directly to the 5 key themes of the People Plan and to the individual initiatives and projects in place aimed at delivery of the required outcomes.

Mr Hoare asked who is monitoring the progress of these objectives/KPIs. Mrs Goodby explained she is the overall lead and that there is a people plan board in the PMO room at Sandwell that is revised weekly.

Mr Lewis asked about the timeframe for the chartered manager programme, as it shows it will take 3 years for all line managers to be signed up and that we will not have accredited managers for 3 years, and how this incorporates into the people plan. Mrs Goodby explained that there roll out was devised around other projects that are being rolled out in month one (ie PDR & EPR). Mr Lewis asked for the timeframe to be reviewed for programme.

Action:

- **Timeframe of chartered manager programme to be reviewed to see if can be completed sooner (RG)**

6. Digital plan

Dr Stedman explained there are 6 work steams commencing which are:
Digital plan

- Infrastructure
- Security
- EPR
- Digital delivery
- Collaboration
- MMH IT

Mr Lewis challenged the governance process which had produced the documents and also questioned ratings of AG where in essence the authors had no detail. Dr Stedman accepted that a more robust scrutiny processes was needed and outlined changes within the Digital Committee designed to make it less 'insular'. Mr Lewis drew the MPA's attention to his Board papers on governance.

Infrastructure

Mr Harris explained that they have purchased a new switch lead which will help significantly with the IT issues and will increase our system performance by 50%. There will be no downtime for the changeover and there will be no impact on any tests or any validation required. Ms Barlow asked if there are any other issues that have not been diagnosed that we need to be aware of. Mr Harris stated he did not believe so but the process was an iterative one and sp he could not give an absolute undertaking.

Action:

- Digital governance model to be refreshed to ensure issues are being highlighted and resolved (RS)

6.1 Scorecard — **SWBHMPA (04/17) 007**

Dr Stedman explained that the validation event occurred this week and there has been good clinical and non-clinical representation. The 3 main areas of focus are IT, business readiness and staff/user awareness.

One item that has raised concerns is the capacity/readiness of Cerner to respond to our needs. Dr Stedman stated when he has challenged previously with their resourcing they responded with excuses. Discussion commenced about contract management and that traction is not been received from the company.

Mr Hoare asked about the risk and timescale to the delivery. Dr Stedman explained there is an impact on the final configuration and that there is a disconnect between what is being asked for and what is being delivered which is impacting on the timescale of the project. Mrs Goodby asked if a log was being kept of the issue encountered by Cerner. Dr Stedman confirmed there was and it was being kept by the project lead.

Action:

- Discussion about Cerner's performance to commence and Gateway payments to be withheld (RSt)

6.2 E-Docs go live decision	**SWBMPA (04/17) 008**

Mr Lewis explained that the issues were discussed in depth at the development sessions last week and some work has taken place and the item will be reviewed at next week's private board meeting. On that basis the subject was deferred.

6.3 Gateway review	**SWBMPA (04/17) 009**

Mr Lewis explained the detail of the paper and that he has made some changes to the initial action plan. He will oversee the process with the owners of the actions. The two most time consuming actions will be getting the documentation into the trust standard format and how we get digital and "the organisation" to link into each other.

The Gateway Plan was agreed.

Action:

- Program documentation to be devised and reviewed at forthcoming meetings (MR)

7. Meeting effectiveness	**Verbal**

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

8. Matters to raise to Board/Audit and Risk Management Committee	**Verbal**

The committee agreed for the following actions to be raised at the May 2017 Trust Board Meeting:

Land disposal

Mr Kenny explained that there is a compliant bid, and that the land sales committee of the board needed to meet.

STC sign off

Mr Lewis asked for STC phase plans to be presented at the next meeting to show how the transition will commence. BTC design phase to be completed to ensure no staff are left 'homeless'. The committee agreed to sign off the STC as is with further updates and refinements required.

People plan

The committee agreed to look again at the timeframe for the chartered manager programme as it is currently 3 years before all managers are accredited.

Gateway review

The gateway review was presented and Mr Lewis noted work being undertaken on digital governance. Mr Waite will become involved in the management of the Cerner contract.

9. Any Other Business	**Verbal**

Mr Lewis asked for an in-depth discussion at the next meeting around STC/BTC phase plans and an update on digital plan.

The next meeting will be held on 23rd June 2017 at 09:30am in Anne Gibson Committee Room, City Hospital.

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE UPDATE	
Date of meeting	26TH June 2017
Attendees	Mr Harjinder Kang (Chair); Mrs Raffaela Goodby; Mr Toby Lewis, Mr Richard Samuda; Mrs Fiona Shorney; Ms Zoe Huish; Miss Yulander Charles
Apologies	Apologies were received from Mrs Elaine Newell and Ms Rachel Barlow.
Key points of discussion relevant to the Board	The key areas of focus were: • **Workforce Consultation 16-18 update** • **Aspiring for Excellence rollout** • **Guardian of Safe working update**
Positive highlights of note	**Workforce Consultation 16-18 update –** There has been significant progress to date around redeployment with regards to the Summer 2016 workforce consultation. Since out last report there is a balance of 18 people in the process of commencing/completing trials in new roles and only 6 employees without suitable offer of alternative employment. The team are working closely with Staff side and have been able to positively iron out any potential issues. Work is also being done to strengthen our working partnership with GPs by assisting them to focus on different ways of working. Our success has been noted within the region as many trusts are now turning to us for advice. **Aspiring for Excellence rollout –** The roll-out of the new performance and development review framework as begun across the trust. To date just over 500 line managers plus Medical line managers have been trained in the new programme with a further 400 due to complete training by the end of July. Positive feedback have been received from the sessions highlighting the; ease of the new paperwork; the platform it gives in supporting consistency for target setting; the training sessions providing managers with the opportunity to network and share views and experiences. Staff have also been encouraged to take part in the training as to date nearly 1500 have participated. To increase exposure training materials will be circulated directly to staff via email and leaflets will be attached to the July payslip for all staff with opportunity to attend drop-in sessions. **Guardian of Safe working update –** This is the first report overview on the 2016 Junior Doctors contract implemented by the Trust to date. This new contract replaces the hours monitoring process of the 2020 terms and conditions with a process of individual exception reporting for doctors when they work beyond their contracted hours. The GOSW can impose fines if specific breaches of the Terms and conditions of Service (TCS) occur where doctor safe working has been compromised. In

	comparison to other local trusts to date there has been no fines levied to the Trust for serious breaches in hours.
Matters of concern or key risks to escalate to the Board	• None
Matters presented for information or noting	• None
Decisions made	
Actions agreed	No specific additional actions beyond those being progressed by management. Next meeting: 25th September 2017.

Harjinder Kang
Chair of People & Organisational Development Committee
For the meeting of the Trust Board scheduled for 6th July 2017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE MINUTES

Venue: D29 Meeting Room, City Hospital **Date:** 17th March 2017, 0900-1030hr

Members Present:
Mr Harjinder Kang, Chair (HK)
Mr Richard Samuda, Non-Executive Director (RS)
Mr Toby Lewis, Chief Executive (TL)
Mrs Raffaela Goodby, Director of OD (RG)

In Attendance:
Ms Lesley Barnett, Deputy Director of OD (LB)
Ms Gemma Towns, Head of Corporate Governace (GT)

Minutes	Paper Reference
1. Welcome, apologies and declarations of interest	**Verbal**
Apologies were received from Ms Rachel Barlow and Ms Elaine Newell.	
2. Minutes of the previous meeting	**SWBWOD (03/17) 002**
The minutes of the meeting held on 9th December 2016 were agreed as a true record.	
3. Matters arising from previous meeting, 9th December 2016	**SWBWOD (03/17 003**

(a) Minute 4, Workforce Consultation: Mrs Barnett confirmed the ED workforce review pilot had concluded in October 2016. Mrs Barnett confirmed that the pilot of shifts ending at 3pm had not worked and as a result shift patterns had been changed to conclude at 6pm. This action was marked as closed on the log.

(b) Minute 4, medical bed reduction scheme: Mrs Goodby confirmed this had been presented to the Trust Board. The matter was marked as closed on the log.

(c) Minute 4, Security Scheme: Mr Lewis confirmed he had rejected the scheme and asked for further information. The scheme had not proceeded due to 1) restraint – Mr Lewis had agreed this issue - , 2) paid vs unpaid breaks and, 3) 8 hour or 12 hour shifts. Mrs Barnett confirmed that this scheme remained open. The Committee directed that due to the length of time that had passed without resolution that Mr Lewis and Mrs Goodby met with the Deputy Director of Facilities and Head of Security to discuss and close this matter. Mr Lewis advised that he wished to move away from a seven day night pattern as this was not good practice. The matter remained open with a revised action.

(d) Minute 6, E-rostering, Thornberry usage: Mr Lewis confirmed that Thornberry usage for HCA had been switched off and a date will be submitted shortly for turning off Thornberry usage for nurses. The Committee discussed the recent and the upcoming reduction in the Trust Bank hourly rate. Mr Lewis suggested it may be useful for the Black Country Alliance (BCA) to jointly agree to cease Thornberry use. Mr Lewis and Mr Samuda agreed to raise this matter at an upcoming BCA meeting. The Committee discussed the reasons for Thornberry usage and Mrs Goodby outlined the process for booking Thornberry staff. This matter was marked as closed on the log.

(e) Doctors' sickness absence reporting: Mrs Goodby agreed to circulate information on this matter outside of the meeting. She confirmed there had been an increase in the number of Doctors reporting sickness absence. Mrs Goodby confirmed the process for Doctors was the same as the rest of the organisation.

(f) E-rostering, booking robustness: This matter has been closed.

There were no other matters arising.

ACTION:

- **Security: Meeting to be arranged between TL, RG, Deputy Director of Facilities and Head of Security to discuss and close this matter (TL)**
- **Thornberry: TL and RS to raise at a BCA meeting a proposal for BCA members to cease using Thornberry (TL)**
- **Doctors' sickness absence: Information to be circulated outside of the meeting (RG)**

4. Workforce consultation 16-18	**SWBWOD (03/17) 004**

Mrs Goodby confirmed that excluding medical records staff, eleven staff members did not have redeployment solutions. Mrs Barnett advised that twenty three medical records staff required redeployment. She clarified that all medical records staff could not have been re-deployed at the same time as the department was still operational. The medical records scheme will close in July 2017. Mrs Barnett advised that the OD team were working with medical records staff to upskill them for redeployment. The OD team were also working with Trish Kehoe, Head of Health Care Records, to develop each staff member's individual plan. The Chair asked how active the BCA were in sharing suitable vacancies; Mrs Goodby advised that some of the affected staff worked specific hours and were local to a hospital site resulting in a vacancy at a neighbouring Trust being possibly unsuitable for this cohort. Mrs Goodby confirmed that redundancy will not be considered until all alternative avenues had been exhausted. The Committee requested the cost of redundancy for the affected staff members was identified and shared with the Committee. Mr Lewis clarified that the cost of non-medical records staff had been accounted for in the 16/17 financial year and medical records staff will be accounted for in the 17/18 financial year.

The Committee were of the view that focus should be placed on the 2018 workforce review consultation (phase III) including reflecting on lessons learned from phases I and II of the workforce consultation review. Mrs Goodby confirmed that the Trust had improved its workforce consultation review processes and had improved communication with staff. Mr Lewis was of the view the actioning of proposed changes, such as the security review, required further improvement before phase III of the consultation was engaged. Mr Lewis advised that over the next ten days he would make a decision on residual vacancies, guided by Mrs Goodby on if those vacancies existed and if they did, on a solution to the issue.

The Board received the report.

ACTION:

- **Cost of redundancy for affected staff to be identified and shared with the Committee (LB)**

5. People Programme	**SWBWOD (03/17) 005**

Mrs Goodby advised she was working with the PMO team and identifying the outcomes and benefits of the People Plan. The mapping process was due to close and infographics will be provided to communicate to staff the key messages of the People Plan. Mr Lewis requested the work with the PMO was completed by May to enable dissemination to staff at the Leadership Conference. The Committee noted the importance of the new PDRs to the People Plan. The Committee discussed compulsory organisational-wide objectives in PDRs and Mrs Goodby stated these should be used minimally.

Mr Lewis suggested a heat map/scorecard which visually identified People Plan data for this Committee and the Major Projects Authority Committee should be provided to ensure the People Plan retained prominence with EPR and the Midland Met Hospital (MMH). Mrs Goodby agreed to return a paper to the next meeting, noting this was separate to the infographics to be provided by the PMO. The Committee noted that the same data may be presented

to each Committee but with different purposes.

The Committee discussed the SWBH Chartered Manager scheme. Mr Lewis advised that a complaint from managers may be that they are not always given time to manage staff. Mr Lewis suggested it was identified which of these roles should not manage staff due to other conflicting responsibilities. The Committee also discussed how staff often managed upwards which was not desirable. The Committee noted the opportunities the People Plan presented to the Trust and enhance management skills.

The Board received the report.

ACTION:

- **Heat map/scorecard to visually identify the data for the Committee and the MPA Committee to be provided (RG)**

6. Aspiring for Excellence rollout	**SWBWOD (03/17) 006**

Mrs Goodby advised that the paper had been updated since the March 2017 Trust Board meeting. The approach to training had been revised to fewer but larger scale events to bring together staff and provide the launch with greater visibility within the Trust. Staff training will be completed during Q1 and Q2 with a mixture of internal and external training delivery.

Mrs Goody confirmed there will be two PDRs for Doctors with the Trust PDR conducted first. Mrs Goodby advised that some of the objectives could be shared between both PDRs. The Committee discussed the cultural change for Doctors associated with the Trust's focus on behaviours. The Committee discussed the link between MMH and 24/7 working; the Committee were of the view the objectives set through PDRs will help prepare staff for a different way of working.

The Committee discussed the content of the PDRs and the need to ensure the paperwork was succinct and easy to complete, noting that the user-friendliness of the PDR will be critical to its success. Mrs Goodby confirmed the PDR paperwork will be clear and examples included. The Committee discussed the language of the descriptors, noting this will be of importance to managers when interpreting the scores for their staff.

The Committee discussed the performance scores. The Chair suggested that examples of behaviour for each of the scores should be provided and anticipated that the majority of staff would score in the middle, noting that was an acceptable performance level. The Chair suggested consideration was given to staff scoring the highest and how those staff members could be retained. The Committee noted that performance will be reviewed annually and the PDRs should make it clear to staff that performance could be impacted by complacency. The Committee requested that training was both practical and informative.

The Committee received the paper.

7. Consequences	**Verbal**

Mr Lewis confirmed he had discussed the matter with the Executive Group and a paper will be returned to the May 2017 Trust Board meeting. Further consideration will be given to a remuneration strategy which will be linked to performance.

8. Progress on recruitment	**Verbal**

(a) Senior team recruitment: Mrs Goodby advised that Mr Pollitt had retired from the Trust but will return in April 2017 to take on a role with a focus on operational delivery of the People Plan. Mr Pollitt's vacated role had been refreshed to encompass Learning and Development, Equality and Diversity and SWBH benefits. Bethan Downing had been appointed as the Deputy Director, Organisational Development and Learning on

15th May 2017. The Committee requested a paper was presented to the next meeting identifying which senior staff members will be responsible for the strands of the People Plan.

(b) Nursing recruitment: Mrs Goodby confirmed that 157 out of 230 vacancies had been filled: 72 students had been offered roles, 36 vacancies had already been filled, 36 job offers had been made at a recent recruitment fair and 13 band 6 nurses had been recruited. Mrs Goodby confirmed the recruitment campaign for nurses continued. Mrs Goodby advised that whilst it was promising that offers had been made the focus needed to be on ensuring those nurses started at the Trust and were inducted. A number of engagement sessions will be held for new starters and open to existing staff. New nursing staff will be joining immediately and throughout the coming months with a larger student cohort joining in September/October. Mr Lewis asked that communications with the new starters were timed around existing events to ensure a consistent message.

ACTION:

- **Paper to be presented to the June 2017 meeting identifying which senior staff will be responsible for strands of the People Plan (RG)**

9. Matters to raise to the Board and Audit & Risk Management Committee	**Verbal**

The Committee wished to raise the following matters to the Trust Board:

- Workforce Consultation: There were a small number of staff members who had yet to be redeployed.
- Nursing recruitment: The Committee noted the good progress made to fill nursing vacancies and the plans to ensure nurses started working at the Trust and benefited from a structured induction programme.

10. Any other business	**Verbal**

There were no items of any other business.

11. Date and time of next meeting	**Verbal**

The next meeting will be held on 26th June 2017 at 1530 – 1700h, D29 meeting room, City Hospital.

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE MINUTES

Venue Anne Gibson Committee Room, City Hospital **Date** 26th May 2017, 1030h – 1200h

Members attending:

Ms. O. Dutton	Chair and Non-Executive Director
Mr. M. Hoare	Non-Executive Director
Ms. R. Barlow	Chief Operating Officer
Miss K. Dhami	Director of Governance
Dr. R. Stedman	Medical Director
Mr. T. Waite	Director of Finance

In attendance:

Ms. D. Talbot	Associate Director of Nursing
Mrs. S. Cattermole	Executive Assistant

Minutes	**Paper Reference**
1. Welcome, apologies for absence and declarations of interest	**Verbal**

Apologies were received from Mr. Samuda, Ms. Parker and Ms. Newell. The members present did not have any interests to declare.

2. Minutes of the previous meeting	**SWBQS (05/17) 002**

The minutes of the meeting held on 28th April 2017 were agreed as a true record.

3. Matters and actions arising from previous meetings	**SWBQS (05/17) 003**

a) Minute 7 : Mortality reviews for vulnerable patients : Dr. Stedman reported that there is a renewed approach for mortality reviews that forms part of the wider vulnerable patient issues – a report will be bought back to the June 2017 Q&S meeting.
b) Minute 6 : Transition patients – closed, agenda item.
c) Minute 7 : Integrated performance report – puerperal sepsis data – closed, agenda item.
d) Minute 7 : Integrated performance report – clinic cancellations and plans for performance improvement – closed, agenda item.
e) Minute 7 : Integrated performance report – SOP's for new indicators – item not discussed.
f) Minute 6 : Quality Account – Miss Dhami to speak to Ms. Wilkin about them being printed in other languages – item not discussed.
g) Item 9 : Clinical Audit – DNACPR – closed, agenda item.

3.1 Puerperal Sepsis Data [SWBQS (05/17) 004] : Dr. Stedman confirmed that a recent 'look back' exercise in Q3 2016/17 of the puerperal sepsis, indicated that the Trust was over diagnosing (and treating) sepsis in view of the high number of low risk, labouring women being treated on the sepsis pathway and then, neonates requiring prophylactic IV antibiotics. A review of the sepsis pathway identified that the thresholds for trigger were too low. Ms. Dutton queried if this would require extra training and Dr. Stedman confirmed that staff are being made more aware via the use of screening tools. Audits are carried out via the audit tool that is built into the sepsis pathways in the new EPR system at the push of a button. The outcome of the three wound infections in February was explained and the actions being taken to reduce factitious reporting were considered.

3.2 Clinical cancellations and plans for performance improvements: Ms. Barlow informed committee members that the

planned A&E improvements were on track. She expressed confidence in the designed interventions but said that it would come down to behaviours to deliver the required target achievements. The new Deputy COO for Planned Care is in post and will look at cancellation information more closely. Ms. Dutton asked about the effects on A&E improvements when patients are given a wider choice of appointments and was informed that this would affect statistics as patients are allowed to move their appointments as many times as they wish, however this will be taken into account when looking at pathways and patient treatment. A comprehensive report to be brought back to August Q&S meeting.

ACTION : A comprehensive report on clinical cancellations and plans for performance improvements to be brought back to August Q&S meeting.

4. Patient story for the May Trust Board	**Verbal**

In the absence of Ms. Newell, Ms. Talbot advised that the patient story that will be going to the Trust Board in June is a patient who was cared for on Priory 2. His story covers his initial admission as an acutely unwell patient, his experience being cared for on Critical care and the ward, including the management of his pain control, his interactions with the MDT and the highs and lows of his experience on the ward as a long stay patient. His story consists of both good aspects of care and aspects of care he feels we can improve on. He has discussed these with the team and relate to his experience as a long stay patient on the ward and the communication and dialogue with the consultant as he at times felt frustrated that nothing was happening with his care when actually things were being planned but not clearly communicated with him. He has identified good practices and areas of improvement and would like to share these with the Board.

5. Safety Plan Update	**SWBQS (05/17) 005**

Progress in implementing the Safety Plan across the Trust was presented by Ms. Talbot, including feedback on the roll-out onto the medical wards. Examination of the ward compliance data raised questions over the robustness of the methodology being applied. Following a query from Ms. Dutton, members were informed how the buddies were handpicked based on their background and specialist area of work. There is a lot of work being done on the Buddy Network Plan Roles which will be supported through Action Learning Sets that are being implemented as they will be needed later in the year for the Digital Plan roll out.

Limited attendance by the 'buddies' at a recent Safety Plan training event raised concerns about dependency on this role to support this Plan, Red to Green and Consistency of Care. To help with this, training will be provided via a 5 minute training video being used at QIHD and Doctors induction. The team are planning in advance to obtain logging details ie NHS mail addresses are sourced and an example template with a step by step guide is provided. The process has now been simplified to aid this work. The Comms Team are setting up link to engaging with staff and inform them what the Safety Plan is about.

EDD and ward compliance stats were discussed and explained. The team are looking at diagnostic codes, predicting EDD based on what happens and amending accordingly. EPR– work is taking place to include this in admission/discharge. Care plans will be looked at in MDTs and specialties advised to discharge. Examination of the ward compliance data raised questions over the robustness of the methodology being applied. The immediacy of response to non-compliance with an 'always event' was unclear. Queries were raised about how mistakes are corrected. The reply given was that the staff member is spoken to immediately and isssues are dealt with at local level and route-cause analysis work is looked at via MDTs and staff huddles. It was agreed that work needs to be done on a trajectory of improvement and consequences if work is not carried out. Ms. Talbot agreed to put a team of staff together to work on this and report back to Ms. Newell.

Ms. Talbot confirmed that the July items committed were on plan, with us now at the stage of evaluating PDSA1 and starting PDSA2 wave.

A follow-up report from the Chief Nurse was requested for the next meeting.

6. DNACPR Audit Findings and Response	**SWBQS (05/17) 006**

Dr. Stedman outlined the DNACPR Audit findings and response which showed that the altered Resuscitation Status' have been poorly documented previously. The audit has reviewed in depth the quality of the documentation and the completion

of the forms. There is an increase in compliance of documentation and assessing capacity, however there is uncertainty as to when the decision is being made. The audits showed a continuing problem of not always recording assessments of patients' mental capacity and not documenting that discussions with family members have taken place where patients lack capacity. A change to valid best interest decision needs to be made and to explore the best interest question. A plan to address the concerns and how to implement the best interest training is to be presented to the Committee in June, with a re-audit to follow when the measures are in place.

ACTION : A plan to address the concerns to be presented to the Committee in June, with a re-audit to follow when the measures are in place.

7. Transition Services Progress Report	**SWBQS (05/17) 007**

Dr. Stedman presented the gap analysis that has been updated to include data on Dermatology, Gastroenterology and Neuro-disability. The Trust-wide transition guidelines have been approved and are now on the intranet and have been sent to all Clinical Directors for dissemination within their directorates. The CYP champion has presented the pathway at the Paediatric QIHD and Sandwell and City hospital Grand Rounds. Ophthalmology has identified key workers for Transition and are further improving their pathway. Returns have now been received from all services. Asthma care was highlighted in a recent Child death overview annual report and a working group is being set up to look at the transition care of paediatric asthma patients that come into the hospital via ED. A query was raised about what happens to students; it was agreed that they would be taken into account by networking with the University and Primary Care.

8. Integrated Performance Report	**SWBQS (05/17) 008**

Mr. Waite reported that a response for dealing with the quality indicators that have consistently failed to meet the set performance targets is being discussed at the next Exec Meeting. Items briefly discussed included :

- Safeguarding Training – Children level 3 below agreed trajectory as is adult advanced; RAP for A&E and Diagnostics agreed but still show as not achieving. Safeguarding e-learning options and levels of training are being looked at. Mr. Waite confirmed that he is waiting on the trajectory to deliver the plan.
- Neutropenic Sepsis – there have been improvements on prior months but it remains below 100% standard with 25% of patients not receiving treatment within the required 1 hour timeframe.
- Hip Fractures – best practice tariff performance in month worsened to 41% from last month at 91.3% caused by 13x NOFs in one day plus elevated trauma lists**. Ms. Barlow to explain why this had such an affect at the next meeting.**
- Pressure Ulcers – discussions took place regarding the 'eradicate campaign.' Any first sign of redness, the Tissue Viability Team attend and look at the patient care plan.
- Mixed sex accommodation – all information is authorised by Ms. Barlow. The urgent care flow statistics were explained. Ms. Barlow confirmed that she is carrying out walkabouts with Ms. Parker over the next few weeks.
- The complaints data was briefly discussed.

ACTION : Ms. Barlow to explain the impact of the 13 x NOFs in one month at the next meeting.

9. 2016/17 clinical audit plan outturn report	**SWBQS (05/17) 009**

Miss Dhami outlined the 2016/17 clinical audit plan outturn report compliance status. There were two good compliance reports and thirteen partial compliance reports. The outcome information has not yet been received for two reports and there were three poor compliance reports. These are for Individualised patient care, Fluid Balance Charts and the Deteriorating patient – Early Warning Score. Actions to improve compliance have been identified. Queries were raised on how the compliance status fits in with the Safety Plan. The Safety Plan is a key element of the care and treatment plan for all compliance reports and improvements should be seen in the next audit round.

10. Monthly Serious Incident report	**SWBQS (05/17) 010**

Dr. Stedman updated the committee members on a recent Never Event that occurred on Wednesday (24th) involving a wrong side block on an orthopaedic patient in theatres at Sandwell. The Group Director of Surgery, Ajai Tyagi, will attend the

Board on Thursday (1st June) to explain why controls put in place following a similar incident in 2015 failed.

11. 2016/17 Complaints and PALS Report	**SWBQS (05/17) 011**

Miss Dhami outlined the details of the Complaints and PALS enquiries received between 1 April 2016 and 31 March 2017. The report provided high level data on PALS and Complaints, the reasons those complaints were made and work underway to improve complaints management.

In this year, it is reported that the complaints activity has increased, from 935 to 1026, and also shows that 81% (at the time of reporting) of complaints have been managed within their target date. This was a reduction on the previous year where a 93% response rate had been achieved. The main reasons for the deteriorated performance this year was attributable to a planned workforce re-organisation within the Governance Team and completing priorities within the Clinical Groups. Themes and outcomes remain consistent with previous quarters and show a continued focus on lessons learned, and quality responses that are caring, transparent, timely and responsive to the needs of complainants.

The goal set for 2017/18 is to achieve a 97% response rate.

Highlights will be presented at the Trust Board meeting.

12. Meeting effectiveness	**Verbal**

The meeting discussions were felt to be useful and constructive; however the forward plan needs more assurance.

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

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

- **Consistent reds on IPR data**
  A response for dealing with the quality indicators that have consistently failed to meet the set performance targets is being discussed at the next Exec Meeting. Items briefly discussed included Safeguarding Training, RAP for A&E and Diagnostics, Neutropenic Sepsis, Hip Fractures, Pressure Ulcers, mixed sex accommodation and Complaints data.
- **2016/17 Clinical Audit Plan Outturn Report**
  Compliance status discussed. 2 good compliance reports, 13 partial compliance reports, outcome information not yet received for 2 reports and 3 poor compliance reports. These are for Individual patient care, Fluid Balance Charts and the Deteriorating patient – Early Warning Score. Actions to improve compliance have been identified.
- **Monthly Serious Incident Report**
  A Never Event occurred on Wednesday (24th) involving a wrong side block on an orthopaedic patient in theatres at Sandwell. The Group Director of Surgery, Ajai Tyagi, will attend the Board on Thursday (1st June) to explain why controls put in place following a similar incident in 2015 failed.

14. Any other business	**Verbal**

No other items were called out for discussion.

Next meeting: 30th June 2017 at 8.30h in the Anne Gibson Committee Room at City Hospital. Members were asked to accept the change to the time in their diary.

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FINANCE & INVESTMENT COMMITTEE MINUTES

Venue: Meeting Room 2, Trust Headquarters, Sandwell Hospital

Date: 31st May 2017, 1300h – 1400h

Members present:

Mr Richard Samuda	Chairman
Mr Tony Waite	Director of Finance

In attendance:

Mr Tim Reardon	Associate Director of Finance
Mrs Elaine Quinn	Executive Assistant

Minutes	**Paper Reference**
1. Welcome, apologies and declarations of interest	**Verbal**
The Chair welcomed all to the meeting. Apologies had been received from Ms Barlow, Mrs Goodby, Mrs Perry and Mr Kang. The members present did not have any interests to declare.	
2. Summary notes of the teleconference held on 3 May 2017	**SWBFI (05/17) 002**
The summary notes of the teleconference were agreed as a true record.	
2.1. Matters arising and update on actions from the previous meetings	SWBFI (05/17) 002(a)
The Committee noted the updated action log and that all outstanding actions had been closed. Mr Waite agreed to send to Mr Samuda a copy of the waterfall chart that detailed the key reasons behind the failure of a plan to secure a £6.6m surplus and an outturn deficit of £12m. This had been submitted to the May meeting of the Trust Board. [Action complete] Mr Samuda queried the CCG £3.5m data challenges raised latterly in 2016.17 by the CCG. Mr Waite confirmed that in finalising the accounts for 2016.17 no diminution in income had been recognised in respect of these challenges despite the absence of a full and final settlement for the year. This was on the basis that the trust and CCG had declared to respective regulators trust income which aligned to CCG recognised expenditure. The draft contract for 2017.19 has resolved those data challenges which related to non-PbR based activities. The trust should anticipate routine data challenges in respect of PbR based activities consistent with the CCG's transactional approach to contract management and QIPP.	
3. Financial Performance – P01 April 2017	**SWBFI (05/17) 003**
Mr Reardon reported that the P01 headline performance was as per plan but had been reliant on significant unplanned technical support. The STF income had been assumed as earned for P01, although it was noted that consistent P&L delivery to plan and ED 4hr remediation to 90% by June for the performance component would be required to confirm that was a sound assumption. The capital expenditure programme was noted as being pursued as plan although subject to review having regard to MMH delay. CRL remained to be confirmed by NHSI, with dialogue on-going.	

Cash borrowing requirements were subject to routine assessment. A loan review and application meeting had been scheduled with NHSI for 7th June 2017.

Planned care activity was reported as exceeding plan for April, with consequent income over-recovery on SLA income. Theatre efficiency remained the biggest opportunity for improvement. P01 had relied on over-performance in outpatient activity to cover a shortfall in admitted care.

There had been a reduced agency spend in P01, however, this remained above plan trajectory. The pay bill was noted as £26.4m (vs. £26.5m last month) with agency spend being £1.6m (vs. £1.9m).

There was a discussion in relation to SWBH taking part in a national piece of work with EY, who were currently reviewing the CIPs and engaging with teams to monitor grip and control. The draft phase 1 report was noted as being on the agenda later in the meeting. Phase 2 of the work was due to be concluded the following week. The final draft report was awaited and was to be finalised with the Executive team. Given that phase 3 was a multi-million pounds assignment, the Executive team would give further consideration to the EY proposal to establish the quality of work in terms of subject matter expertise, together with any proposed added value vs. the work the Trust was already undertaking via the PMO office.

4. Cash Remediation	**SWBFI (05/17) 004**

Mr Reardon presented the update on key matters in terms of the cash remediation plan and the consequent impact on the Trust's approach to potential borrowing requirements. He highlighted that March 2017 cash was managed to be compliant with EFL requirements. This was achieved through working capital management and the timing of capital invoices across the year end. That working capital management [creditor stretch & debtor recovery] was consistent with the cash remediation plan and should be sustainable on a forwards basis.

It was noted that significant progress continued to be made in respect of securing enhanced and advanced proceeds of surplus asset disposal. Specifically, relating to the prospective transfer of surplus land at City Hospital to the HCA at a value of c£18.6m [vs. £10m assumed in the financial plan]. It was anticipated that those proceeds would be secured in early Q2 of 2017-18 [vs. Q2 2018-19 in plan]. The prospective receipt of those proceeds in 2016.17 was noted to have revised the Trust's approach to loan finance.

The financial plan assumed draw down of £22.5m of capital loan facilities in 2017-18 and a further £2.0m in 2018-19. Initial draw down of the facility was planned for P04 of 2017-18.

It was now proposed that in the first instance, the Trust would progress an application for a rolling working capital facility of a similar sum. This would be intended to provide cover for any slippage in timing of capital receipt and downside scenarios [e.g. failure to secure STF funding or resolve the £13m savings 'gap' in the 2017-18 financial plan].

The process to secure a rolling working capital facility was noted to remain in progress with NHSI. This operates to a four-week approval cycle. An updated cash flow indicates that due to modest capital expenditure in Q1, a loan is not required in P04 as previously indicated. Confirmation of access to any necessary revenue loan finance is scheduled for June, which provides a four week contingency on the NHSI process.

Any such facility should be at an interest rate of 1% on the basis that the Trust has accepted its financial control total and the financial plan shows an internally funded capital programme.

5. Production Plan	**SWBFI (05/17) 005**

Mr Waite presented the P01 position on the planned care production plan for 2017-18. He reported that activity and income had been delivered ahead of plan. It was noted that there had been a mix of activity for April that differed to that planned. Day case and inpatient activity was noted as below plan, propped up by new outpatient referrals, with follow-ups in line with plan.

Anticipated activity for May was noted to be ahead of plan, although projections were subject to change if slots are cancelled and assumed walk-ins do not happen.

Early June projections are c25,000 units of activity with a value of c£4.7m remain to be booked. This reinforced that further improvement was required in booking on a timely and complete basis, including better compliance with the 8/6/4/2/0 discipline for theatre activity.

6. Financial Improvement Programme – Phase 1 output	**SWBFI (05/17) 006**
The phase 1 output report was received and noted by the Committee.	
7. Matters to highlight to the Trust Board and Audit & Risk Management Committee	**Verbal**
The Committee wished to highlight the following matters: • good progress with the Production plan; • the effective management of the processes necessary to a cash loan; • the financial improvement work being undertaken by EY	
8. Meeting Effectiveness Feedback	**Verbal**
The Committee felt the matters on the agenda were the key matters that it needed to focus its attention on.	
9. Any Other Business	**Verbal**
There were no items of any other business.	
10. Details of the next meeting	**Verbal**
The next Finance and Investment Committee meeting will be held on 30th June 2017 at 1030h – 1200h in the Anne Gibson Committee Room, City Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Chief Executive's Report – July 2017

Public Trust Board

The Trust has completed our assessments of fire risk generally, and of cladding in particular. This repeats the annual cycle of assurance, and similarly identifies no risks to be concerned about. In particular the specific cladding used in Grenfell is not an issue for us, and we altered the issued specification for cladding at procurement for Midland Met to prohibit such use in 2014. Of course fire risk remains in any building and this spring we publicised major changes to our fire training systems, to place much greater emphasis on evacuation preparedness and less on theoretical learning. Deployment of those changes has been ongoing for some time but intensifies this summer.

The Board's meeting today has a focus on business continuity and emergency resilience, in both the public and private sessions. This reflects the work done over the last twelve months to strengthen our arrangements, conscious of, among other things, the major IT changes that we have begun to undertake.

Financial performance remains rightly a focus of considerable attention. By the time the Board meets we would expect to have sufficient cost improvement projects in place to meet our obligations this year, which move us back from deficit to surplus. Execution of those schemes, and the prevention of countervailing expenditures is a priority for all of our clinical groups, notably medicine and surgery, each of which benefit from new leadership teams with fresh drive on old issues.

I would also direct the Board's attention to the escalated action that I will oversee in respect of DNA CPR and DOLs. This matter has been escalated by the quality and safety committee chair for additional action after localised assurances fell short of what is required.

1. Our patients

The Board's papers today include a quantified update on our Safety Plan deployment, as well as the pre-work in medicine covered by the Consistency of Care project. Both are proceeding well and we would expect to have concluded the initial rollout inside this calendar year. The creation of an Always Culture is one that takes time. It relies on staffing consistency, IT consistency, but above all leadership emphasis on every shift. The introduction of named ward leaders among the consultant body in medicine, and in due course elsewhere, is intended to help to make this a multi professional effort. In thinking through our consideration of never events we need to satisfy ourselves that that same intent can be demonstrated in our theatre environments.

Before the Board next meets we expect to open the Non Invasive Ventilation (NIV) Unit at Sandwell. This will serve the whole site and will occasion a handful of patients each week moving between sites after stabilisation to receive the best care. This major investment reflects learning from serious incidents in 2015-16 and underlines the Trust's commitment to commit resource to safety, even as we work to cut and then eliminate our deficit.

Emergency care at the Trust remains under pressure. The intensive urgent care improvement weeks saw some steps forward, which are militated against by rising vacancy rates among key staff. There is

very focus on these issues and on ensuring that staff feel supported as we look to drive improvements on a whole Trust basis. Our plan remains to deliver 90% for the four standard in Q2 and that demands that at least fifty patients a day experience considerably shorter waits for decisions. At the same time we are working with partners to address the very long waits experienced by some adults and adolescents for ongoing mental health care services. This is a priority for the SWB A&E delivery board and should be a focus for collective action. It remains undemonstrated that there are sufficient tier 4 beds available locally, even after two years of system wide work, and the matter therefore remains a red rated risk on our Board's risk register.

2. Our workforce

I am pleased to be able to report significant progress with the recruitment drive we have to hire Healthcare Assistants. We have significant gaps in this important workforce, especially at ward level and the response to recent advertising has been very positive. Our extensive training offer and commitment to team development plays a part in that response, and we are cautiously optimistic of making offers at or beyond our vacancy level.

At the time of writing we have maintained a no Thornbury position throughout the month of June. The arrangements for alternative approaches have, in the main worked well. The safe staffing report is attached and permits scrutiny of whether minimum number guarantees are being reached and fill rates lessened. With our focus on both better rostering and improved sickness management, we ought to be able to make these changes without harm. That said, on two occasions I have intervened to try and assist with solutions. There is more work to do on provision of mental health staff to support patients in our care, especially when we are in effect retaining a patient pending a suitable bed elsewhere.

Staff are now working with a combination of paper and electronic notes, with the advent of our case-note scanning project. From July 1st we hope to be fully electronic. To date our own resilience and IT challenges have not crystallised as difficulties. We have experienced some supply chain difficulties which we are working to resolve. A post project review will be undertaken and overseen through the Major Projects Authority. The lessons learned are important to our count-down to EPR which is still targeting November 2017.

Rollout of training for the Aspiring to Excellence appraisal system is moved ahead well. We are on track with manager, including medical manager training. As the 13 week plan document records we have further work to do to confirm the rewards and sanctions package to sit around this major new initiative. The system has been well received and the emphasis on both identifying potential and managing behaviours through our Care Promises has been welcomed by colleagues. Completion of appraisal under the old system for 2016-17 remains required and we will now move into conduct considerations with any employees where this is not resolved.

In addition to my normal annexes I also append operational details of the European Investment which we have jointly secured around the new hospital. I will provide the Board with an oral update on this scheme.

3. Our partners

We continue to work with partners to deliver improved continuity of care. Our innovative third sector Sapphire service is now live across the organisation. At the same time we are working with Sandwell MBC to see how best to integrate some health and social care services particularly at Rowley Regis. This may better direct Better Care Fund investments. This is timely as we progress analysis for our

long term bed base ready for publication of a review later in Q2. At the time of writing we remain 30 beds above our target state for 2017-18.

Exciting developments continue to expand access to local primary care. We are seeking agreement to permit Trust senior clinicians to book into such appointments in an effort to better direct patients through the various elements of local emergency care, to create a singular system. At the same time, we are working to better support local care homes to prevent avoidable admissions into beds within the Trust. The wrap around support needed by care homes is well understood, and the Trust has won awards in the last two months for our work in this field. The challenge is to scale up.

4. Our regulators

The Trust is responding to the current Competition and Markets Authority investigation into the proposed acquisition of Heart of England by UHB NHS FT. Changes at the Royal Orthopaedic Hospital may presage a similar set of questions, and the changes to create a single community and mental health provider across some parts of the local landscape. The Trust has no ideological view on the merits of competition in healthcare, but recognises that policy for the NHS preferences this, and accordingly the investigation is into how competition is best sustained rather than whether competition has merit. The Board has always taken a view that the city of Birmingham, in education, service or research, benefits from a pluralist approach and that one size does not fit all with the varied needs and varied communities in the conurbation.

Our CQC draft report remains pending for July 2017.

5. Sustainability and transformation planning

The next Board meeting will consider a final formal proposal in respect of Black Country Pathology. This is a pressing matter as we need to decide whether to deviate from our planned approach to pathology which placed a hot lab into Midland Met (which remains under all options) and a main hub at Sandwell. Any such deviation has to be warranted to be ready in time for the transfer of care to Midland Met and the disposal and move from the City site.

The STP moves forward and the Partnership Board of the STP has confirmed its unanimous and strong view that the current boundaries of the partnership should be maintained. This is welcome and we should look forward to confirmation of that decision through NHS Improvement and NHS England. The singular community of Sandwell and West Birmingham is the founding logic for the construction of the Midland Met hospital. Any move away from that will damage and potentially destroy both the financial case, but more importantly the operational and clinical case for a single acute hub.

Wider STP governance questions are considered in private through the draft memorandum of understanding. Productive and constructive discussions continue across the major providers in the Black Country to examine how best to build on current successes including the Black Country Alliance.

Toby Lewis
Chief Executive
June 30th 2017

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:	2nd July 2017

EXECUTIVE SUMMARY:

May Summary

The summary level Unify data does not demonstrate any major variance month on month across this period. The average CHPPD for registered nurses across the trust is 4.8 hours which is consistent with 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 at 97.3% and 95.4% respectively. This slight under fill is offset by daytime fill rates for support staff at 95.4% and 101.6%. This is again consistent with previous month's figures.

Work has completed on the 6 monthly staffing reviews utilising the Safer Nursing Care Tool. SNCT recommends that no significant staffing changes are made on the basis of a single review. However, on the basis of the data provided, funded ward staffing numbers appear to be in line with those recommended. The analysis will be repeated in November, alongside other measures of acuity, dependency and staffing to inform the ongoing correct establishments for the wards.

Current information suggests that there may be the potential to further skill mix community wards which will release costs to offset some areas requiring uplift

The tool lacks the sensitivity to adjust for additional staff required for focussed care. Ward areas are currently trialling a model of TAG nursing with some uplift to untrained staffing numbers. This will positively impact reduced bank / agency spend. The trial will run until September and further inform cost going forward.

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:

June Trust Board

USE-IT! – Project Update

Urban Innovative Actions USE-IT! (Unlocking Social and Economic Innovation Together)

What is the Urban Innovative Actions programme?

Urban Innovative Actions (UIA) is an initiative of the European Commission that provides urban areas throughout Europe with resources to test new and unproven solutions to address urban challenges. The Initiative has a total ERDF budget of EUR 372 million for 2014-2020.

The project maximum budget is €5 million over three years with an 80% co-financing rate. The total project budget for the USE-IT! bid is EUR 3,639,867, of which EUR 2,911,894 is ERDF (please note, these figures may change following contract negotiation, if successful).

Birmingham's proposal: USE-IT!

Birmingham's proposal, USE-IT! (Unlocking Social and Economic Innovation Together!) aims to strengthen the link between micro-assets in poor neighbourhoods to macro-assets (capital and infrastructure projects) in order to reduce displacement and maximise economic and social benefits of urban development for marginalised residents.

Our initial focus is on Greater Icknield (see map in Annex 1) , a transect that cuts across the core urban area of Birmingham and Sandwell local authorities: Almost 20% of households have no-one with English as their first language; rates of persistent poverty are more than four times the city-regional average; the majority of children live in England's 10% most deprived areas and more than 40% of residents have no educational qualification (2011 census and IMD 2015).

By creating greater innovation that links major urban developments adjacent to poor neighbourhoods, we aim to create greater substitutability in the use of resource and ensure greater integration of the poor into major developments to improve city-regional resilience and sustainable urban development.

The overarching objectives of USE-IT! are to:

- Develop a reciprocal relationship between the community and agents of change (e.g. hospital, developers, businesses, universities) working collaboratively to unlock innovation.
- Engage with and further support local people producing and actively engaging in social, economic, physical, cultural activity that enhance life chances.
- Increase civil capacity and resilience.
- Develop richer insight into communities through a Community Research model to develop a more systematic approach to tackling entrenched poverty.

Work packages

The three main work packages are as follows:-

Work package 4 - Community research training: unlocking innovation in Sustainable Urban Development for Deprived Urban Communities
Lead: University of Birmingham. Contact: P.W.LEE@bham.ac.uk

Recruitment and training of 60 Community Researchers (CRs) over the lifetime of USE-IT! Our CRs will be enabled to have leadership roles to drive and influence change; they will be trained in research methods aimed at unlocking and linking opportunities in new urban developments. CRs will identify challenges and innovations to problems that traditional public policies have failed.

The work and findings of the Community Researchers will provide community-based intelligence that will feed into all other Work Packages: Their work will inform the creation of a matching skills service to enhance employment support and support for poor communities to spin-out social enterprises that are socially innovative or build economic outputs from existing resources. We will also build on community assets to identify innovative forms of community finance that could be sustainably used longer-term in this area and to support replication.

Work package 5 - Matching job skills in the community with demand
Lead: Sandwell and West Birmingham Hospitals NHS Trust. Contact: james.pollitt@nhs.net /conrad.parke@sandwell.gov.uk

This work package will have a particular focus on the health sector, matching job skills in the community with skills shortages in the NHS. This Work Package will:

- Gather data on existing & future skills shortages in the NHS.
- Link to CRs to discover residents with the appropriate but underutilised overseas qualifications.
- Offer these individuals tailored support to address any immediate day-to-day concerns such as health, housing, legal or benefits advice.
- Offer these individuals a package of support aimed at: getting their overseas qualification recognised in the UK; addressing any pre-employment needs such as language development and helping them get job ready for a career in the NHS.

(See Annex 2 for a project process chart)

Work Package 6 - Social enterprise and social production.
Lead: ISE (Institute of Social Entrepreneurs). Contact: Sarah.Crawley@i-se.co.uk

This work package takes a place-based approach to supporting residents to trade their way out of poverty and social exclusion by supporting the creation of a community of social entrepreneurs. This innovative approach takes the collective use of 'assets' from the community, private enterprise or the public sector to create new replicable economic models to stimulate social enterprise to address social, economic and environmental issues in this area of Birmingham.

The work package will build a critical mass of social entrepreneurs working to solve issues and react to market opportunities across health, food, technology, education and tourism. This network will develop links between local people, businesses, public sector bodies, local groups and local investors to create a body of likeminded people keen to connect with, and support community-rooted entrepreneurs and social producers.

USE-IT! partners

The USE-IT! bid brings together 16 project partners:

1. Birmingham Chamber of Commerce
2. Birmingham City Council *(Lead for Work Packages 1 Project Preparation, 2 Project management, and 3 Project closure and knowledge transfer)*
3. Birmingham City University *(Lead for Work Package 3: Communication)*
4. Birmingham Voluntary Services Council
5. Canal and River Trust
6. Citizen Coaching CIC
7. Co-operative Futures
8. Father Hudson's Care (Brushstrokes)
9. Health Exchange CIC
10. iSE (Initiative for Social Entrepreneurs) *(Lead for Work Package 6: Social enterprise and social production).*
11. Karis Neighbour Scheme
12. KPMG *(Lead for Work Package 7: Understanding and strengthening community assets and finance)*
13. Localise West Midlands
14. Sandwell and West Birmingham Hospitals NHS Trust *(Lead for Work Package 5: Matching job skills in the community with demand).*
15. Smethwick Church Action Network
16. University of Birmingham *(Lead for Work Package 4: Community research training: unlocking innovation in Sustainable Urban Development for Deprived Urban Communities).*

Sandwell MBC will also be a partner and will provide a project officer to support Work Package 5 but will not access the European funding.

A Community Board will also be set up as a mechanism to formally engage, communicate with, and consult with wider stakeholders.

Facts about the call

A total of 378 proposals were received by the Urban Innovative Actions secretariat.

USE-IT! Is one of only 18 that were approved and the only one approved in the UK.

Update on Progress to date for Work Package 5 **NHS The Learning Works**

June 2017 sees The Learning Works progress positively with the ESF funded USE IT three year project.
The Learning works is required will deliver a minimum of twenty outcomes per year (60 in total)
To date we have 41 clients on the books and we are actively working with them to secure employment. Our client's professions currently include: Pharmacists, Doctors (GP's and consultant grade medical staff), Paediatricians, Nurses, Dentists, and a Public Health Officer

Many of the USE IT project clients require support with tuition and access to examinations to support International English Language Testing System (IELTS).
We are working with our project partner Brushstrokes to provide a programme of learning.
We have a growing number of expressions of interest from Doctors wishing to explore how the Use IT project can support them return to practise. Doctors need to complete IELTS exam registration £160 per client. In addition Doctors are required to achieve Professional and Linguistic Assessments 1&2 – shown below

Professional and Linguistic Assessments Board (PLAB) test fees **See additional info on next page for fee exemption**	**Effective from 1 February 2016 to 31 March 2018**
Part 1 of the PLAB test	£230
Part 2 of the PLAB test	£840
Request for clerical check of results for the PLAB test	£45

In addition Doctors are required to join the medical register feed shown below

Fees to join the medical register	**Effective from 1 April 2016 to 31 March 2018**
Application for full registration with a licence to practise for doctors who hold, or have previously held, provisional registration	£200
Application for full registration with a licence to practise for doctors who submit their application within two years of passing a primary medical qualification (and do not hold, or have not previously held provisional	£200

Fees to join the medical register	Effective from 1 April 2016 to 31 March 2018
registration)	
Application for full registration with a licence to practise for doctors not covered by the scenarios above	£425

The majority of our current clients have refugee status.

Refugee Doctors applying for registration with a license to practice in the UK are able to get help with registration fees.

USE IT clients who have applied for asylum may be able to get help with registration fees if they are:

- Recognised as a refugee under the 1951 United Nations Convention and granted limited leave (5 years)
- Granted exceptional leave to remain (granted prior to 1 April 2003)
- Granted humanitarian protection
- Granted other leave

The Learning Works continues to host community engagement events; June's event was attended by nineteen clients' with a further eleven to attend our next one. Clients from this event included a **Radiologist, a Dermatologist, three paediatricians, a medical officer, an imaging officer and a lab technician.**

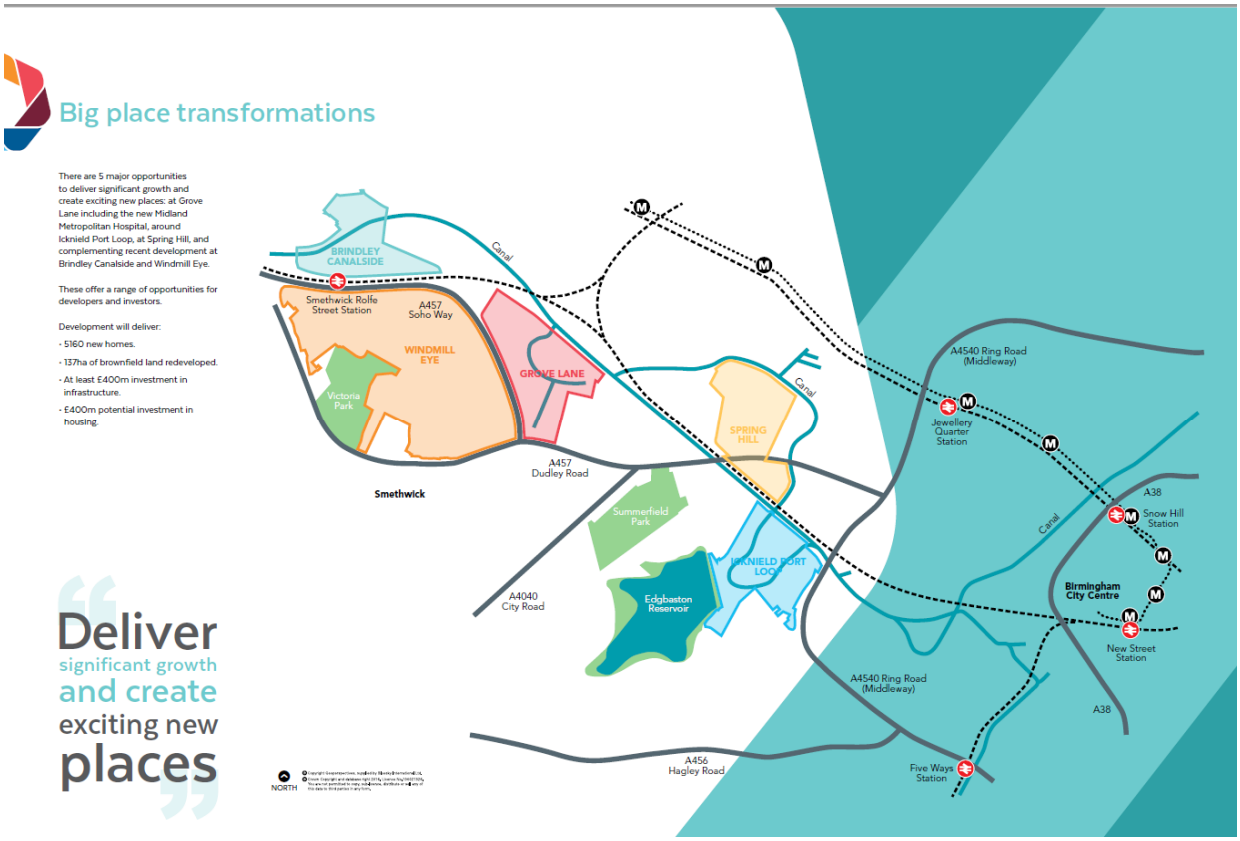
We are finalising a programme of IELTS tuition for our client's in partnership with Brushstrokes, with two dates already issued to complete initial assessment.

https://www.ielts.org/

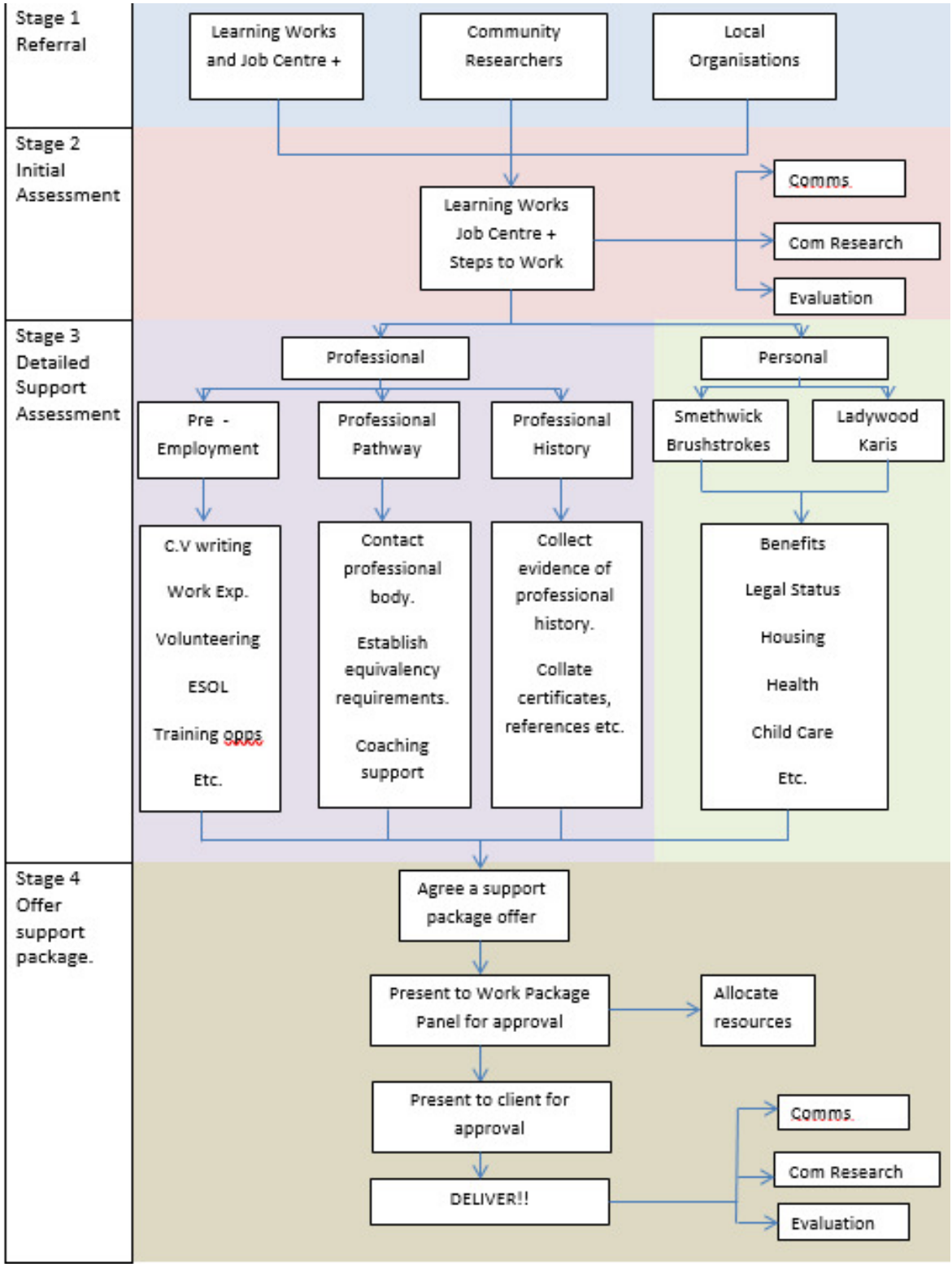
http://www.gmc-uk.org/doctors/fees.asp#PLAB2

USE IT Clients are being encouraged to access our bespoke coaching and mentoring sessions which is leading to positive outcomes, in particular around job application and interview skills.

Annex 1 – Map of USE-IT! Project are



Annex 2 – Work Package 5 Project Process Chart



Recruitment Activity Report

Report Date: 27/06/2017

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	969.47	972.39	991.89	1033.64	*1033.64*	*1033.64*	*1033.64*	*1033.64*	*1033.64*	*1033.64*	*1033.64*	*1033.64*
		FTE	FTE In Post	830.10	820.97	841.98	834.31	*836.29*	*840.90*	*893.99*	*908.01*	*907.03*	*913.05*	*957.07*	*964.09*
		FTE	New Starters	5.83	1.97	5.46	5.00	*4.61*	*63.45*	*22.62*	*7.62*	*14.62*	*52.62*	*15.62*	*7.62*
		FTE	Leavers	15.43	7.29	13.13	3.02	*0.00*	*10.35*	*8.60*	*8.60*	*8.60*	*8.60*	*8.60*	*8.60*
		FTE	Vacancies in month	139.37	151.42	149.91	199.33	*197.35*	*192.74*	*139.65*	*125.63*	*126.61*	*120.59*	*76.57*	*69.55*
	Offers External Applicants	FTE	Conditional offers (in month)	5.60	9.44	25.80									
		FTE	Offers Confirmed (in month)	3.00	11.54	5.33									
Band 6 Nurses	SIP	FTE	Establishment	572.09	576.36	576.36	576.36	*576.36*	*576.36*	*576.36*	*576.36*	*576.36*	*576.36*	*576.36*	*576.36*
		FTE	FTE In Post	527.99	530.10	526.49	529.61	*532.11*	*536.11*	*539.86*	*543.60*	*547.35*	*551.09*	*554.84*	*558.59*
		FTE	New Starters	2.93	2.45	3.80	3.50	*5.00*	*7.00*	*7.00*	*7.00*	*7.00*	*7.00*	*7.00*	*7.00*
		FTE	Leavers	1.00	1.92	0.68	1.00	*1.00*	*3.25*	*3.25*	*3.25*	*3.25*	*3.25*	*3.25*	*3.25*
		FTE	Vacancies in month	44.10	46.26	49.87	46.75	*44.25*	*40.25*	*36.50*	*32.76*	*29.01*	*25.27*	*21.52*	*17.78*
	Offers External/Internal Applicants	FTE	Conditional offers (in month)	9.80	3.52	6.16									
		FTE	Offers Confirmed (in month)	2.00	2.72	2.00									
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	28.08	28.08	27.16	29.16	*29.16*	*31.26*	*30.67*	*32.08*	*32.70*	*30.28*	*30.70*	*31.10*
		FTE	New Starters	0.00	0.80	2.00	0.00	*2.10*	*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	-19.83	-19.83	-18.91	-20.91	*-20.91*	*-23.01*	*-22.42*	*-23.83*	*-24.45*	*-22.03*	*-22.45*	*-22.85*
	Offers External Applicants	FTE	Conditional offers (in month)	0.00	0.00	0.80									
		FTE	Offers Confirmed (in month)	0.00	1.80	0.00									
Band 6 Midwives	SIP	FTE	Establishment	175.55	175.55	175.55	175.55	175.55	175.55	175.55	175.55	175.55	175.55	175.55	175.55
		FTE	FTE In Post	130.67	129.59	126.85	*126.53*	*125.93*	*126.99*	*126.78*	*126.57*	*126.36*	*126.16*	*125.95*	*125.74*
		FTE	New Starters	0.00	0.00	0.60	0.00	*1.05*	*1.05*	*1.05*	*1.05*	*1.05*	*1.05*	*1.05*	*1.05*
		FTE	Leavers	0.00	0.81	0.92	0.60	*0.00*	*1.26*	*1.26*	*1.26*	*1.26*	*1.26*	*1.26*	*1.26*
		FTE	Vacancies in month	44.88	45.96	48.70	49.02	*49.62*	*48.56*	*48.77*	*48.98*	*49.19*	*49.39*	*49.60*	*49.81*
	Offers External/Internal Applicants	FTE	Conditional offers (in month)	1.00	1.00	0.60									
		FTE	Offers Confirmed (in month)	0.00	0.80	0.00									
Medical Consultants	SIP	FTE	Establishment	316.03	313.96	313.96	313.96	313.96	313.96	313.96	313.96	313.96	313.96	313.96	313.96
		FTE	FTE In Post	282.57	285.17	287.17	281.32	281.32	279.32	279.17	279.02	278.87	278.72	278.57	278.42
		FTE	New Starters	2.00	0.00	0.00	0.00	*1.00*	*2.39*	*2.39*	*2.39*	*2.39*	*2.39*	*2.39*	*2.39*
		FTE	Leavers	2.30	2.00	5.85	0.00	*3.00*	*2.54*	*2.54*	*2.54*	*2.54*	*2.54*	*2.54*	*2.54*
		FTE	Vacancies in month	33.46		26.79	32.64								
	Offers External Applicants	FTE	Conditional offers (in month)	3.00	0.00	3.00									
		FTE	Offers Confirmed (in month)	0.00	0.00	1.00									
Band 2 HCAs	SIP	FTE	Establishment	485.02	482.30	490.30	523.37	*523.37*	*523.37*	*523.37*	*523.37*	*523.37*	*523.37*	*523.37*	*523.37*
		FTE	FTE In Post	411.72	417.04	429.87	429.87	*429.87*	*452.53*	*463.35*	*474.17*	*484.99*	*495.81*	*506.63*	*517.45*
		FTE	New Starters	2.53	6.80	1.00	0.00	*23.25*	*15.00*	*15.00*	*15.00*	*15.00*	*15.00*	*15.00*	*15.00*
		FTE	Leavers	3.92	0.40	1.00	0.00	*0.59*	*4.18*	*4.18*	*4.18*	*4.18*	*4.18*	*4.18*	*4.18*
		FTE	Vacancies in month	73.30	65.26	60.43	93.50	*93.50*	*70.84*	*60.02*	*49.20*	*38.38*	*27.56*	*16.74*	*5.92*
		FTE	Conditional offers (in month)	7.61	7.56	31.00									
		FTE	Offers Confirmed (in month)	5.25	1.61	1.00									
Band 3 HCAs	SIP	FTE	Establishment	95.44	93.14	93.14	93.14	*93.14*	*93.14*	*93.14*	*93.14*	*93.14*	*93.14*	*93.14*	*93.14*
		FTE	FTE In Post	93.21	91.63	91.03	91.63	*91.63*	*92.43*	*91.83*	*91.23*	*90.64*	*90.04*	*89.44*	*88.85*
		FTE	New Starters	0.00	0.00	1.60	0.00	*0.80*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*
		FTE	Leavers	1.00	1.80	1.00	0.00	*0.00*	*0.60*	*0.60*	*0.60*	*0.60*	*0.60*	*0.60*	*0.60*
		FTE	Vacancies in month	2.23	1.51	2.11	1.51	*1.51*	*0.71*	*1.31*	*1.91*	*2.50*	*3.10*	*3.70*	*4.29*
	Offers External/Internal Applicants	FTE	Conditional offers (in month)	0.00	2.26	0.00									
		FTE	Offers Confirmed (in month)	0.00	5.21	1.80									

Notes:

Establishment: WTE contracted. For nurses and HCA's includes a wte increase due to the opening of Lyndon 5 as a substantive ward from May 17 and OPAU amd Priory 5 from July 17. Figures have not yet been adjusted to reflect the ceassation of the gynea-oncology service from the end of Oct 17.

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

New starters forecast: Based on new starters in previous year and estimated starters as a result of recruitment campaigns held in and response rate of FYS to

Leavers - July, August: 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 wte leaving the organisation. For band 5 staff nurses/midwives, this also includes the wte 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. For band 5 nurses have assumed that turnover will improve by 1% by October 2017 as a result of agreed interventions to successfully on-board new hires, reducing the turnover to just under 12%, resulting in a reduction in leavers of

Conditional Offers: Includes external offers only for Consultant, band 5 posts and HCA's and both internal/external for band 6 posts.

Band 5 Nurse Offers: Sept 17 starters - 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 with start in post fair, Recruitment Fairs forecast additional 15 offers from SWBH fair in July, 7 offers from RCN fair in Liverpool in Sept, 12 offers from RCN fair London in Oct and 8 offers from RCN Fair Nottingham in Nov

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

Band 6 Midwives: Establishment adjusted to refelct 8.25 vacancy factor. 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

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
Forecast for Student Nurses	Recruitment Fairs forecast additional 15 offers from SWBH fair in July, 7 offers from RCN fair in Liverpool in Sept, 12 offers from RCN fair London in Oct and 8 offers from RC 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 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
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. 22.06.17:
Band 2 HCAS	Excludes care support workers (Occ code - all H1's). June report, accellerated assumption of 15 wte a month given positive recruitment feedback during June '17. assume 75%
Conditional Offers	This the total number of offers made in month and will include offers to student nurses. Assume that 50% will be accepted and will result in a new hire
Offer to Hire	Band 5/6 and Midwife - 3 months for staff nurse and midwife HCA - 2 month Consultant - 7 months
Order of assumptions	1. Normal recuitment, 2. Student numbers and 3. recruitment fairs
First two months	Based on 'real' data, thereafter, numbers are forecasted.

N Fair Nottingham in Nov
l are assuming 80% of those still going through the process with start in post

s conversion rate for offers

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	13 Week Plan
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Toby Lewis, Chief Executive
DATE OF MEETING:	6th July 2017

EXECUTIVE SUMMARY:

Board colleagues are invited to discuss both the green and red areas in the attached assessment. The colour rating does not really permit a 'work in progress' rating quite deliberately, as there is another set of actions to come for Q2 and drift is therefore not in our interests. The ratings are my own assessment based on documents submitted by members of my team. We will work with these action lists over the next fortnight to address areas of delayed delivery.

REPORT RECOMMENDATION:

I invite the Board to reflect on progress and on what information it would wish to see at the next two meetings, together with how our Board's committees will ensure that focus is applied to these actions.

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	
Clinical		Equality and Diversity		Workforce	

Comments:

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

PREVIOUS CONSIDERATION:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report to the Trust Board
6th July 2017

13 Week Plan

In April 2017 we tried to put some renewed focus on key actions within the context of our overall 2020 vision and the key pillar plans that support that intent. It is recognised that the Trust is distinctively trying to undertake a broader sweep of change than many peer NHS organisations and that therefore it is right that we constantly review whether we have the capacity to deliver. Addressing the specific actions, rather at this stage than the outcomes, is a route to tracking whether we are putting in place the changed systems and behaviours that we need in good time to succeed. The five areas chosen then, and reported on today, are not the only focus of our attention but they do, together, represent a significant contribution to our 2017-18 annual plan.

Board colleagues are invited to discuss both the green and red areas in the attached assessment. The colour rating does not really permit a 'work in progress' rating quite deliberately, as there is another set of actions to come for Q2 and drift is therefore not in our interests. The ratings are my own assessment based on documents submitted by members of my team. We will work with these action lists over the next fortnight to address areas of delayed delivery.

Taken together, I would suggest the scorecards show strong progress on Aspiring to Excellence and on our Safety Plan. That 'tallies' with the results we are seeing within our weekly Programme Management Office.

Progress on estates is only partial with more work to do on the non-Midland Met elements of the plan, and clearly a residual set of risks associated with new hospital construction and transition.

I&E delivery reflects the financial results and paper on the private board about our delivery infrastructure. We have made improvements in the last twelve weeks but we do not yet have a settled and completed plan that is mile-stoned at every scheme level. PMO support is resolving that, and the executive are reviewing progress in detail on July 4th. I will report orally to the Board on the current state position as we meet. CIP delivery in Q1 is broadly on track and we have seen notable reductions in temporary pay spend, masked in the run rate by pay awards and incremental drift (budgeted for) on the substantive pay bill.

Digital plans show the largest proportion of under or un-delivered items. The Board will recognise that a handful of major schemes are attracting the majority of energy, and we have implemented Merge PACs changes and our casenote scanning project in Q1. Notwithstanding that, we should be concerned by the scale of lag on delivery. The MPA has reviewed 'next two month' plans for digital, which ostensibly were not present previously and I have taken the chair of the Trust's digital committee to seek to ensure that we are gripping this large scale agenda at pace.

I invite the Board to reflect on progress and on what information it would wish to see at the next two meetings, together with how our Board's committees will ensure that focus is applied to these actions.

Toby Lewis
Chief Executive

13 Week Plan

Safety plan: Progress	
Roll out across all inpatient areas	All areas now engaged in roll out
100% compliance with data entry	Surgery ; PC,C & T; W & CH.
	Medicine – early stage roll out – still showing areas of non-compliance
MDT engagement in daily / weekly meetings	There is largely still difficulty in securing involvement of medical staff in weekly MDT – expected to improve with identification of Ward lead consultants
E data entry access – all areas	All areas able to access / input data electronically
Automated reports generated daily	Reports generated automatically daily at 6am
100% compliance with standards – surgery / C & T / W &CH.	Majority of areas >98%. 4 areas <98% with average 3 – 4 non compliant checks overall per day these are N3; D21; L2; SAU. Improvement trajectories set for each area, consequence strategy established for non-compliant wards.
Daily reporting into Red / Green	Not yet in place
Buddy programme established	Buddy programme / training established for SP / CoC projects
Data feed into ward dashboards	Included as part of Early warning trigger tool
Evidence of improved outcomes displayed / fed back to ward teams	Data feed established. Published outcome data scheduled 5th July 17.
Safety plan metrics designed into EPR	Awaiting confirmation regarding observations (Vitalpak replacement)
Finance: Progress	
Have established a profiled plan to hit control total for 2017-18 comprising £20m of CIP and a £13m gap project agreed with NHSI	Challenge and confirm £20m CIPs on a scheme by scheme basis Secure profit on asset disposal to cover £13m gap on N/R basis
Be on trajectory for Q2 volumes/income and have delivered Q1 same	P01 & P02 production plan delivered. P03 & P04 step up not yet confirmed.
Have delivered “Goodbye to Thornbury” project from June 1st	Zero Thornbury shifts in June as at date of reporting

Have a group level non pay and procurement plan in place	Develop KLOEs into robust schemes Extend procurement work-plan
Have a group level agency reduction plan in place	Confirm sufficiency of plans Mobilise / accelerate plans as necessary
Be reporting expenditure reduction meaningfully, with weekly data for key items	Confirm framework for lead to lag data Establish routine data production Reconcile P&L run rate to CIP run rate
Have 75% of 2018-19 plan identified and scoped onto TPRS (aided by FIP2)	Confirm Phase 3 & secure support Confirm route to £41m then £60m
Have a clear accountability framework for budget delivery, including link to consequences regime for individuals, teams and directorates	Confirm consequences regime through CLE & Board
Have a meaningful quality red flag system operating alongside savings plans	Confirm quality KPIs for all schemes Establish routine monitoring & reporting
13 week plan - Digital Commitments – July – Progress Update	
Fully established digital boards in Group PMOs	Work stalled whilst focusing on future state signoff workflows. Need assessment of maturity and next steps from Groups. The update will be provided to Digital Committee in July as part of overall business change assessment.
Complete Merge PACS upgrade and close eFilm	Merge PACS closed. eFilm closed to users. Need to decommission eFilm and rollout remainder of new workstation everywhere.
Complete the replacement of out of date PCs, printers & network infrastructure and so remove the backlog of IT tickets	FY16 PCs replaced. FY17 PCs in progress. IT ticket backlog remains high.
Complete the deployment of VOIP telephony	Target was Sandwell and Rowley by end July, City by December. Further work required on network. Target end date for Sandwell is now August.
Make the decision to go live with Cerner EPR having ensured organisation alignment	Deferred to July as a result of project replanning
Stabilise Winscribe and complete rollout in Acute and Community services	Infrastructure improvements in June and July. Go-live in July.
Complete rollout of case-note scanning and free up the medical records staff	Go-live scheduled 20th June.

Midland Met: Progress	
Have supported Carillion/AECOM to develop a ME&P design for the Midland Met Hospital	The Trusts has and for the foreseeable future will need to continue to support Carillion /AECOM
Undertaken a RDD review of the design to enable progress of the project to be maintained	Whilst the RDD process has continued information has not always been of a required standard. The Trust is also conscious that details of Level 4 will not be issued until the end of June, this being one of the major areas of concern to-date.
Considered the impact of "delay" and Carillion's revised programme	A revised programme confirming the extent of any delay is still to be issued by Carillion
Have agreed a level of recompense with Carillion	This process is delayed as work is undertaken to support any claim for recompense
Conclude the adds and omits process to confirm any necessary variations. The adds and omits process should be concluded in July	Variations will continue beyond July but the number of variations instructed is limited in comparison to other projects of a similar scale
Subject to design consequences to conclude all other variations currently in play	
Conclude the A2 equipment process	The process in on programme to complete in July
Have completed 80% of the equipment audit	This will be achieved in August
Concluded the selection of Managed Service Equipment	Concluded
Develop Commissioning & De-commissioning plans	Work has commenced and will till 2017/18
Develop internal way-finding and signage for Midland Met. A wayfinding strategy including utilising digital technology has been developed.	A presentation is arranged for the 14th July.
Commenced the Operational Commissioning Planning process including identification of Clinical Group leads for operational commissioning.	This work will commence when the major IT investment projects have been completed.

Agreed who goes where locations in the retained estates properties including STC, and City sites.	This work has progressed and is being finalised before being signed off and released to staff
Aspiring to Excellence	
Director of OD visit all clinical group management teams during April & May re PDR engagement	Completed
Branding and confirmation of new paperwork	Completed and launched
All managers written to, invited to training events	Personal invitation from Director of OD, then personalised follow ups and phone calls
Engagement of Staffside	Attended JCNC and regular updates at follow up meetings
Training programme agreed and being rolled out	Designed and signed off, and delivered venues across the Trust
Communications & engagement plan to wrap around new process	Completed and signed off with Director of Communications
Deliver training events with capacity to train all line managers	Completed
Basket of draft objectives developed for key staff groups	Completed for facilities, nurses, doctors, IT / EPR / line managers
Develop financial and non financial rewards by end of April	Completed and in draft format, consulted with NHS employers, Chief Exec, and Non executive colleagues

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Business Continuity – Board review of operational plans**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Phil Holland Deputy Chief Operating Officer Urgent Care**
DATE OF MEETING:	**6th July 2017**

EXECUTIVE SUMMARY:

An organisation's business continuity management system (BCMS) helps it to anticipate, prepare for, prevent, respond to and recover from disruptions, whatever their source and whatever part of the business they affect.

This presentation brief the Trust Board on the completeness of business continuity plans ahead of a core standards assessment over the coming months.

The expansion of expertise and resource in the last year as strengthened our approach to business continuity planning.

In practice the Trust has experience of activating continuity plans and has historically demonstrated it coped well for continuity in the event of eg;

- Floods due to extreme weather
- Loss of mains electricity supply
- Generator failures
- IT failures including CDA
- Damage to building that required evacuation of services
- Infection outbreaks

Looking forward the work planned includes:

- Complete outstanding plans by end July
- Test plans
- Ensure all activated business continuity plans are reviewed and learning disseminated
- Complete core standard assessment – report to Trust Board
- Multi agency development of partial and total loss of site plans to be developed for report back in August to Trust Board
- Planning and testing for MMH and Treatment Centres to be completed in line with commissioning time line

REPORT RECOMMENDATION:

The Trust Board are asked to discuss this item particularly;

- Our current status on plans
- The scenario
- Forward work plan

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

The receiving body is asked to receive, consider and:		
Accept	**Approve the recommendation**	**Discuss**
		X

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Safe and sustainable services
PREVIOUS CONSIDERATION:
Previous core standards report to Trust Board

SWBTB (07/17) 010a

Business Continuity Planning

Content

- Definition
- Capacity and governance
- Business continuity plans
  - where we are
  - Assurance and testing
  - Testing schedule
- Using our plans – a scenario
- Next steps

Definition of business continuity standards

NHS England define Business Continuity as follows

'An organisation's business continuity management system (BCMS) helps it to anticipate, prepare for, prevent, respond to and recover from disruptions, whatever their source and whatever part of the business they affect'

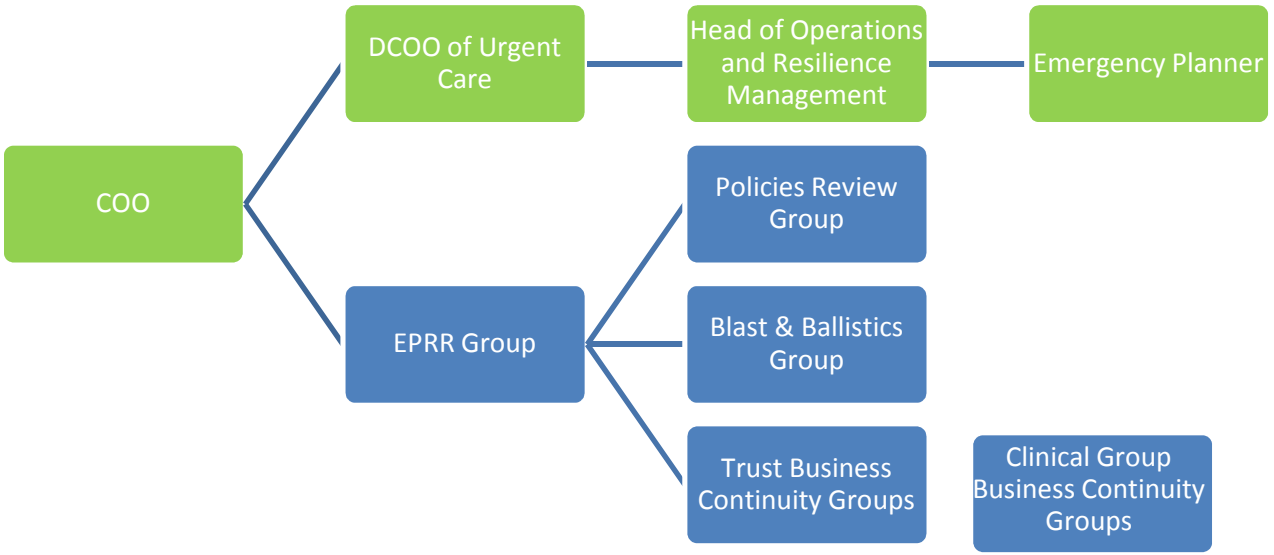
And as set out in the NHS Emergency Preparedness, Response and Recovery (EPRR) Core Standards

'NHS organisations and providers of NHS funded care must have suitable, proportionate and up to date plans which set out how they will maintain prioritised activities when faced with disruption from identified local risks, for example, severe weather, IT failure, an infectious disease, a fuel shortage or industrial action.
This planning should be aligned to current nationally recognised business continuity standards.'

The Trust were 'substantively rated' against the NHSE core standards in 2016, meaning we had no red areas of non-compliance and had <10 amber domains which were related to embedding the business continuity plans. It is anticipated the Trust will be fully compliant this year – the core standard return will be released to Trusts in the next 4 weeks.

Organisational capacity and governance infrastructure

The team and expertise has been expanded over the last year with an emergency planning post and deputy COO



The governance infrastructure is strengthened through the Clinical Groups structure

The EPRR Group is chaired by the COO and is supported by a clinical lead and emergency planning expert.

What Business Continuity Plans do we have

	Medicine	Surgery	Womens and Childrens	Primary Care, Community & Therapies	Imaging and Pathology	Facilities	Estates	Corporate	Governance	Operations	Elective Access	Microbiology	Capacity Mgt	Corporate Nursing	Workforce	Total
Inpatient Wards	15	12	11	1												39
Outpatient Clinics	6	42	8	5	3					1						65
Administration	2	8	6	1				11	9	5	4			2	3	51
Theatres	2	14	1													17
Critical Care		2														2
Diagnostics	3															3
ED & AMU	3	1														4
Cancer		1														1
Sterile Services		3														3
Community Services			6	2												8
Family Nurse Practitioners			1													1
Therapy				4												4
Mortuary					1											1
Imaging					8											8
Pathology					8											8
Microbiology												3				3
Estates							7									7
Facilities						8										8
Capacity Mgt													3			3
Resuscitation														1		1
Chaplaincy														1		1
Tissue Viability														1		1
Total	31	83	33	13	20	8	7	11	9	6	4	3	3	5	3	239

There are 239 local departmental business continuity plans. 173 of those departmental plans are based on 4 core business continuity plans which are localised for:

- Wards
- Outpatient Clinics
- Administration
- Theatres

Key 212 Green plans completed 27 Red plans for sign off in July

Assurance and testing of plans

Red plans 27 of 239 will be completed and signed off in July

- Governance
- Medical Records
- Clinical coding
- Health care records
- Telecoms and Informatics
- Medical Staffing/ bank

Green plans 212 of 239

- All plans have been through departmental, directorate and clinical group review (where appropriate)
- A significant proportion (40%) have been reviewed by the Emergency Preparedness, Response and Recovery (EPRR) team for quality assurance
- The plans will be tested against a number of scenarios in year led by the EPRR team. Learning from these and review of any actual business continuity activation will be reviewed at the EPRR committee and learning disseminated through the Clinical Group and Corporate Directorate structures.
- Locally Plans will be tested at Directorate level to ensure plans are kept up to date.

- Monthly EPRR Committee chaired by the Chief Operating Officer will over see assurance of plans

Testing schedule

We have a test schedule for our business continuity plans in line with our EPRR requirements. Tests will cover a range of departments based on scenarios; eg flood in Rowley Regis testing ward, outpatient and facilities plans; loss of water supply to BTC tests outpatients, theatres, estates plans; failure of sterile service test loss of equipment and sterile service plans .

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Staff Shortage / Sickness (mass nos.)	Pandemic flu								
Loss of Power						Total loss of power and generator			
Fire							Hospital evacuation		
Phone System Failure			Bleep failure , loss of switchboard						
Loss of Water									Malicious intent
Medical gases / suction									
Flooding								Severe weather	
Infection Outbreak					Communicable disease				
Medical Equipment (Essential Supply)				Loss of premises					
IT Failure		Catastrophic IT event							
Major Incident							Command and control exercise		

Using our Business Continuity Plans

Scenario – water leak in clinical area, potential flood and loss of electrical power

The matron of the Delivery Suite has contacted the Site Manager to inform them there is a significant water leak in the Delivery Suite, in the Maternity Unit.

- There is water running through the ceiling in the connecting corridor for the delivery rooms and dripping water has also been seen in 9 of the 18 delivery rooms.
- Estates are on site, there is concern about physical water and potential damage to power, electrical fittings and IT network facilities.
- Housekeeping staff are within the department to try and begin to clean up surface water. Many ceiling tiles are noted to be saturated with water?

Given the potential scale of the emerging incident, consideration will be given via a ETHANE assessment to activate an internal critical incident.

Maternity and estate business continuity plans will be activated – appendix 1.

Maternity business continuity response

Concern	Action
Delivery Suite may need to be closed due to flooding	Full evacuation may be required. Resources required to enable this will include: porters, temporary signage, facilities, medical engineering, contacting next of kin to update, review of patients to consider discharging
Equipment may be unusable due to lack of power (baby tagging, lighting, nurse call etc)	Ensure batteries are charged. Use of torches where necessary, named midwife for every patient, use birth partners and relatives
Consider the impact on patients of loss of power (no resuscitaire, blood gas machine, fetal fibronectin machine etc)	Agree care plans for high risk patients, and those requiring equipment support. Consider transferring to other units.
Door controls and baby tag system will not function without power – this ar a is usually locked down for security	Support staff to man doors into delivery suite and main doors into maternity unit
Patient observations and patient pathways will need to revert to being manual	Manual RXK numbers to be created, manual requests for pathology using runners to take requests, non electrical equipment to use

Estates business continuity response

Concern	Action
Loss of medical gases Loss of heating	Fuel monitoring Standby Generation Electricity Supplier/Network in regular contact Assess extent of impact on supplies and plan temporary circuits Notices to be placed on all lift doors confirming operational condition and nearest alternative lift provision Communication to affected areas Isolation of affected areas Pumping equipment (stored in estates workshops) Seek support from facilities management with regard to Facilities service.
Shut down of plant room, resulting in plant/ equipment being isolated	
Loss of Power	
Risk of electrical shock	
Loss of drainage	

Next steps

- Complete outstanding plans by end July
- Test plans as per schedule
- Ensure all activated business continuity plans are reviewed and learning disseminated
- Complete core standard assessment – report to Trust Board
- Multi agency development of partial and total loss of site plans to be developed for report back in August to Trust Board
- Planning and testing for MMH and Treatment Centres to be completed in line with commissioning time line

Appendix 1
Supporting Information for Scenario

Complete SBARR

Date		Time		Completed by & Role	
S	**Situation** **E**xact location of incident(s)_____ **T**ype(s) of incidents_____ **H**azards – known impacts / risks_____ **A**ccess / Egress_____ **N**umbers – for the loss of premises i.e. number of rooms or staff affected_____ **E**mergency response involved _____ - **S**ecurity - (Police / Fire / Ambulance)				
B	**Background** **T**imings - Incident started at _____ - **ENSURE YOU HAVE STARTED A LOG OF EVENTS**				
A	**Assessment** **C**urrent known impact on People, Places & Property_____ **P**otential implications if situation deteriorates (immediate and up to 12 hours)_____ **D**ecisions made_____ - What have you done, when and why?_____ - What actions are complete?_____ What actions are outstanding?				
R	**Recommendations** **S**trategy **P**riorities for service delivery **A**ssessment of additional equipment requirements as result of Business Continuity Issue				
R	**Review** **S**ummarise & confirm they understand key points				

When did you inform site team?	
Nos	
Landline 07.15-19.45 7 days a week	**0121 5074880**
Mobiles of senior capacity managers via switchboard	
Bleep City (Clinical Nurse Practitioners)	**5401**
Bleep Sandwell (Clinical Nurse Practitioners)	**6126**

Supporting Information for Scenario

BUSINESS CONTINUITY PLANS: FLOODING : Delivery Suite

CAUSATION:

This may be as a result of:	
	Unplanned mains failure off site (bad weather, engineering works, catastrophic failure)
	Unplanned failure on site (e.g. equipment failure)
	Planned interruption of supply to facilitate repair / upgrade work

PREPAREDNESS

Area	Why	Questions/Considerations
Flooding		• Disruption to service delivery • Possibility of total ward relocation and loss of working environment • Risk of harm to patients through inappropriate facilities • Risk of drowning to patients left unsupervised • Risk of spread of infection • Severe impact on acute medical admissions service

ACTIONS FOR WARD STAFF (OPERATIONAL COMMAND)

FLOODING: Delivery Suite

Concern	Actions
Flooding Double click the icons below to access the bed closure plans Policy for opening and closing beds - Ma Checklist forOpening extra beds or ward te	1. Refer to ward closure and opening plan 2. A full ward relocation may be required during investigation of fire and repairing of area – consider a horizontal evacuation, resources required for this action a. Porters b. Temporary signage c. Facilities d. Medical engineering e. IR1 f. Patient Next of Kin to be contacted and updated g. Consider discharges with Senior Medical Team 3. If adapted site is not suitable, consider a secondary move ensuring patients are in the same location 4. Depending on skill mix and patient 5. Contact Control of Infection
RECOVERY	1. Depending on situation and if Ward is viable, follow the Ward closure and opening plan in liaison with Estates, Facilities et al.

BUSINESS CONTINUITY PLANS: LOSS OF POWER (ELECTRICITY): Delivery Suite

CAUSATION:

This may be as a result of:	
	Unplanned Electricity failure off site (bad weather, engineering works, catastrophic failure)
	Unplanned Generator back up failure on site (eg equipment failure)
	Planned Generator back up failure on site (changeover of equipment)
	Industrial Action

PREPAREDNESS

Area	Why	Questions
Generator supply	Understanding which kit is supplied when operating on generator power	Are the staff able to identify the different points on the ward that would be supplied via emergency generator?
		Will there be emergency lighting for the ward?
Charging of kit	Ensuring some resilience	Are staff aware of the battery life of their essential equipment?
		Is all equipment kept fully charged
Contingencies	Understanding of fall back arrangements	***Patient observations:*** All patient observations can be completed manually (low risk women)
		Medical Gases: will work, wall suction will not work with no electricity. Resuscitaire will not work without electricity
		Lighting: torches on wards with battery supplies available
		Nurse-call: will not work?
		Ordering tests and viewing patient reports / data: check IT contingencies
		All beds are manual
		Security – Door Controls: unit not secure without electricity/baby tagging How will patients access serenity from ambulance/ drop off bay in absence of electricity for door control/ intercom?

Supporting Information for Scenario

ACTIONS FOR WARD STAFF (OPERATIONAL COMMAND)

LOSS OF POWER (ELECTRICITY): Delivery Suite

Concern	Actions
If given notice of power outage	Ensure that electrical equipment on the ward is fully charged
Assess Impact on the ward	What equipment is affected: • Lighting • Nurse call • Baby tagging • Resuscitaire • Cardiotocograph not available. • Blood gas machine will not be available

Assess Impact on Patients	Establish which patients may be affected consider:
	• Electrical equipment – resuscitaire – newborn, wall suction, no CTG machines.
	• Unit – small, patient could come out of door and shout for help
	  • Lighting – middle of night, suturing
	  • No Blood Gas Machine or Fetal Fibronectin machine

Alerting	Escalate to Matron / Band 7 – delivery suite, on call manager • Identify impacts and patients requiring equipment support • Agree care plan for high risk patients
Emergency lighting	Distribute torches on Delivery Suite for use by staff Emergency lighting available on delivery suite UPS working in maternity theatres
Patient observations	Use of manual sphygmomanometers, thermometer/ sonicaids and pinnards. Torches for lighting when procedures being carried out.
Nurse call contingency	• Named midwife for every patient • Use birth partners/relatives to alert staff of problems
Door controls	• Check the door controls and make plans if doors are unlocked. Support staff to man doors into delivery suite and main doors into maternity unit.
IT systems	• Revert to manual requests for tests and ring Pathology • Revert to paper notes whilst power outage. • Manual RXK numbers for babies. Will have to obtain NHS numbers for babies once power restored.
Medical Gases (these will continue to function for a while)	• Check the suction function on the wall mounted units • Resuscitaire will supply air/oxygen and suction via cylinders, 30 mins max. To keep links with cylinder man to ensure we have correct amount of cylinders available.
Patient safety	• Will baby tagging work? • No blood gas analyser to perform fetal blood sampling? • No fetal fibronectin machine available to perform fetal fibronectin on women coming into triage with query premature labour?

BUSINESS CONTINUITY PLANS:

LOSS OF IT SYSTEMS: DELIVERY SUITE

CAUSATION:

This may be as a result of:	
	IT systems error
	Server error
	Cyber attack
	Unplanned Electricity failure off site (bad weather, engineering works, catastrophic failure)
	Unplanned / planned Generator back up failure on site (egg equipment failure)

PREPAREDNESS

Area	Why	Questions
Ordering tests / TTOs	Electronic requesting will be down	***Ordering tests and viewing patient reports / data:*** check IT contingencies and ensure adequate copies of paper forms for: • Ordering tests • Discharging patients • TTOs • Undertaking VTE assessments
Viewing patients on ward		Ensure that there are whiteboards available to record (basic) patient details on wards

Supporting Information for Scenario

ACTIONS FOR WARD STAFF (OPERATIONAL COMMAND)

LOSS OF IT SYSTEMS: DELIVERY SUITE

Concern	Actions
Loss of all IT systems No ability to undertake the following: Ongoing clinical record (BadgerNet) Inability to undertake electronic based assessments on patients/ retrieve results of tests in usual manner. Inability to admit/ discharge patients in usual way Written discharge summaries for patients not showing on badger and cannot be printed out to communicate needs for ongoing care	Revert to Paper documents Consider use of I-pads or battery powered laptops for recovery of essential patient history/ information. This may require community midwives/ health visitors to be called in to the unit provide. Identify essential assessments required to ensure patient safety and determine plan of care using paper back-up for this. Prioritise results required to plan ongoing care and contact laboratory for these directly/ dispatch a ward clerk with a collated risk of results required to visit the relevant laboratory to receive essential results. Use paper alternative to be entered retrospectively at recovery point with a central record of patient admissions / discharges to be entered retrospectively once system restored. General principles are to revert to paper and use of the work sheets on each ward to record patient details within each ward area which can then be scanned/ summary entries into essential fields. Ward clerk/ hub to contact relevant team/ healthcare professional to undertake verbal handover in absence of electronic communication. Identify if there is any access to IT systems and the actions for these are given below.
	Patient First ED system • ***Existing Patients:*** will be available in **Lorenzo** and should be processed as normal when function back • ***New Patients*** **newborn/unbooked** should be allocated a pre-numbered "**DUMMY, DUMMY"** label, and their demographics should be updated in **iPM / Lorenzo** which will update **badger** so that documentation is correct.
	New Admissions: • ***Admissions***: into the hospital during this time will not be seen on **lorenzo** • Wards need to complete the **iPM (Lorenzo) Patient Tracker form**, all patients to be put in admission book
	so that the correct data is collected and can be updated when the system is back up and running, • ***Transfers:*** need to be completed in the admission book/transfer, Lorenzo to be updated after • ***Discharges:*** need to be completed in the admission book and discharge folder
	Existing Inpatients: • ***Transfers and discharges of existing inpatients:*** to be updated on Lorenzo and badger • ***Lack of updated clinical record resulting in retrospective paper entry.***
	Diagnostics: • ***iCM***: requesting and results system **will not be available** during the outage. • ***Pathology requests:*** during this time need to be **requested on paper**. **Pathology results** can be checked using the direct Telepath link: **http://sw-tpweb/TELEPATH/** or the **iLAB** link on the right hand side of the homepage of **Connect** second row down, last icon. Click on **new window**, next to **Enquiry**. The logon details are username: **ENQ**, password: **enq99** If these are not available then ring Pathology for results
	VTE assessments/ safety plan: • Access master document for paper back-up and complete accordingly.

Supporting information for scenario: Actions for Estates

Service Impact Analysis

Critical Function (essential activity):	**FLOODING**

A: Effect on Service if disrupted:

Time	Effect on service if disrupted:
First 24 hours	• Loss of medical gases • Shut down of plant room, resulting in plant/ equipment being isolated • Loss of heating • Loss of Power • Risk of electrical shock • Loss of drainage • Loss of AHUs • Business Continuity plan for area effected will be deployed
24 – 48 hours	• As above plus • Loss of medical gases • Shut down of plant room, resulting in plant/ equipment being isolated • Loss of heating • Loss of Power • Risk of electrical shock • Loss of drainage • Loss of AHUs • Business Continuity plan for area effected will be deployed
Up to 1 week	• As above
Up to 2 weeks	• As above

B: Resource Requirements for Recovery:

Time	No. of staff	Relocation?	Resources required	Data required	Responsible person or role title
First 24 hours	On Call Estates Staff	Communication to affected areas Isolation of affected areas Pumping equipment (stored in estates workshops) Seek support from facilities management with regard to Facilities service.	Redacted	Site plans – services drawing Estates Drive Essential permits & RAMS	On Call Estates Manager as first point of contact ring 0121 554 3801 or refer to the estates intranet site. Duty Consultant Microbiologist to be notified **As Well As :-** Chief Operating Officer Director Estates
24 – 48 hours	All Staff	As above plus Remote working Clear up operation and remedial repairs commence Confirm to Corporate Finance Account & Director of Estates cost pressure.			As above
Up to 1 week	n/a				
Up to 2 weeks	n/a				

Supporting information for scenario: Actions for Estates

Service Impact Analysis

Critical Function	**LOSS OF (MAINS) ELECTRICITY SUPPLY**

A: Effect on Service if disrupted:

Time	Effect on service if disrupted:
First 24 hrs	• Essential supplies will be provided by standby generators on site in the event of external mains failure. • The following areas do not have generator support: • SGH MRI • Leasowes • Halcyon • Should a generator fail there will be a loss of supply to the area served by the faulty unit- Local business continuity plans will need to be implemented. • Standby Generator and fuel tank monitoring will be carried out when generators are running by estates staff. • Should a generator fail, a major incident will be declared.
24 – 48 hours	• As above plus • Temporary supplies to be mobilised for circuits effected by the failed standby generator • Load shedding to be considered – Chiller plant, Lifts, Theatre plant • Monitor all metered panels and switchboards every 8hrs logging meters readings • All areas to apply their own business continuity plans to minimise electricity usage • On call team to work a rotating shift to maintain on site presence • Generator Maintenance provider contacted for on line servicing requirements • Business Continuity plan for area effected will be deployed
Up to 1 week	• As above plus backup generator(s) to be sourced and connected to system
Up to 2 weeks	• As above

B: Resource Requirements for Recovery:

Time	No. of staff	Relocation?	Resources required	Data required	Responsible person or role title
First 24 hrs	On Call Estates Staff	Fuel monitoring Standby Generation Electricity Supplier/Network in regular contact Assess extent of impact on supplies and plan temporary circuits Notices to be placed on all lift doors confirming operational condition and nearest alternative lift provision	Redacted	Site plans – location of generators Cable runs. Drawings Essential permits & RAMS	On Call Estates Manager as first point of contact. Contact via switchboard Duty Authorised Persons (High Voltage) to be notified. – Via on call estates manager Duty Authorised Persons (Low Voltage) to be notified. – Via on Call estates manager **As Well As :-** Chief Operating Officer Director Estates
24 – 48 hrs	All Estates Staff	Standby generator Fuel Alternative menus (facilities) Refuel oil tanks Confirm to Corporate Finance Account & Director of Estates cost pressure.		Site plans – location of generators Cable runs. Drawings Essential permits & RAMS	As above
Up to 1 week	All Estates Staff	Refuel oil tanks	As above	As above	As above
Up to 2 weeks	All Estates Staff	Refuel oil tanks	As above	As Above	As above

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Risk Registers
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Allison Binns, Deputy Director of Governance
DATE OF MEETING:	6 July2017

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 Board is asked to **NOTE** and **DISCUSS** the high (red) rated risks currently on the Trust's 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:

At the June Risk Management Committee and the Clinical Leadership Executive

Sandwell and West Birmingham Hospitals NHS Trust

Report to the Trust Board on 7 July 2017

Trust Risk Register

1. INTRODUCTION

This report is to provide the Trust Board with an update on the Trust Risk Register (TRR).

2. TRUST RISK REGISTER

The Trust Risk Register is at **Appendix A.** Clinical Groups and Corporate Directorate risk owners are reminded of the need to review / update their individual risks on the system by the end of the second week of the month so that current information is reflected on the automated risk report that goes to Executive Directors each month.

No new risks were escalated for Trust Board to discuss.

3. HIGH IMPACT RISKS

As requested, a review of high impact, low likelihood risks was undertaken which resulted in a total of 186 risks across all risk registers in the Trust.

Of those with a likelihood of less than 3 (risk rating of less than 15) some were duplicates, some have already been resolved and some are issues not risks. A number of these risks were estates risks and need reviewing for both their impact and likelihood score. The Director of Estates has agreed to recalibrate these risks by 31 August 2017.

The risk owners of the remaining risks will be asked to review the scoring and actions for their risks and report to the Risk Management Committee prior to reporting the resulting high impact risks to the CLE in August and the Board in September 2017.

This review gave an opportunity to look at those high impact risks with a likelihood equal to or greater than 15 (indicating a red risk). Some of those risks were again duplicated and some covered the same issues. The risk owners will be asked to review these with a view to them being included on the Trust Risk Register. These risk subjects are listed below.

- Issues with Ormis (theatre database)
- Medical rota within Neonates
- Use of Mesh in gynaecology operations
- Middle grade cover in the Emergency Departments
- 19 pin Nurse call systems (Estates)
- WMAS transfer of children to hospital

4. RESULTS ACKNOWLEDGEMENT

A risk assessment on results acknowledgement is being produced following this being a contributory factor in a few serious incidents. This will identify a potential high risk of harm to patients leading to a delay or missed opportunity to provide the right treatment.

The risk assessment will be presented at the July 2017 RMC by the Medical Director.

5. RECOMMENDATION

The Board is asked to **NOTE** and **DISCUSS** the high (red) rated risks currently on the Trust's Risk Register

Allison Binns
Deputy Director of Governance

28 June 2016

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) - our plan accommodated 35 actual or pending DTOC patients; those numbers have increased to 89-109 over November/December period We are unable to consistently staff the additional beds safely. The Trust will consider the closure of the un-substantively staffed beds in the new year. 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	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	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 Work with WMAS on risk assessment to understand their response to these scenarios	Rachel Barlow	31/03/2017	26/05/2017	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
				on patient outcomes.		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							
666 Live (With Actions)	Paediatrics	Lyndon Ground	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	31/03/2017	03/04/2017	Quarterly	Tolerate

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
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	ADAPT joint health and social care team in place. Progress made on new pathway. Joint health and social care ward established in October at Rowley.	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	31/03/2017	26/10/2016	Quarterly	Treat
1603	Live (With Actions)	Finance		Costs Not Planned	As a result of significant reliance on non-recurrent measures and balance sheet flexibility to support the Trust's financial performance cash balances have been eroded and there is a risk that this may compromise future investment plans.	4x5=20	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	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	Tony Waite	31/03/2018	22/11/2016	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
						stop' issues 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		appropriate creditor stretch, timely debtor recovery and pharmacy stock reduction - Establish and progress cash generation programme including accelerated programme of surplus asset realisation					
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	31/03/2017	22/05/2017	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.	3x4=12	Contingency bed plan to be agreed in October for winter 2016/17. Current unfunded beds have temporary staffing. Bed programme to ensure robust implementation of EDD planning on admission and implementation of red/green working on wards.	Rachel Barlow	31/03/2017	26/10/2016	Monthly	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	31/03/2017	22/05/2017	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.					
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	17/05/2017	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
325	Live (With Actions)	Informatics	Medical Director's Office	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 from cyber attack.	4x4=16	Prioritised and protected investment for security infrastructure via Infrastructure Stabilisation approved Business Case Information security assessment completed and actions underway.	3x4=12	MDM Tighten up use of MDM controls. Remove out of date accounts and update old OS versions. This has been neglected and therefore is a security risk. 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. Review Network Firewall Rules Review network firewalls rules. Remove inessential services. 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	Mark Reynolds	30/06/2017	20/01/2017	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
									should harden the Trust infrastructure against attack, recognising that securing the physical network is a challenge on the estate.					
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	Phase 2 Transformation implementation in progress. Consultation sign-off October 2016. Phased implementation of individual plans over a two year period, started Q1 2016-17.	Raffaela Goodby	31/03/2018	20/09/2016	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
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.	4x4=16	Contingency arrangement is for a general ophthalmologist to deal with OOH emergency cases. Agreement with BCH to access paediatric specialists advice and where specialist care is required patients can be transferred to BCH. There is a cohort of anaesthetists who are capable of anaesthetising children under 3 who can provide back-up services when required. Where required patients can be transferred to alternative paediatric ophthalmology services beyond the local area.	3x4=12	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 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. A full OOH paediatric on-call service to be set up in negotiation with commissioners, BCH and other ophthalmology units across the region.	Roger Stedman	30/11/2018	22/05/2017	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
								Midland Met will treat paediatric emergencies and will have access to paediatric anaesthetists within 24 hours.					
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	Mark Reynolds	31/03/2017	16/01/2017	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
						Infrastructure work to refresh networks and desktops is underway.							
768 Live (With Actions)	Operations	Elective Access Inpatient	Performance	There is a risk that data quality errors arise due to an inadequate referral management system which could lead to delays for patients.	**5x3=15**	Historical backlog of open referrals closed in Q3 2015. SOP and training in place as part of actions at time. Audit of current open referrals open pathways completed and shows some remaining inconsistencies in referral management practice.	**3x3=9**	Closed referral validation to be completed.The programme is near completion with a delivery plan for the end of October. CSC to fix bug on PAS system. The initial technical development has not fully fixed the bug. the further development would require a full PAS upgrade and CSC / HIS have advised this is not likely to be until later than 2017-18. Data quality programme to be completed.	Rachel Barlow	31/12/2016	26/10/2016	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.	**4x3=12**	SOP in place Substantive Deputy COO for Planned Care appointed and new Head of Elective Access in place. Improvement plan in place for elective access with training being progressed. 52 week breaches continue to be an issue for the Trust. The RCA identified historical incorrect pathway administration and clock stops. There has been no clinical harm caused to patients. The 52 week review was completed with TDA input. The action plan is focused on prospective data quality check points in the RTT pathway, competency and training.	**3x3=9**	Implement full action plan. Planned care PMO is being established to oversee programme delivery as scheduled. 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	31/03/2017	26/10/2016	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
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.	3x3=9	Embed Informatics implementation and change activities in Group PMOs and production planning Develop and publish implementation checklists and timescales for eDocs and EPR. Report progress at Digital PMO and Ctte Agree and implement super user and business change approaches.	Mark Reynolds	30/06/2017	22/03/2017	Monthly	Treat
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.	3x3=9	Recruitment being managed by UHB. Good progress reported for the GI position.	Roger Stedman	31/01/2017	26/05/2017	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
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	31/03/2017	26/05/2017	Monthly	Treat
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.	2x3=6	BCA plans to be delivered to commence in April 2016. PPAC & staff currently being consulted and volunteers for rotas sought. Working on Rota to cover our first commitment Saturday 30th April. The BCA service started in April as planned, with 1st SWBH weekend end April. So far, all weekends have been covered but there are	Rachel Barlow	31/12/2016	12/04/2017	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
							Locum arrangements in place to support workforce plan. Two consultants recruited who will start in 2017.		some concerns around potential shortages of radiographers, with no radiographer currently available for a weekend in November and at the New Year - the qualified ones are committed in CT. The CD for IR is arranging radiologist locum cover for some of the weekends, and Walsall is providing some additional cover. Pilot to cover Saturday and Sunday 9-5pm at SWBH, Wolverhampton and Dudley with BCA commenced April 16; SWBH has received it's first OOH patient. To be done on a rotational basis. Over reliance on one consultant, but 2 more are starting in the New Year. Recruitment is progressing but availability of vascular IR sessions is proving an potential barrier, as our sessions at UHB have been taken. Some sessions have been arranged at Dudley, and talks are taking place with UHB.					

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
								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.					
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**	Review / amend pathway Staff vacancies recruited to. Latest audit (Nov 15) provides assurance that wait times have significantly improved; 9 days on each site. Monthly monitoring of performance carried out to check that staff recruitment maintains sustainable change. New 2 stop chemotherapy model introduced to equalise waits from beginning of May 2016. New model implemented and improvements being monitored by Cancer Board.	**1x4=4**	Further Executive review at performance management review in November to confirm if the solution has succeeded in full.	Rachel Barlow	31/12/2016	26/05/2017	Quarterly	Treat

SWBTB (07/17) 011

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	DOLS and DNACPR Improvement plan
SPONSOR (EXECUTIVE DIRECTOR):	Roger Stedman, Medical Director
AUTHOR:	Heather Matthews, Business Manager MDO
DATE OF MEETING:	6 July 2017

EXECUTIVE SUMMARY:

Following concerning audit findings regarding the state of adequate recording of DNACPR discussions with patients and family, and also DOLS – This slide deck outlines for Q&S committee our approach to bringing about an improvement in this area of clinical practice.

Improving practice in this area is hampered by current lack of live up to date data on recording of mental capacity and DNACPR status. Our management information relies on intermittent retrospective spot audit of paper documentation.

The first key step in our improvement journey is to establish reliable setting of DNACPR flag on eBMS – this will give us live reports of patients with a DNACPR order in place.

Specific education plans for staff are required to improve understanding of statutory duties in this area. In addition changes in process within current state as well as future state following implementation of EPR.

REPORT RECOMMENDATION:

NOTE and DISCUSS the DOLS and DNACPR improvement plans

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Safe, High quality care

PREVIOUS CONSIDERATION:

Q&S Committee

DNACPR and DOLs

Background

Attempting resuscitation following cardiorespiratory arrest is not always in a patients best interest. This may be due to futility, the patient's prior expressed wishes or due to the nature of their diagnosis and prognosis. These instances should be proactively identified early through best interests discussions involving the multidisciplinary team. Consultation with patients and, as appropriate, their family and/or carers should be undertaken and decisions made should be clearly documented in the patient's records.

A recent audit of our processes highlighted inconsistencies in our implementation of DNACPR and DOLs. Although there has been improvement in compliance and assessing capacity there is uncertainty as to when the decision is being made. It was encouraging to see that out of 126 samples all DNACPR decisions were found to be appropriate, however there was room for improvement in many areas of the process particularly regarding documentation of the appropriate 'best interests' decision making in patients lacking capacity and updating of eBMS to reflect the patient's status.

With regards to DOLs nurses demonstrated a poor understanding of deprivation of liberty when questioned with scenarios and the existing sticker system for demonstrating DOLs had been considered was found to be confusing.

Audit Findings

DNACPR	DOLs
Rolling sample audits are carried out monthly with data collection through the Safety Thermometer methodology	Nurses were unsure when to raise a DOLs. Of those asked and were sure less than half could rationalise and apply to practice with given scenarios
DNACPR decisions in those sampled were all found to be appropriate	Most nurses were confident they can raise an application but different systems in place for making DOLs referrals. Old SAP1s were still being used on some wards
Assessments of patients' mental capacity are not always recorded	There is confusion around the sticker system in place. Stickers are in place to prompt nurses to consider whether DOLs is appropriate and request them to circle whether it has been considered but when considered the rationale is not always being recorded to the decision outcome
Discussions with family members are not always documented where patients lack capacity	Ward structures were inconsistent with how they shared information around vulnerable adults within the teams
Not all DNACPR forms are signed	All wards had identified nurses in charge but were not always aware of how many patients were on deprivation of liberty
Not all decisions and reasons are documented in the medical records	For patients who did have DOLs in place, it was not always obvious due to lack of recording of information
A quarter of treatment escalation plans are not completed	Patients identified on focussed care – Not obvious whether a DOLs was in place or that the family had been informed and Johns Campaign discussed
Compliance with updating patients' status on eBMS is low	CQC have notified SWBH of mandated training strategy to be completed by June including Band 5 and above training at Level 2. review of this has already started

DNACPR Recommendations / Action Plan

Item	DNACPR	How
1	All medical staff to complete the eLearning programme surrounding decision making and completing of the resuscitation status form	eLearning
2	Clarification on understanding of DNACPR • DNACPR decisions must be appropriate • DNACPR must be discussed with patients who have capacity • Where a patient lacks capacity, the patient's family and/or carers should be involved in the discussions • Where DNACPR decisions are made by non consultants the timescale for consultant review is 24 hours for City and Sandwell Hospitals and 48 hours for Rowley Regis Hospital DNACPR form will stay with the patient for the duration of their life unless there is a change in situation	Various comms - Heartbeat, Hot Topics, Team Briefings, Teaching sessions, video, Ward QIHD, Spot checks
3	Clarification on documentation requirements for DNACPR • Consultants must document the DNACPR decision and the reason behind it in the medical records DNACPR forms must be signed by the consultant Patients DNACPR status must be added onto eBMS • Treatment escalation plans must be completed • 'Not for CPR' must be ticked	Various comms - Heartbeat, Hot Topics, Team Briefings, Teaching sessions, video, Ward QIHD, Spot checks
4	Re audit	Resus Team

DNACPR considerations with EPR

Item	DNACPR
1	All Patients on Cerner Millennium will have a Resuscitation Status - this is assumed to be 'For Resus' at the start of admission
2	Resuscitation Status is clearly visible as a flag in the demographic 'banner' and also the 'Care Compass' white board view.
3	The DNACPR task mandates the completion of a Treatment Escalation Plan – which includes a prompt for mental capacity assessment, as well as details of who is consulted in a best interests decision and details of that conversation.
4	DNACPR is 'signed' by the user but also 'assigns' responsibility to a consultant. This can be endorsed at a later date
5	Reporting will be available although full details of this are not yet available
6	Unlike current state the new DNACPR is not easily 'portable' i.e. taken in to the community

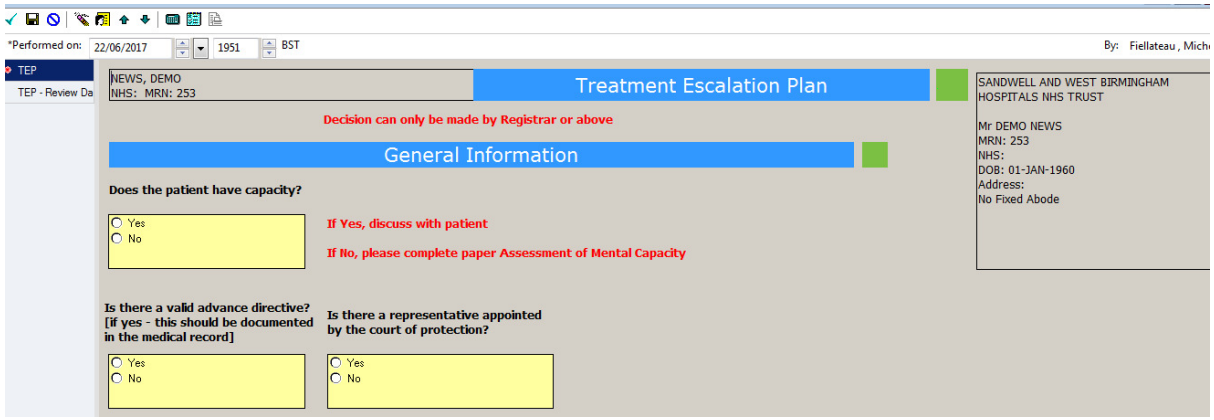
DOLs Recommendations / Action Plan

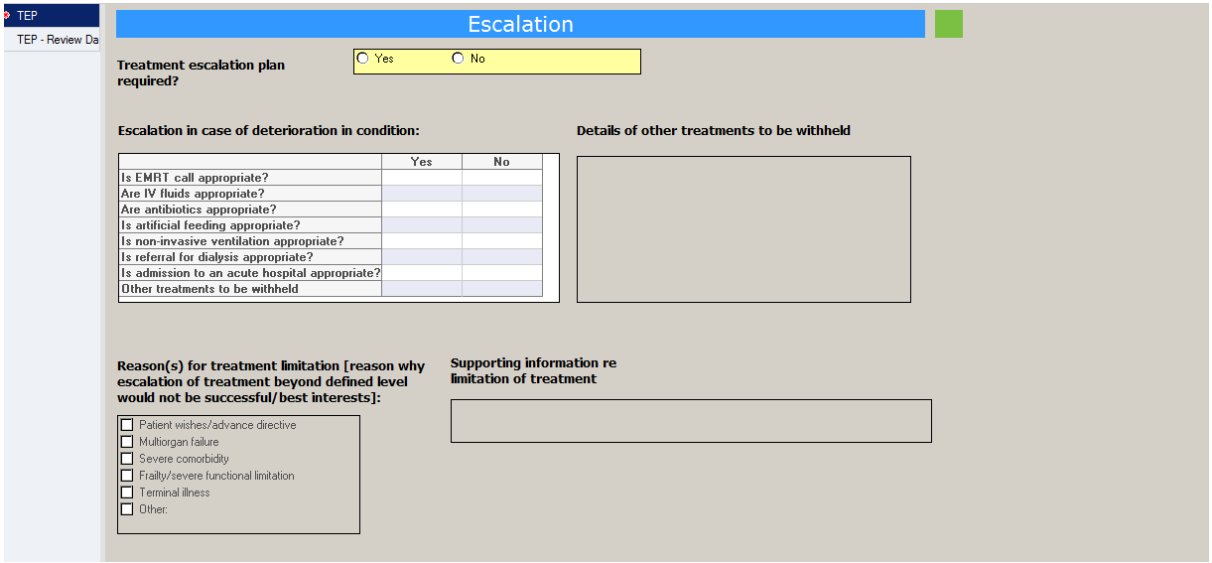
Item	DOLs	How
1	Review training metrics and strategy (training gaps already highlighted by CQC)	• Draft 1 training strategy completed following guidance Inter Collegiate document and scheduled for review at Julys SG steering group. • Widen target groups for SG level 2 training currently mandated at band 7 and above. ELearning packages under exploration to achieve outcomes. • Introduce level 3 class room base clinical band 8s and above to understand underpinning legislation and systems for investigation • Monitor assessment compliance via safety plan data • Develop consequence strategy
2	Develop an implement support plan for DOLs in clinical areas	• Vulnerable adult assessment page added to SAP 1 giving staff guidance to recognition of deprivation of liberties. • Video arranged to be recorded July to assist staff with the completion of assessment • Flow chart available to give overview of DOLs consideration displayed in all staff areas and copy in end of bed folders • Flow chart on practicalities of raising DOLs available on connect with relevant contacts • Policy in place • Bespoke training incorporated to the safety plan • To widen MT
3	Ensure all old SAP1 forms have been destroyed	• Medical illustrations have destroyed old surplus stock • Audit shared with GDONs ward managers with recommendation to ensure areas have destroyed old forms. • Message added to staff communications for ward manager to ensure old stock has been destroyed. • On launch and delivery of new documentation delivered to wards message to destroy old stock was reinforced. • Walk round of all wards to ensure all old stock has been destroyed. During this walk around no old stock had been identified

DOLs Recommendations / Action Plan

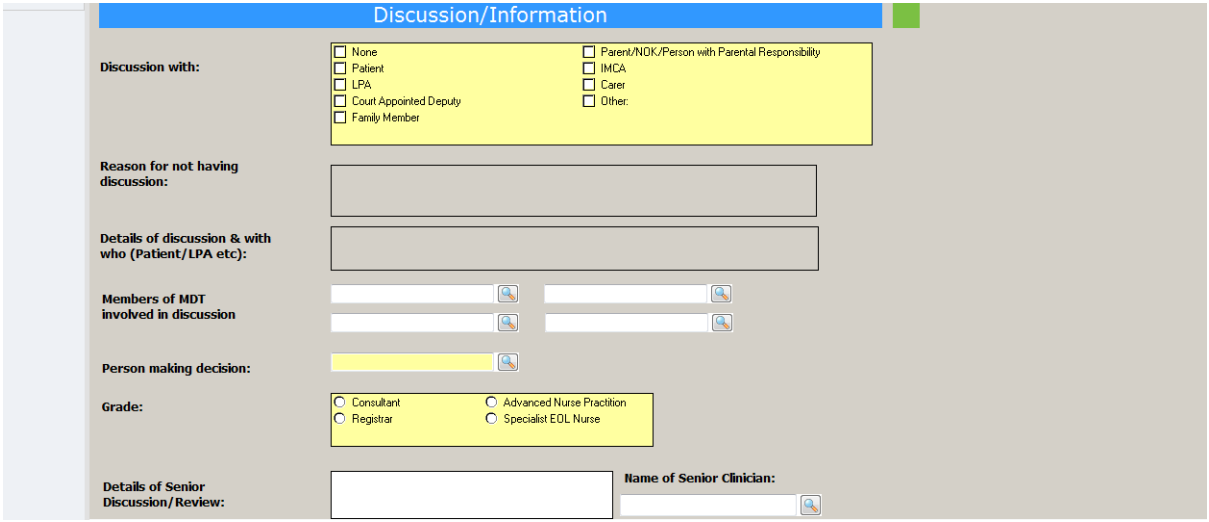
Item	DOLs	How
4	Stop using sticker system to indicate DOLs has been considered	• Achieved as above.
8	Ensure mandatory fields are built in to EPR for mental capacity	• Achieved as part of the admission process
10	Re audit application of MCA and DOLs	• All DOLs data shared with SG team maintained o dash board. • Numbers DOLs applied for by SWBH submitted to informatics monthly to be collated for IPR • Capacity standard in SP. Wards auditing compliance and inputting daily • SG nurse audits a 5% sample on all wards on quarterly basis feeding outcomes to GDONs/Matrons • 5 random applications per month audited in terms quality and relevance of information to guide teaching plans for practitioners. • CN team to identify high risk areas and undertake unannounced review of all records to ensure process in place and followed.

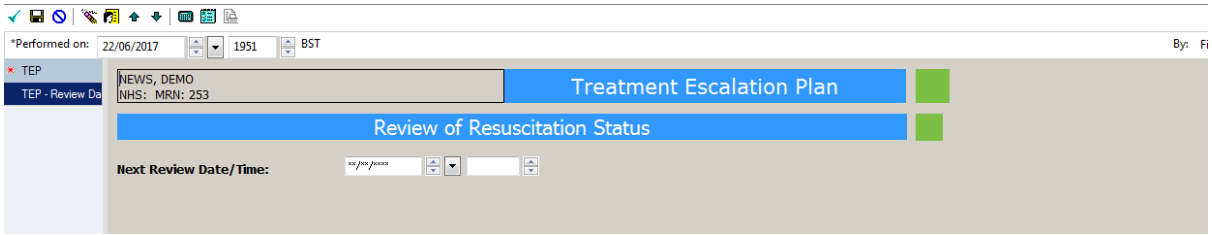
Cerner Millennium – TEP Screen Shots





Cerner Millennium – TEP Screen Shots





SWBTB (07/17) 013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	2016/17 Never Events: action plan review
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Allison Binns, Deputy Director of Governance
DATE OF MEETING:	6 July 2017

EXECUTIVE SUMMARY:

In response to a request at the June Board a review has been carried out to confirm that status of the actions arising from the investigations into the four Never Events that occurred between April 2016 and March 2017, in Maternity, Trauma & Orthopaedics, Ophthalmology and Gynaecology Twenty two actions were identified from the investigations of which eighteen have been implemented.

One action, relating to counting of parts of the instruments used in trauma surgery, has not been implemented after reviewing the level of risk together with the other identified actions and the effect this may have on efficiency. Two of the actions identified for Ophthalmology outpatients have not been implemented as they were decided by the Group to not be feasible. A third is planned but to date has not been implemented.

On-going monitoring will continue through various ways, including clinical audit reviews, in-house inspections, KPIs, observations, patient feedback, to ensure sustained delivery.

REPORT RECOMMENDATION:

The Board is recommended to **RECEIVE and NOTE** updates from Executive Directors for the four Never Events which occurred in 2016/17.

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 investigation reports, including actions plans, have previously been received by the Board.

Trust Response to Never Events occurring in 2016/17

1. Retained item at surgery

Incident date	Department/Ward	Lead Investigator
08.06.16	Maternity Labour Ward	Dr J Bleasdale, Anaesthetist

Incident synopsis:
A retained vaginal pack was discovered on delivery suite at City hospital on the 08.06.16 when the patient self-referred 3 days post emergency lower segment caesarean section.

Incident investigation synopsis:
There were a number of opportunities to avert this incident. Problems with the supply of large packs meant these were not available necessitating the use of an alternative. It is also unusual practice but not uncommon to use more than one vaginal pack following obstetric operations. Despite correctly documenting that there were two retained vaginal packs in situ on both the white board in theatre and in the theatre care plan, this did not translate onto the operation notes, the electronic patient record or verbally during handovers.

	Action	Action completed?	How do we know?	What monitoring is in place?
1.	Throat packs are no longer used in Maternity theatres.	**Yes**	These were removed straightaway and requirement for large packs escalated appropriately and immediately.	The specialty theatre manager monitors with bar coding and stock reviews.
2.	Staff to reflect on the incident and share learning including accessing documentation at the time of pack removal.	**Yes**	Discussed at an Obstetric QIHD attended by 62 staff of all disciplines.	Through attendance register and agenda.
3.	Initiate the use of fluorescent wristbands in gynaecology and maternity (1 wristband per pack) as a visual alert to ensure all packs are removed when relevant.	**Yes**	Visual observation of the wristband in use. Expanded the idea to include all surgical specialties.	Daily audit review and continued communications about importance.
4.	Develop a process for completion of the operation sign-out, so that staff document when packs, balloons etc are to be removed. The correct staff MUST be present for the sign-out	**Yes**	Completed as part of the trial use of the fluorescent wristbands.	Observational audits of practice.
5.	Initiate a programme of safety briefings and lunchtime meetings over a month to highlight documentation and handover issues to take place	**Yes**	Discussed at morning safety briefings, Consultant Forum, QIHD and local newsletter.	Standing agenda item on QIHD as monitored through documentation and handover.
6.	Develop a system for notifying theatre leads when there is a supply issue and approved alternatives are to be used.	**Yes**	All bar codes for maternity theatre stock have been provided and 'packs' are bar-coded. They now also state what the packs are so it is clearly visible.	This system is working well and there is an earlier point in the stocking process which flags when supplies are running short, together with an effective communication book
7.	Provide further training and develop a SOP for correct completion of Badgernet (maternity electronic patient record)	**Yes**	Further training has been provided to both doctors and midwives within Obstetrics and standard operating procedures (SOP) developed for correct completion of Badgernet (maternity electronic patient record) for intra-partum and triage stages.	Ongoing review of records indicates these are improving and planned audit for August 2017.

2. Retained item at surgery

Incident date	Department/Ward	Lead Investigator
01.09.16	Trauma & Orthopaedic Theatres	Mr A Tyagi, Ophthalmologist

Incident synopsis:
A retained drill guide used as part of an open reduction internal fixation (ORIF) of the left humerus operation in Theatre 4, Sandwell General Hospital on 29.6.16 was left in situ.

Incident investigation synopsis:
Although the operation was straight forward it was recognised that the fracture was large and that the drill guide became obscured by the muscle. The instrument count did not identify that there was an item missing which led to it being left in the patient when it should have been removed. As the drill guide is made from the same material as the 'plate', there should not be any adverse complication from leaving it place until the fracture has healed.

	Action	Action completed?	How do we know?	What monitoring is in place?
1.	Instigate a protocol for operations that take place under x-ray control, that there must be a surgical pause for the operating team to thoroughly review the x-ray image and positively identify that the image is for the correct patient.	**Yes**	A surgical pause was introduced and is now part of the WHO checklist during 'time-out'. It has been cascaded to all Directorates, all surgeons and all theatre staff directly.	This is audited on a monthly basis as part of the WHO surgical checklist audit. Data for April 2017 shows 100% compliance with the snapshot done.
2.	For ORIF operations, the drill guide must be recorded on the whiteboard to aid accurate instrument counting.	**No**	Trialled and after thorough discussion with theatre managers and Group Director agreed that this was not a feasible action.	Not applicable
3.	Instigate a process where the scrub nurses that complete the instrument count should visually confirm each item during the count (rather than just verbal confirmation).	**Yes**	Random observational reviews have shown this is happening in all cases seen.	Random observation of theatre lists.
4.	Discuss standardising relevant instrument trays with Bbraun and add risk to Theatres Risk Register	**Yes**	All basic trays have been standardised. Some of the more complex trays have not been standardised and issue remains on the risk register	Tray standardisation can be seen on a daily basis.
5.	Instigate a process where the next patient on the operating list will not be sent for until the final count is completed.	**Yes**	Clarified to ALL the surgeons, anaesthetists and the theatre staff directly via email. SOP produced.	Nursing staff initiate call for the next patient only after the count despite some pressure to send earlier.
6.	Ensure staff are aware of actions of previous never event so that practice is standardised.	**Yes**	Discussed at September QIHD for surgical specialties and theatres. 43 staff attended. Further communicated via email.	Attendance register and agenda.

3. Wrong site surgery

Incident date	Department/Ward	Lead Investigator
03/11/16	Ophthalmology	Dr J Bleasdale, Anaesthetist

Incident synopsis:

On 3 November 2016 during an afternoon session, two patients with similar names and dates of birth attended the Birmingham and Midlands Eye Hospital (BMEC) Outpatients.
Patient 1 was attending an outpatient's review clinic and patient 2 required Lucentis injections in each eye.

When Patient 2 was called for their injection Patient 1 stood up and went into the room. The operator in the room had a temporary copy of the notes for Patient 2. Patient 1 was consented for the procedure, using the details of Patient 2, and bilateral injections were performed in accordance with normal procedure – including WHO checklist and pause for procedure confirmation and SOP stamp. Following the injections Patient 1 was sent home.

At about the same time Patient 1 was called for visual acuity tests and Patient 2 stood up and went into the room. Patient 2 then had a visual acuity test and eye drops and was sent for, and had, an OCT scan, none of which were necessary.

At approx. 5.30pm, Patient 2 notified the nurse in charge that they had been waiting for their injections. The nurse explained that the injection list had finished, apologised and said they would be contacted with another date for their injection.

Incident investigation synopsis:

This incident occurred following an accumulation of environmental (timing, co-location and busy clinic) and human (distraction and pressure error) factors. However, the fundamental error was a failure to positively identify Patients 1 and 2 at any stage during their visit to BMEC Outpatients.

	Action	Action completed?	How do we know?	What monitoring is in place?
1.	Implement a process whereby staff retrieving any patient from a waiting area must positively identify the patient.	**Yes**	Part of QIHD agenda and has been monitored. Results show this is happening – audit compliance 100%	Continuous observational and Lucentis audits 6 monthly.
2.	Develop a process whereby patients undergoing an invasive procedure (injections or laser treatment) in outpatients are issued with a patient identification wristband at clinic registration.	**No**	Positive patient identification is the best option for this. Same clinician checks show this would not improve safety	Not applicable
3.	The Injection Clinic Waiting Room has been isolated from the other waiting areas and patients for injections are directed straight to that area. Isolate the Injection Clinic Waiting Room from the other waiting areas and make sure that patients for injections are directed straight to that area	**Yes**	Patient flow and observation of patients attending clinic.	Staff aware of waiting areas for specific clinics and kiosks direct appropriately.
4.	Strengthen the consent process so that: - No consent is taken on the day for patients having their first injection - For patients having subsequent injections, consent can be on the day only after confirmation with a Consultant.	**Yes** **Yes**	Revised SOP communicated states that the injector will discuss with the senior Medical Retinal Clinician to review the risks and benefits of deferring treatment as IVT is a time dependent procedure.	Audit showed that no consent for new patients have been done on the day. Audited 6 monthly.

5.	The Injection Clinic SOP has been updated and the checking process shared with learning from main BMEC theatres serious incidents. Update Injection Clinic SOP and checking process with shared learning from main BMEC theatres serious incidents	Yes	Updated SOP, all nurses provided with a copy and one available in all rooms.	Revisited during team meetings and QIHD.
6.	Undertake video-reflexivity exercise to in the Injection Clinic once the necessary changes have been embedded	No	Not completed but due to commence during quarter 3.	To be confirmed
7.	Assess the feasibility of the electronic self-check-in system recognising two patients with the same surname attending outpatients for the same session and create an alert.	No	This has been assessed and is not possible.	Not applicable

4. Retained item at surgery

Incident date	**Department/Ward**	**Lead Investigator**
11.01.2017	Gynaecology	Dr J Bleasdale, Anaesthetist

Incident synopsis:
A patient returned to the Gynaecology clinic following emergency surgery five weeks previously at which point a retained ribbon gauze pack was identified that should have been removed prior to discharge from hospital following surgery.

Incident investigation synopsis:
Actions were taken following the last retained swab Never event (July 2016) including a change in policy and procedures to include the use of coloured wrist bands to indicate deliberately retained swabs following surgery. In this instance that policy change was fully followed by the surgical team – the nature and position of the retained swab was documented in the notes and the wrist band was in place. The staff member that prepared the patient for discharge removed the wrist band when she believed the pack to have either already fallen out or been removed.

The investigation identified a number of factors that contributed to this human error:

- Practice regarding the use of retained packs in this particular procedure varies between practitioners and also depending on clinical circumstances – therefore the use of ribbon gauze in this procedure is not consistent
- The member of staff that made the error was aware of the policy change – however was not fully briefed regarding the detail, due to being a regular night shift worker. This led to overlooking policy detail – including the requirement for 2 staff members to be involved in removing packs.
- The changes to the 'Safer Surgery Policy' had been ratified by the Theatres Board however the new policy had not been uploaded onto the intranet.

	Action	**Action completed?**	**How do we know?**	**What monitoring is in place?**
1.	Introduced a policy that clearly demonstrates the number of packs intentionally left in the patient at the end of a surgical procedure that will need to be removed at a later time.	**Yes**	Safer Surgery Policy updated and available on the intranet.	None in place as yet but will form part of the Theatre safety audit which will be carried out over the next 2 months.
2.	Permitted the use of ribbon gauze as clinically indicated but stopped use of Jelonet and blue gauze.	**Yes**	Shared at QIHD in March 2017.	Agenda and attendance.

Conclusion

Of the twenty two actions identified following the investigations into these Never Events some are key drivers to change which would materially improve safety for patients. These are listed below

- In our **first** retained item incident, the introduction of a fluorescent wristband is the key driver, supported by effective documentation and communication. The trial in gynaecology and maternity proved successful and thus their use was rolled out to all theatres.
- The **second** retained item incident required a visual check at two points to provide assurance to prevent recurrence. The introduction of the surgical pause ahead of wound closure is the first check. As a second check, nursing staff visually identify the surgical instruments to ensure all are present.
- Positive Patient identification was the key driver for preventing a recurrence of the **third** incident, as this would undoubtedly have prevented the incident from occurring, regardless of all of the other actions. This is a simple inexpensive action, which should be promoted and used to promote safety in all departments.
- The **fourth** incident is linked in some way to the first, identifying that communication and documentation are key contributors in most cases.

This review of the Trust's response to last year's Never Events confirms that the key drivers for change have been identified and implemented. Continuous monitoring will ensure sustained practice and minimise recurrence.

Allison Binns
Deputy Director of Governance

28 June 2017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Never Event Update
SPONSOR (EXECUTIVE DIRECTOR):	Roger Stedman, Medical Director
AUTHOR:	Allison Binns, Deputy Director of Governance
DATE OF MEETING:	6 July 2017

EXECUTIVE SUMMARY:

On 13 June 2017, PN was booked into clinic for laser treatment for her left eye, having had the right eye treated in April 2017.

Due to a prior patient having some issues, the doctor had to leave clinic to discuss this with a Consultant, which meant the clinic started late. In an effort to catch up the process of getting the patient seen initially, eye pressures checked, Identification checked and the necessary eye drops instilled, was rushed.

Part of the checking process is to verify which eye is to be treated through use of the medisoft record (Ophthalmic electronic patient record), the manual records and by asking the patient.

The local laser rules (2017) state:

- Confirmed the eye to be lasered
- Confirmed that the correct consent form has been signed and filed
- Confirmed the exact laser procedure to be carried out

The information contained on Medisoft identified within the management plan that both eyes are to receive laser treatment at 360^{o} with the right eye being done first. This was done on 12 April 2017 and documented in the manual record and the operative section of Medisoft. The consent form was available with the manual records and stated that 'right then left selective laser trabeculoplasty' had been agreed to. This sequential consenting is 'normal' practice and not clinician specific.

It was identified before the patient left clinic that the right eye had been treated again. An apology was given. The patient was seen the following day to check for any harm to the eye, of which there was none at this point, however she will be monitored.

There was a previous Never Event involving a patient undergoing Ophthalmic laser treatment in November 2013.This incident involved the same treatment but was performed on the wrong patient. The actions from this incident which are relevant to the current incident are:

1. *Review of current booking rules for laser clinics – appointments were staggered in January 2014*
2. *Consider provision of nurse to assist in laser clinic – establishment did not allow for this.*
3. *Consider making site marking a requirement for laser procedures – CD advised all medical staff in an email Jan 2014.*
4. *Review of consent procedure for laser patients – consent takes place in clinic to give patients consideration time.*

With regard to this recent Never Event, a nurse did check the identification of the patient prior to having her treatment, but was not involved in the site and side of the procedure check. No one marked the eye to be treated, but without an additional check, the wrong eye may still have been marked and treated.

Recommendations:

1. Review what process for checking side and marking is in place. Reinforce need to do this with support of a second checker.
2. Revisit the role of the nurse supporting this clinic.
3. Assess the risks of having two consent forms (one for each eye) versus one consent form with sequential procedures.

This Never Event was largely due to human error. The processes and procedures to safely provide laser treatment to patients are in place and if followed would prevent a further incident of a similar nature. The only immediate solution to prevention, is to carry out laser treatment to both eyes at the same appointment, however there are also risks to the patient of this.

REPORT RECOMMENDATION:

NOTE and DISCUSS the overview information for this Never Event.

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Safe, High quality care

PREVIOUS CONSIDERATION:

SWBTB (07/17) 014a

Laser Eye Never Events Actions

The most recent laser eye never event follows a similar never event that occurred in November 2013. This paper reviews the actions taken following that never event, reflects on decisions made regarding those actions and provides a proposed updated action plan for the current never event.

Never Event – 12/11/2013 – Wrong Patient in Ophthalmology Outpatient Procedures (Laser)

Root Cause – Failure of positive patient identification procedure

Contributing factors – Weaknesses in laser safety training,
- Outpatient booking procedures – all patients booked to arrive at start of clinic,
- No nursing assistance in clinic,
- No site marking,
- No two part consent (obtained on day of procedure).

Action plan

A) Root Cause: Training/System failure.					
	Action	**By Whom**	**By When**	**Evidence/Measure**	**Date Achieved**
A1	Review current laser rules in eye clinic, make amendments as appropriate and commence regular audit of clinics to ensure compliance. Amendments required to include a) Correct LPS b) Remove redundant lasers c) Ensure all current lasers have up to date laser rules. d) Document to be dated	**Lead Consultant/Matron**	**Immediate**	Action to be monitored by Surg B Review of current laser rules completed.(20.11.13) Amended Local Laser Safety Rules to be agreed and circulated to all laser users and appropriate nursing staff.	**20/11/13**
A2	List of authorised	**Matron/ DGM**	**Immediate**	Action to be monitored	**01/01/14**

	laser users to be updated and a database to be compiled and kept up to date.			by Surg B New proforma has been developed (ZK) and current users are signing forms. (20.11.13) **Update 01/01/14:** Database created for City and circulated to A&E & OPD	
A3	Review of Laser Safety training with a view to reinstating session on induction training.	**Consultant Physicist/ Matron/ Lead Consultant**		Action to be monitored by Surg B New Junior Doctors are currently signing induction sheet when receiving laser rules and being given information regarding laser safety. (Current practice) Group currently investigating possibility of securing Core of Knowledge Training for medical staff and LPS. LY to contact St Georges 25.11.13. with regards to training and folder. ES to contact Queen Elizabeth for training options.	

B) Root Cause: Human Error. Failure to positively identify patient in accordance with trust procedure.					
	Action	**By Whom**	**By When**	**Evidence/Measure**	**Date Achieved**
B1	All out-patient procedures to be risk assessed, reviewed and audited to ensure positive patient identification is carried out in line with trust policy.	**Lead Consultant/ Matron**	**31/12/13**	Action to be monitored by Surg B Email sent out to all medical staff from Mr Sung reinforcing the need for appropriate ID checks.13.11.13 Action to be monitored Corporately Audit results to be fed back to Group Governance Board 19.12.13	**13/11/13** **01/01/14**

				Update 01/01/14: Audit carried out on 02/12/13 – 39 pts reviewed – 100% compliance achieved	
B2	Potential of ID checks to be placed on Risk Register	**Matron**	**31/12/13**	Action to be monitored by Surg B To be discussed for inclusion at the next Group Governance Meeting **Update 01/01/14:** Risk Assessment completed	**01/01/14**

C) Issue arising: Clinic procedures:					
	Action	**By Whom**	**By When**	**Evidence/Measure**	**Date Achieved**
C1	Review of current booking rules for laser clinics	**Matron/ OPD Manager/ Lead Consultant**	**30/12/13**	Action to be monitored by Surg B Recommendations to be considered at Group Governance Meeting on 19/12/13 **Update 01/01/14:** Laser clinic bookings now staggered	**01/01/14**
C2	Consider provision of nurse to assist in laser clinic.	**Matron/ OPD Manager/ Lead Consultant**	**30/12/13**	Current establishment does not allow for allocation of trained nurse to all clinics. If correct ID checks are performed then risk of error is reduced	**01/01/14**
C3	Consider making site marking a requirement for laser procedures	**Matron/ OPD Manager/ Lead Consultant**	**30/12/13**	CD has emailed out to all medical staff. All clinicians are required to mark eyes	**01/01/14**

D) Issue arising: Informed Consent procedure:					
	Action	**By Whom**	**By When**	**Evidence/Measure**	**Date Achieved**
D1	**Review of consent procedure for laser patients**	**CD Glaucoma**	**Immediate**	Action to be monitored by Surg B Agreed that consenting	**05/12/13**

				will take place at listing in clinic where not emergency decision. This will allow patients to consider more fully their surgery. CD has emailed out to all medical staff.	
D2	Consider provision of appropriate Patient Information Leaflets to aid patient understanding	**OPD Manager**	**31/12/13**	Action to be monitored by Surg B a) Leaflets for laser patients – to contact companies / patient groups to see about obtaining appropriate leaflets. b) Ensure that appropriate in conjunction with Trust Leaflet Group **Update 01/01/14:** No leaflets available from companies at present – further investigation underway to locate being undertaken	**01/01/14**

E) Learning Point: Shared Learning					
	Action	**By Whom**	**By When**	**Evidence/Measure**	**Date Achieved**
E1	Learning Points from this incident to be circulated to all staff to raise awareness of the requirement for positive identification of patients prior to undertaking treatment/procedures	**MD/CE**	**Immediate**	Action to be monitored Corporately Learning points from "Never Events" published in Staff Bulletin and via CE's Friday message on Connect Page on Intranet. Case discussed at Trust Board	**Dec 13**

All the above actions have been carried and become established practice *except*

C2 – nursing assistance in outpatient procedure clinics and

C3 – Site marking by clinician

A risk assessed decision was made not to increase nursing establishment in order to provide for two person checking and site marking. In the absence of nursing support site marking has proved impractical for sole operators.

Never Event – 13/06/2017 Wrong site procedure in Ophthalmology Outpatient Procedures (laser)

Root Cause – Failure to verify correct site for treatment by checking medical record for what procedure had gone before

Contributing Factors
- sole operator in busy clinic,
- no supporting nursing staff,
- no site marking,
- single prior consent obtained for multi-site procedure carried out on separate occasions

Proposed Action Plan

A1	Re-consider provision of nurse to assist in laser clinic.	**Matron/ OPD Manager/ Lead Consultant**	**31/07/2017**		
A2	Re-consider making site marking a requirement for laser procedures	**Matron/ OPD Manager/ Lead Consultant**	**31/07/2017**		
A3	**Review of consent procedure for laser patients – consider separate consent forms for separate eyes on different occasions**	**CD Ophthalmology/ Deputy Director Governance**	**31/07/2017**		

Conclusion

Actions previously considered following laser eye surgery never event in 2013 but rejected should be re-considered. A full risk assessed options appraisal of consenting procedures for multi-site multi-episode laser eye surgery should be carried out.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Consistency of Care Programme: Progress Report
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	6 July 2017

EXECUTIVE SUMMARY:

A report on the progress made to deliver the Consistency of Care Programme is presented to the Board.

REPORT RECOMMENDATION:

The Board is recommended to **NOTE** the progress made to date with the Consistency of Care Programme and **DISCUSS** the findings to date and seek assurance that programme aim will be achieved.

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:

Previously considered by the Board at the April Development session.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report to the Trust Board: 7 July 2016

Consistency of Care in Medicine

Basics of good care consistently delivered

1. The issue

At its meeting in January 2017 the Board initiated a programme of work to address concerns about the consistency of basic care provided to patients on our medical wards. This was in response to a series of 'data points' held by the Trust giving cause for concern. Despite attention, long standing worries about documentation completeness and timeliness, the personalisation of care, and the way in which teams interact remained.

This paper provides a report on progress made and the next steps.

2. Programme scope

The CofC programme includes the medical wards (x13), assessment units (x4) and emergency departments (x2) at City and Sandwell Hospitals; a total of 19 locations.

3. Programme aims

The basics of good care are consistently delivered across all 19 areas included in the programme. Warning triggers cause us to look for positive assurance that we have a system of care that works, from which deviation can then be tackled and minimised. Working directly with each ward clinical team, they will implement action orientated improvement work and deliver change.

4. Progress to date

a. Two Listening into Action (LiA) **staff engagement** events held in March to launch the CofC Programme. The results of the ward teams' self-assessments of current care provision were shared alongside the future state, i.e. what good looks like.

b. 'First cut' **improvement plans** produced by each ward and presented to Executive colleagues in face-to-face meetings. All plans were found to be in need of refinement to varying levels and sent back for revision.

c. A team of **in-house 'buddies'** identified to work with individual wards to provide guidance, coaching and constructive challenge. The buddies also support the Red to Green initiative and Safety Plan implementation and monitoring to ensure an integrated approach.

d. An audit methodology devised to validate ward self-assessments of nursing and medical **documentation completeness and timeliness**. Audits conducted on a number of wards; none achieved 100% compliance but some were close. Feedback provided and the challenge set for

improvements to be made speedily. A prototype is being developed for shift by shift checking of documentation completeness involving peer to peer challenge.

e. Leadership improved through clarifying the **role of the ward manager** and the Matron and appointing **named ward consultants**. The requirement for ward based team meetings has provided a focal point for conversations to take place on a routine basis. The Trust-wide introduction of ward based QIHDs in April have provided a monthly forum for multi-disciplinary time on improvement work.

f. On-going work to **reduce the number of unfunded beds** has supported the CofC programme with some success as has the focus on addressing nurse and doctor **recruitment and retention** issues. There remain a significant number of nursing vacancies, particularly at Band 5 level.

g. **Safety Plan roll-out** on the medical wards at the beginning of June, with the first month being devoted to familiarisation with 'the ask' of completing the documentation and complying with the requirements. Early indications show mixed success, with well-staffed wards showing better results.

h. Work is underway to put in place effective **'push and pull' mechanisms** that provide reliant movement of patients from the Assessments Units to the most appropriate ward as soon as possible. Included in this work is meeting the original set Expected Date of Discharge (EDD).

i. Local performance intelligence and the ward response to the development of improvements plans has allowed the Executive to assign wards to **3 level; 'good', 'in the middle' and requiring intensive support**. In the case of the latter a self-assessment methodology has been created that allows the development of a location specific improvement plan.

5. Next steps

a. Follow-up meetings are scheduled to take place in the next few weeks to **review progress and receive revised improvement plans**, with the clinical teams most in need of direction being seen first.

b. A second LiA staff engagement event takes place on 24 July 2017 to share learning and celebrate successes.

c. The aim is to have the majority of wards 'signed-off' as being good and consistently delivering the basics of care by the end of quarter 2.

6. Recommendation

The Board is recommended to **NOTE** the progress made to date with the Consistency of Care Programme and **DISCUSS** the findings to date and seek assurance that programme aim will be achieved.

Kam Dhami
Director of Governance

28 June 2016

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Safety Plan progress update
SPONSOR (EXECUTIVE DIRECTOR):	Elaine Newell – Chief Nurse
AUTHOR:	Elaine Newell – Chief Nurse
DATE OF MEETING:	2nd July 2017

EXECUTIVE SUMMARY:

41 wards are now engaged in the deployment of the Trusts safety plan – medicine having commenced roll out on the 1st June. Detailed task level plans for each PDSA cycle are in place.

Analysis of data for the 4 week period 21st May – 18th June (inclusive of Medicine) shows 53,045 compliant checks against a possible 54,739 (97% compliance rate). A significant improvement in compliance can be expected in July, once medicine has embedded the process within their ward areas.
30 day Improvement trajectories have been set for 4 ward areas (Lyndon 2, SAU, Newton 3 and D21) and an overarching consequences approach agreed.

Thematic areas of non-compliance are VTE; Medicines reconciliation and MCA/DoLs. A series of root cause analysis reviews will be carried out on each of these subject areas before the end of July and will inform a rapid programme of improvement actions. In conjunction, a series of quality assurance checks will validate compliance data across all standards.

Following feedback from the PDSA 1 review, training has been revised for buddies. Initial feedback from the medicine roll out suggests that there has been greater visibility of buddies – possibly due to alignment with the consistency of care project.

The informatics team are currently working on capturing outcome data. This work will be completed by 5th July.

REPORT RECOMMENDATION:

The committee are asked to note the above findings and those demonstrated within the PMO display

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	**x**	Environmental	x	Communications & Media	x
Business and market share	**x**	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:
May Q & S

Safety plan – progress report

Elaine Newell – Chief Nurse

13 week plan - Safety plan: Progress 13th June 17	
Roll out across all inpatient areas	All areas now engaged in roll out
100% compliance with data entry	Surgery ; PC,C & T; W & CH. Medicine – early stage roll out – still showing areas of non-compliance
MDT engagement in daily / weekly meetings	There is largely still difficulty in securing involvement of medical staff in weekly MDT – expected to improve with identification of Ward lead consultants
E data entry access – all areas	All areas able to access / input data electronically
Automated reports generated daily	Reports generated automatically daily at 6am
100% compliance with standards – surgery / C & T / W &CH.	Majority of areas >98%. 4 areas <98% with average 3 – 4 non compliant checks overall per day these are N3; D21; L2; SAU. Improvement trajectories set for each area, consequence strategy established for non-compliant wards.
Daily reporting into Red / Green	Not yet in place
Buddy programme established	Buddy programme / training established for SP / CoC projects
Data feed into ward dashboards	Included as part of Early warning trigger tool
Evidence of improved outcomes displayed / fed back to ward teams	Data feed established. Published outcome data scheduled 5th July 17.
Safety plan metrics designed into EPR	Awaiting confirmation regarding observations (Vitalpak replacement)

SAFETY PLAN STATS | Ward Compliance %

>> CONVERT To Ticks/Crosses

>> CONVERT To PATIENTS

in this period 63,479 checks undertaken, of which 2951 failed. This gives an overall compliance rate of 97% inc' of medicine

Patients Checked Each Day

	#####	#####	######	######	Jun 01	Jun 02	Jun 03	Jun 04	Jun 05	Jun 06	Jun 07	Jun 08	Jun 09	Jun 10	Jun 11	Jun 12	Jun 13	Jun 14	Jun 15	Jun 16	Jun 17	Jun 18	Jun 19	Jun 20	Jun 21	Jun 22	Jun 23	Jun 24	Jun 25	Jun 26	CHECKED PATIENTS	CHECKS	FAILED CHECKS	% SUCCESFULL CHECKS PER PATIENT
City - Neonatal Unit	1	2	4	2	0	0	3	0	2	2	3	0	1	3	3	1	1	0	0	2	0	0	0	1	3	1	2	1	2	2	42	798	59	92.61
City AMU 1					26	5	18		8	11	5	10	7	4	8	4	8	7	7		6			11		9			9	6	169	3211	83	97.42
City AMU 2					5	7	4	7	9	6	7	5	2		4	5	5		5	11	11		16	6	8		8	6	3	8	148	2812	50	98.22
City D11					20	3	3	4	1	2	1	3	3	2	2	1	2	7	2	3	3	2	1	1	1	4	0	4	0	0	75	1425	68	95.23
City D15					22	1	6	2	0	4	4	4	3	4	1		3	3	2	3	2	4		2	3	4	4	2	1	2	86	1634	41	97.49
City D16					21	2		4	1	4	4	4	2	3	3			4	3	5	12	3		5	3	2	1	4	3	1	94	1786	123	93.11
City D19	1	0	1	0	0	1	0	0	1	0	0	1	0	1	4	0	5	0	0	0	1	0	1	0	1	1	0	0	0	1	20	380	2	99.47
City D21	1	0	1	4	5	1	6	1	5	4	3	3	3	3	1	3	5	2	3	3	3	2	2	6	4	4	0	0	7	2	87	1653	98	94.07
City D26					21	4			3	5	1	3	3	0	1	1	3	4	5	4	2	4	2	3	4	2	2	2	0	0	79	1501	2	99.87
City D27	0	2	2	2	6	2	4	0	6	3	3	4	2	4	0	1	5	6	7	2	6	2	0	1	2	4	3		0		79	1501	0	100.00
City D43	1	2	0	1	1	5	1	3	0	3	3	5	3	3	1	3	2	4	5	5	5	3	0	4	2	3	7	4	0	1	80	1520	10	99.34
City D47	0	1	0	0	1	1	1	0	0	0	1	0	0	0	0	0	0	1	0	0	0	1	0	1	2	2	5	3	1	0	21	399	1	99.75
City D5					15	1			2	3		1	1			2	1	1	2	2	5	2	3	5	4	3	2	1	4	2	62	1178	42	96.43
City D7					15				2	3	4	3	3		2	1	0	1	2	4			6	4	5	2	4	0	2	2	65	1235	52	95.79
City EGAU	1	0	2	1	0	1	0	0	2	1	1	2	0	0	1		2	1	2	2	1	0	1	0	0	0	2	0	0	0	23	437	0	100.00
City Eye Ward	1	1	2	3	2	2	0	1	0	3	1	1	3	1	2	0	4	3	3	0	2	2	3	0	2	1	1	0	1	1	46	874	19	97.83
City Female Surgical Ward	0	3	5	1	4	3	3	0	1	3	6	3	0	5	1	0	8	1	4	4	4	2	1	4	1	1	0	0	3	2	73	1387	21	98.49
City M1	3	3	0	8	6	2	2	3	2	4	4	3	4	4	2	5	2	4	3	4	4	2	4	3	3	3	5		2		94	1786	7	99.61
City M2	0	5	5	7	6	6	8	8	3	7	6	6	6	5	5	7	3		4	5	4	4	3	5	2	5	3	7	5	3	143	2717	1	99.96
LEASOWES	0	0	0	1	0	0	1	2	1	2	0	1	1	0	0	1	0	1	0	0	1	1	1	0	1	0	2	1	0	0	18	342	2	99.42
Rowley Eliza Tinsley	0	3	1	1	1	1	4	2	0	1	1		4	2	0	1	0	5	1	2	4	1	1	1	3	0	1	2	2	0	45	855	34	96.02
Rowley Henderson	0		0	0	2	1	0	0	0	0	2	1	1	1	1	0	0	0	0	1	1	2	0	1	0	1	1	0	1	0	17	323	45	86.07
Rowley McCarthy	1	1	5	1	0	2	1	0	1	1	2	2	2	0	2	0	2	0	1	2	3	0	1	1	3	2	2	1	0	0	39	741	3	99.60
Sandwell AMU A					6	30	15	5	14	8	9	18	13	12	21	15	28	23	7	24	26	13	14	12	13	5	32	19	14		396	7524	288	96.17
Sandwell Lyndon 1	0	2	1	3	1	3	0	1	0	3	1	7	3	4	2	1	1	1	3	0	2	1	3	2	4	1	3	2	3	2	60	1140	2	99.82
Sandwell Lyndon 2	1	6	4	4	4	12	6	6	3	4	6	3	3	9	4	4		9	7	5	9	10		10	7	9		4	6	14	169	3211	237	92.62
Sandwell Lyndon 3	3	0	0	2	3	5	3	0	4	2	1	6	5	3	3	0	1	4	4	2	6	2	0	1	0	6	4	0	0	0	70	1330	35	97.37
Sandwell Lyndon 4					34	3	6	6	1	6	8	3	6	10	0	2	4	5	3	4	3	1	1	4	3	5	6	3	6	2	135	2565	91	96.45
Sandwell Lyndon 5					30	1	8	3	0	0	4	2	0	0	1	3	3	2	0	0		0	2	4	0	3	0		0		66	1254	127	89.87
Sandwell Lyndon Ground	0	1	0	0	1	0	0	0	0	0	1	0	0	0	2	0	0	2	1	0	1	1	0	0	0	7	1	1	8	1	28	532	3	99.44
Sandwell Newton 3	4	3	1	4	2	3	4	4	2	5	2	1	3	5	4	3	3	2	2	6	4	3	3	4	4	5	3	2	3	3	97	1843	23	98.75
Sandwell Newton 4					28	0	0	3	0	0	1	1	0	0	0	0	2	1	1	1	0	0	0	28	1	0	0	3	0		70	1330	31	97.67
Sandwell Newton 5					14	0	3		0	2	3	1	2	0	0	1	2	0	2	0	2		3	0	1	2	3	0	0	1	42	798	137	82.83
Sandwell OPAU					3	8	17	1	1	2	2		6	2	3	1	1	8	3	3	2	3	3	5	6	3					83	1577	34	97.84
Sandwell Priory 2	1	3	2	3	4	3	1	0	0	3	1	1	6	2	1	3	3	1	1	0	2	4	4	4	2	3	5		2	3	68	1292	30	97.68
Sandwell Priory 4					13	0	1	3	4	2	1	3	1	2	5	1	7	3	7	7	3	4	2	2	3	2	3	1	5		85	1615	21	98.70
Sandwell Priory 5					34	6	11	5	5	10	6	9	5	6	5	0	6	11	4	4	7	1	0	8	0	0	8	8	4	2	165	3135	75	97.61
Sandwell SAU	4	9	2	3	10	8	5	0	9	9	11	4	12	12	2	7	14	4	7	4	6	4	8	12		9	10	10	7		202	3838	154	95.99

SAFETY PLAN STATS | Numbers

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

>> CONVERT To Ticks/Crosses

>> CONVERT To PERCENTAGES %

+ CLICK HERE FOR TRUST LEVEL by INDICATOR	May 28		May 29		May 30		May 31		Jun 01		Jun 02		Jun 03		Jun 04		Jun 05		Jun 06		Jun 07		Jun 08		Jun 09		Jun 10	
	NC		NC		NC		NC		NC		NC		NC		NC		NC		NC		NC		NC		NC		NC	
+ City - Neonatal Unit	0	1	0	2	0	4	9	2	0	0	0	0	0	3	0	0	0	2	0	2	0	3	0	0	2	1	2	3
+ City AMU 1									11	26	2	5	24	18			6	8	0	11	2	5	2	10	5	7	0	4
+ City AMU 2									8	5	0	7	6	4	7	7	0	9	2	6	1	7	0	5	0	2		
+ City D11									45	20	0	3	0	3	0	4	0	1	0	2	0	1	0	3	20	3	0	2
+ City D15									12	22	0	1	4	6	2	2	0	0	3	4	5	4	4	4	2	3	2	4
+ City D16									25	21	0	2			2	4	4	1	29	4	0	4	0	4	0	2	0	3
+ City D19	0	1	0	0	0	1	0	0	0	0	2	1	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	1
+ City D21	0	1	0	0	0	1	10	4	13	5	1	1	1	6	0	1	5	5	4	4	1	3	1	3	2	3	0	3
+ City D26									2	21	0	4					0	3	0	5	0	1	0	3	0	3	0	0
+ City D27	0	0	0	2	0	2	0	2	0	6	0	2	0	4	0	0	0	6	0	3	0	3	0	4	0	2	0	4
+ City D43	0	1	0	2	0	0	0	1	0	1	0	5	0	1	0	3	0	0	0	3	0	3	0	5	10	3	0	3
+ City D47	0	0	0	1	0	0	0	0	0	1	0	1	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0
+ City D5									30	15	0	1					0	2	0	3			1	1	0	1		
+ City D7									31	15							14	2	1	3	3	4	0	3	0	3		
+ City EGAU	0	1	0	0	0	2	0	1	0	0	0	1	0	0	0	0	0	2	0	1	0	1	0	2	0	0	0	0
+ City Eye Ward	0	1	0	1	0	2	0	3	0	2	0	2	0	0	0	1	0	0	0	3	1	1	0	1	4	3	0	1
+ City Female Surgical Ward	0	0	1	3	1	5	0	1	0	4	1	3	1	3	0	0	0	1	0	3	6	6	0	3	0	0	2	5
+ City M1	0	3	0	3	0	0	3	8	0	6	2	2	0	2	0	3	0	2	0	4	0	4	0	3	0	4	1	4
+ City M2	0	0	0	5	0	5	0	7	0	6	0	6	0	8	0	8	0	3	0	7	0	6	0	6	0	6	0	5
+ LEASOWES	0	0	0	0	0	0	0	1	0	0	0	0	0	1	2	2	0	1	0	2	0	0	0	1	0	1	0	0
+ Rowley Eliza Tinsley	0	0	14	3	2	1	0	1	0	1	0	1	3	4	0	2	0	0	0	1	0	1			4	4	0	2
+ Rowley Henderson	0	0			0	0	0	0	0	2	2	1	0	0	0	0	0	0	0	0	1	2	20	1	4	1	1	1
+ Rowley McCarthy	0	1	0	1	0	5	0	1	0	0	0	2	0	1	0	0	0	1	0	1	0	2	0	2	0	2	0	0
+ Sandwell AMU A									5	6	10	30	26	15	4	5	7	14	2	8	8	9	8	18	8	13	26	12
+ Sandwell Lyndon 1	0	0	0	2	0	1	0	3	0	1	0	3	0	0	0	1	0	0	0	3	0	1	0	7	0	3	0	4
+ Sandwell Lyndon 2	4	1	33	6	0	4	0	4	15	4	0	12	0	6	26	6	0	3	0	4	24	6	0	3	0	3	34	9
+ Sandwell Lyndon 3	0	3	0	0	0	0	0	2	0	3	0	5	9	3	0	0	1	4	0	2	1	1	0	6	0	5	0	3
+ Sandwell Lyndon 4									12	34	3	3	3	6	3	6	0	1	9	6	5	8	2	3	2	6	7	10
+ Sandwell Lyndon 5									75	30	0	1	3	8	8	3	0	0	0	0	10	4	4	2	0	0	0	0
+ Sandwell Lyndon Ground	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
+ Sandwell Newton 3	3	4	1	3	0	1	0	4	0	2	2	3	0	4	0	4	1	2	4	5	0	2	0	1	0	3	2	5
+ Sandwell Newton 4									30	28	0	0	0	0	0	3	0	0	0	0	0	1	0	1	0	0	0	0
+ Sandwell Newton 5									22	14	0	0	54	3			0	0	0	2	8	3	0	1	0	2	0	0
+ Sandwell OPAU									3	3	4	8	5	17	1	1	0	1	0	2	1	2			3	6	0	2
+ Sandwell Priory 2	0	1	1	3	0	2	2	3	5	4	4	3	0	1	0	0	0	0	1	3	2	1	0	1	1	6	1	2
+ Sandwell Priory 4									8	13	0	0	1	1	1	3	2	4	0	2	1	1	2	3	0	1	0	2
+ Sandwell Priory 5									40	34	0	6	0	11	0	5	0	5	2	10	0	6	0	9	0	5	0	6
+ Sandwell SAU	2	4	7	9	0	2	0	3	6	10	13	8	4	5	0	0	11	9	11	9	5	11	1	4	28	12	17	12
Total Non Compliant Checks that Day	9	23	57	47	3	38	24	51	398	##	46	133	144	##	56	74	51	93	68	128	85	119	45	124	95	119	95	112

+ CLICK HERE FOR TRUST LEVEL by INDICATOR	Jun 11		Jun 12		Jun 13		Jun 14		Jun 15		Jun 16		Jun 17		Jun 18		Jun 19		Jun 20		Jun 21		Jun 22		Jun 23		Jun 24		Jun 25		Jun 26		Total				
	NC		NC		NC		NC		NC		NC		NC		NC		NC		NC		NC		NC		NC		NC		NC		NC		Non Compliant Checks	Patients	LAST 4 weeks COMPLIANCE %	Qtr 1	
+ City - Neonatal Unit	0	3	1	1	3	1	0	0	0	0	0	2	0	0	0	0	0	0	1	1	0	3	0	1	0	2	1	1	1	2	39	2	59	42	92.6	95.3	✘
+ City AMU 1	0	8	0	4	1	8	5	7	0	7			0	6					5	11			6	9					10	9	4	6	83	169	97.4	97.4	✘
+ City AMU 2	0	4	1	5	0	5			1	5	5	11	1	11			4	16	2	6	0	8			8	8	0	6	0	3	4	8	50	148	98.2	98.2	✘
+ City D11	0	2	1	1	1	2	0	7	1	2	0	3	0	3	0	2	0	1	0	1	0	1	0	4	0	0	0	4	0	0	0	0	68	75	95.2	95.2	✘
+ City D15	1	1			0	3	0	3	2	2	1	3	1	2	1	4			0	2	0	3	0	4	0	4	1	2	0	1	0	2	41	86	97.5	97.5	✘
+ City D16	4	3					0	4	0	3	0	5	20	12	0	3			30	5	0	3	9	2	0	1	0	4	0	3	0	1	123	94	93.1	93.1	✘
+ City D19	0	4	0	0	0	5	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	1	0	0	0	0	0	0	0	1	2	20	99.5	98.4	✘
+ City D21	2	1	2	3	4	5	0	2	5	3	3	3	3	3	0	2	3	2	6	6	6	4	6	4	0	0	0	0	17	7	3	2	98	87	94.1	95.8	✘
+ City D26	0	1	0	1	0	3	0	4	0	5	0	4	0	2	0	4	0	2	0	3	0	4	0	2	0	2	0	2	0	0	0	0	2	79	99.9	99.9	✘
+ City D27	0	0	0	1	0	5	0	6	0	7	0	2	0	6	0	2	0	0	0	1	0	2	0	4	0	3			0	0			0	79	100.0	98.0	✓
+ City D43	0	1	0	3	0	2	0	4	0	5	0	5	0	5	0	3	0	0	0	4	0	2	0	3	0	7	0	4	0	0	0	1	10	80	99.3	99.5	✘
+ City D47	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	1	1	0	2	0	2	0	5	0	3	0	1	0	0	1	21	99.7	99.6	✘
+ City D5			0	2	0	1	0	1	0	2	0	2	1	5	0	2	1	3	1	5	1	4	0	3	0	2	0	1	7	4	0	2	42	62	96.4	96.4	✘
+ City D7	0	2	1	1	0	0	0	1	0	2	0	4					1	6	1	4	0	5	0	2	0	4	0	0	0	2	0	2	52	65	95.8	95.8	✘
+ City EGAU	0	1			0	2	0	1	0	2	0	2	0	1	0	0	0	1	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	23	100.0	99.9	✓
+ City Eye Ward	0	2	0	0	0	4	4	3	0	3	0	0	1	2	2	2	0	3	0	0	0	2	7	1	0	1	0	0	0	1	0	1	19	46	97.8	97.3	✘
+ City Female Surgical Ward	0	1	0	0	2	8	0	1	1	4	0	4	4	4	0	2	0	1	2	4	0	1	0	1	0	0	0	0	0	3	0	2	21	73	98.5	97.4	✘
+ City M1	0	2	0	5	0	2	0	4	1	3	0	4	0	4	0	2	0	4	0	3	0	3	0	3	0	5			0	2			7	94	99.6	99.8	✘
+ City M2	0	5	0	7	0	3			0	4	1	5	0	4	0	4	0	3	0	5	0	2	0	5	0	3	0	7	0	5	0	3	1	143	100.0	100.0	✘
+ LEASOWES	0	0	0	1	0	0	0	1	0	0	0	0	0	1	0	1	0	1	0	0	0	1	0	0	0	2	0	1	0	0	0	0	2	18	99.4	99.6	✘
+ Rowley Eliza Tinsley	0	0	0	1	0	0	3	5	0	1	0	2	4	4	0	1	0	1	3	1	0	3	0	0	0	1	0	2	1	2	0	0	34	45	96.0	92.5	✘
+ Rowley Henderson	7	1	0	0	0	0	0	0	0	0	2	1	2	1	4	2	0	0	2	1	0	0	0	1	0	1	0	0	0	1	0	0	45	17	86.1	91.3	✘
+ Rowley McCarthy	0	2	0	0	0	2	0	0	0	1	0	2	0	3	0	0	0	1	0	1	0	3	0	2	1	2	2	1	0	0	0	0	3	39	99.6	99.1	✘
+ Sandwell AMU A	38	21	0	15	4	28	15	23	7	7	4	24	21	26	26	13	17	14	21	12	3	13	0	5	10	32	1	19	17	14			288	396	96.2	96.2	✘
+ Sandwell Lyndon 1	0	2	0	1	0	1	0	1	0	3	0	0	0	2	0	1	0	3	0	2	0	4	0	1	0	3	0	2	2	3	0	2	2	60	99.8	99.8	✘
+ Sandwell Lyndon 2	1	4	2	4			1	9	0	7	3	5	5	9	1	10			0	10	28	7	44	9			16	4	0	6	0	14	237	169	92.6	94.7	✘
+ Sandwell Lyndon 3	4	3	0	0	10	1	0	4	0	4	0	2	0	6	10	2	0	0	0	1	0	0	0	6	0	4	0	0	0	0	0	0	35	70	97.4	98.0	✘
+ Sandwell Lyndon 4	0	0	1	2	13	4	2	5	2	3	3	4	5	3	2	1	0	1	5	4	2	3	5	5	2	6	0	3	3	6	0	2	91	135	96.5	96.5	✘
+ Sandwell Lyndon 5	2	1	5	3	5	3	2	2	0	0	0	0			0	0	2	2	7	4	0	0	4	3	0	0			0	0			127	66	89.9	89.9	✘
+ Sandwell Lyndon Ground	0	2	0	0	0	0	0	2	0	1	0	0	1	1	0	1	0	0	0	0	0	0	0	7	0	1	0	1	2	8	0	1	3	28	99.4	99.6	✘
+ Sandwell Newton 3	2	4	0	3	1	3	0	2	0	2	0	6	0	4	0	3	0	3	1	4	0	4	5	5	0	3	0	2	1	3	0	3	23	97	98.8	97.3	✘
+ Sandwell Newton 4	0	0	0	0	0	2	0	1	0	1	0	1	0	0	0	0	0	0	0	28	1	1	0	0	0	0	0	3	0	0			31	70	97.7	97.7	✘
+ Sandwell Newton 5	0	0	0	1	0	2	0	0	2	2	0	0	34	2			2	3	0	0	15	1	0	2	0	3	0	0	0	0	0	1	137	42	82.8	82.8	✘
+ Sandwell OPAU	1	3	0	1	0	1	2	8	3	3	4	3	2	2	3	3	0	3	2	5	0	6	0	3									34	83	97.8	97.8	✘
+ Sandwell Priory 2	0	1	0	3	1	3	0	1	0	1	0	0	1	2	1	4	5	4	0	4	2	2	0	3	2	5			0	2	1	3	30	68	97.7	95.7	✘
+ Sandwell Priory 4	6	5	0	1	0	7	0	3	0	7	0	7	0	3	0	4	0	2	0	2	0	3	0	2	0	3	0	1	0	5			21	85	98.7	98.7	✘
+ Sandwell Priory 5	13	5	0	0	0	6	4	11	0	4	0	4	3	7	0	1	0	0	4	8	0	0	0	0	7	8	2	8	0	4	0	2	75	165	97.6	97.6	✘
+ Sandwell SAU	0	2	0	7	5	14	1	4	2	7	1	4	0	6	9	4	0	8	14	12			13	9	3	10	0	10	1	7			154	202	96.0	96.7	✘
Total Non Compliant Checks that Day	81	97	14	77	50	136	39	131	27	113	27	124	109	153	59	84	35	89	108	161	58	101	99	114	33	133	23	91	62	104	51	61				96.8	

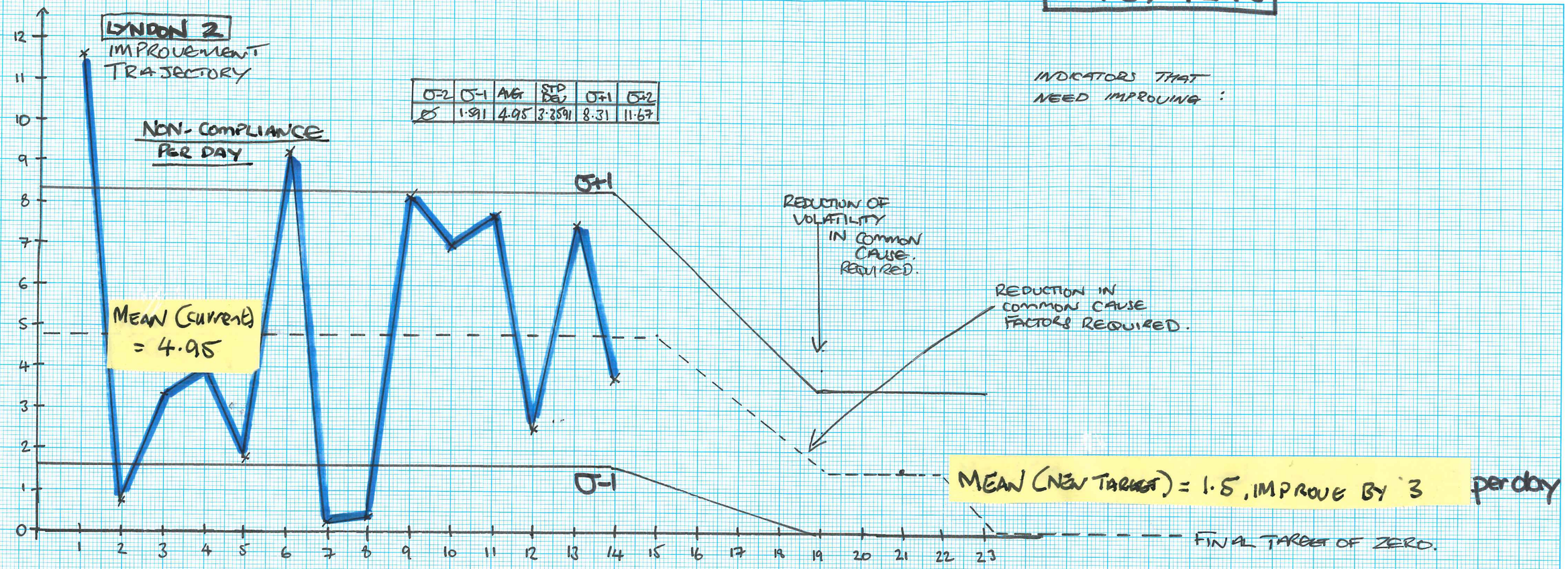
SAFETY PLAN

LYNDON 2

IMPROVEMENT TRAJECTORY

NON-COMPLIANCE PER DAY

σ-2	σ-1	AVG	STD DEV	σ+1	σ+2
∅	1.591	4.95	3.3591	8.31	11.67

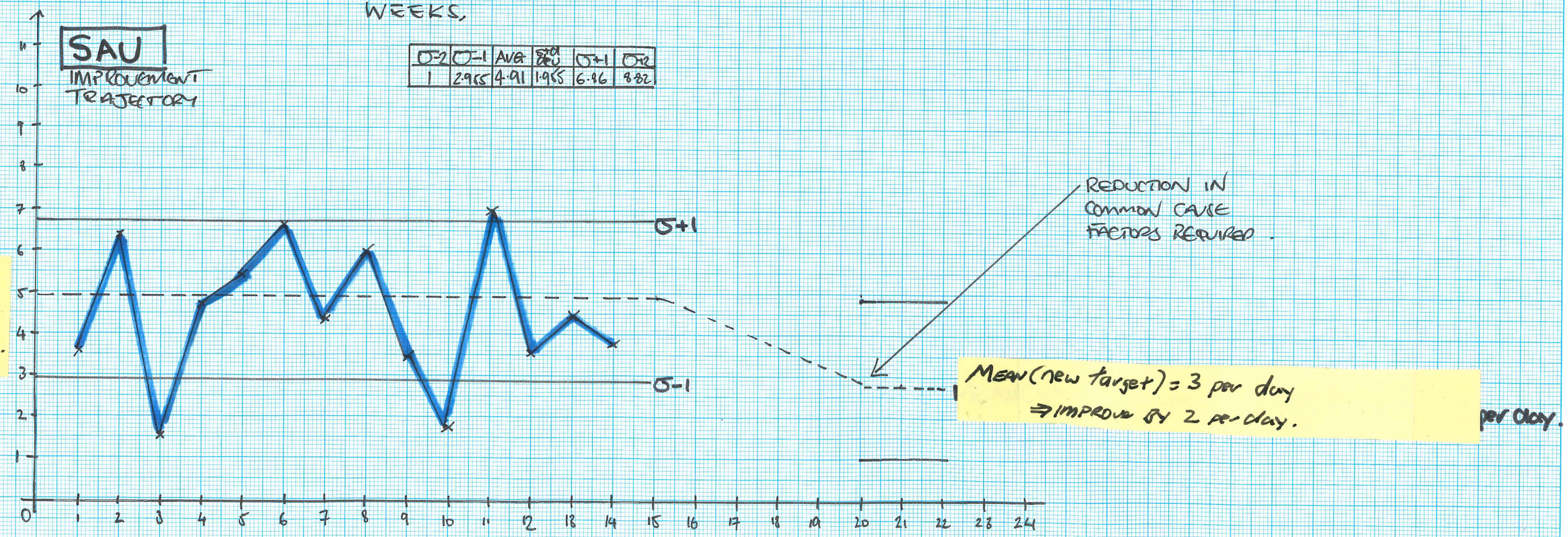


INDICATORS THAT NEED IMPROVING :

SAU

IMPROVEMENT TRAJECTORY

σ-2	σ-1	AVG	STD DEV	σ+1	σ+2
1	2.955	4.91	1.955	6.86	8.82



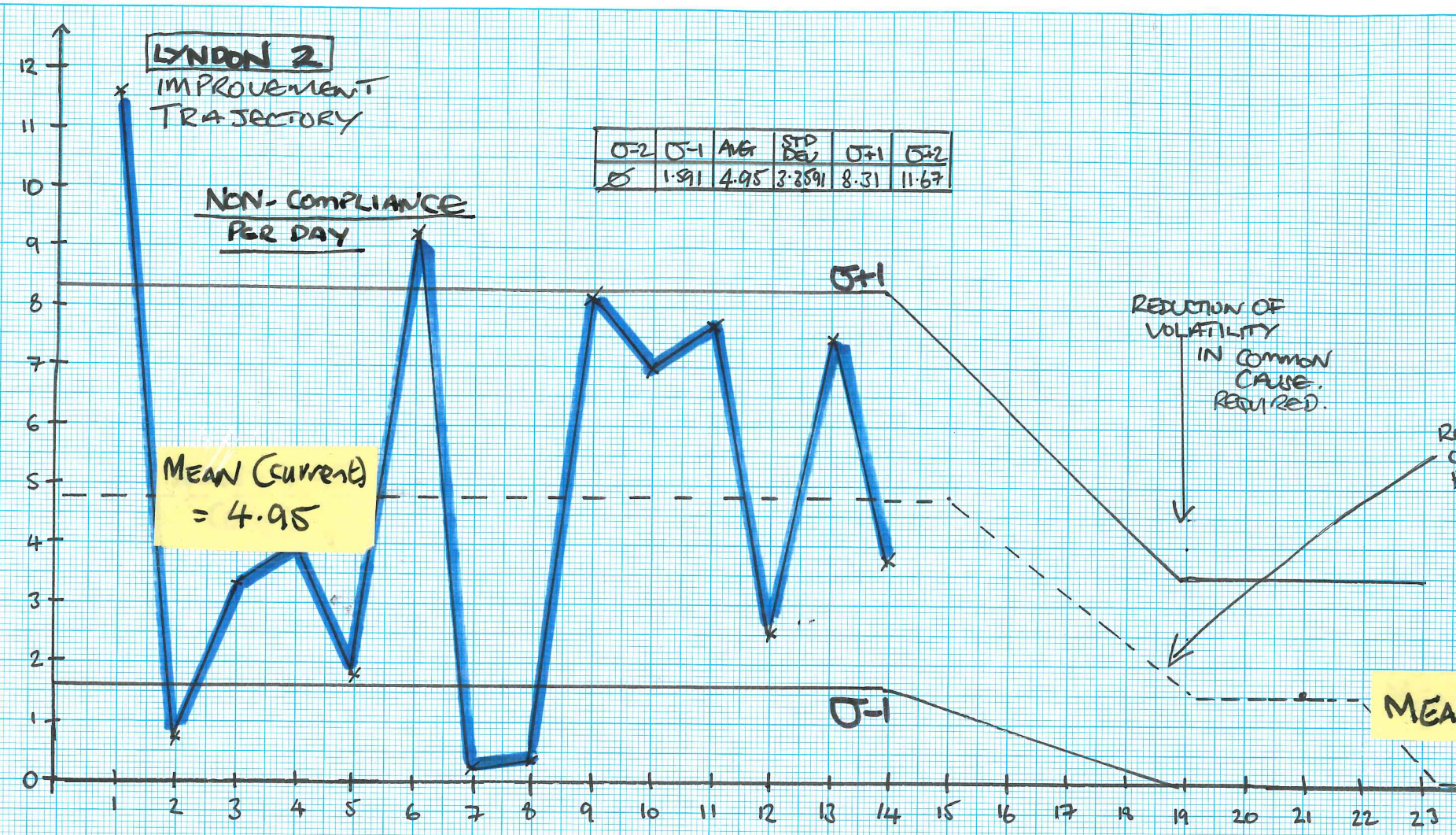
SAFETY PLAN

LYNDON 2

IMPROVEMENT TRAJECTORY

σ-2	σ-1	AVG	STD DEV	σ+1	σ+2
∅	1·591	4·95	3·3591	8·31	11·67

NON-COMPLIANCE PER DAY

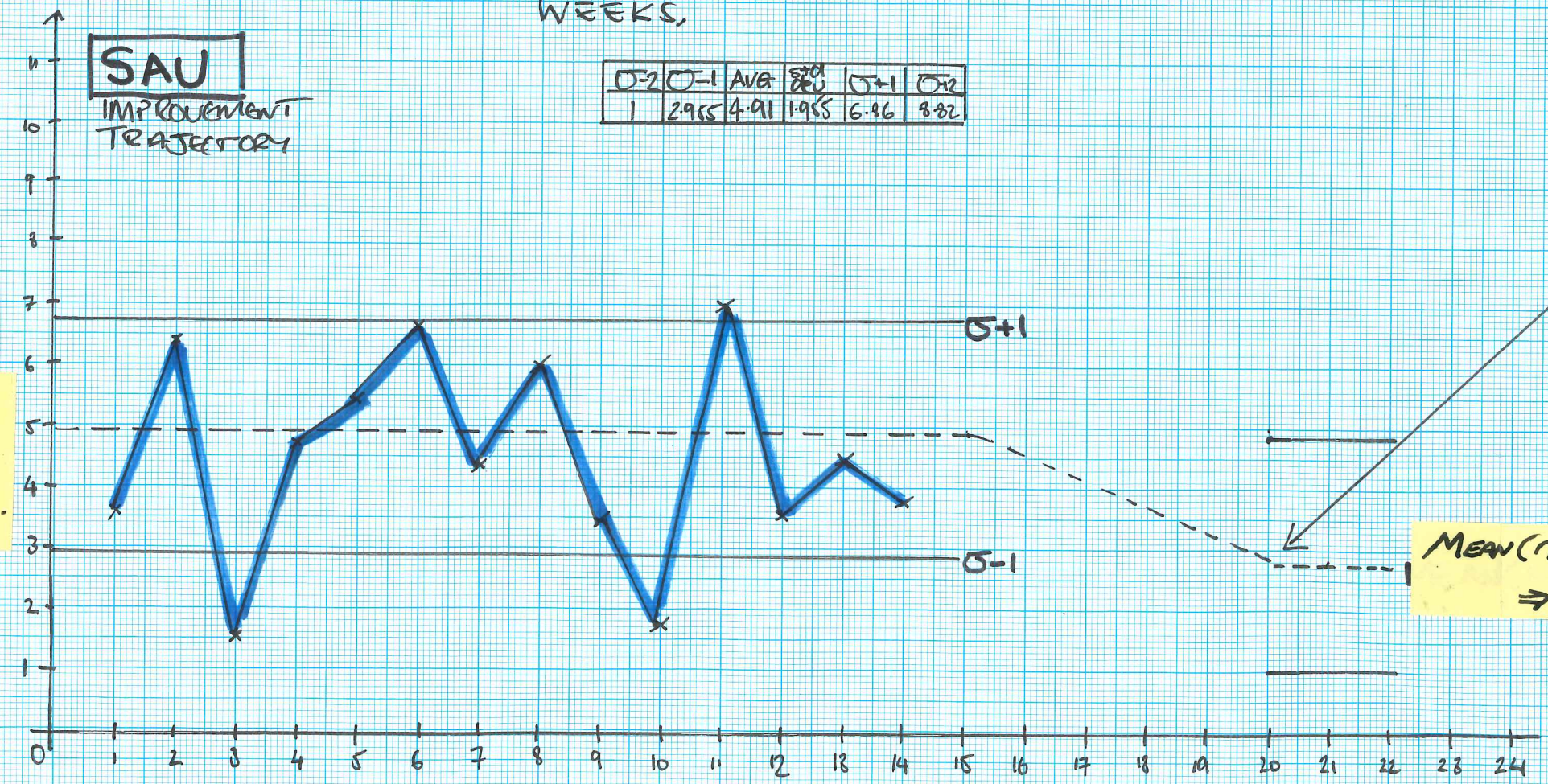


INDICATORS THAT NEED IMPROVING :

SAU

IMPROVEMENT TRAJECTORY

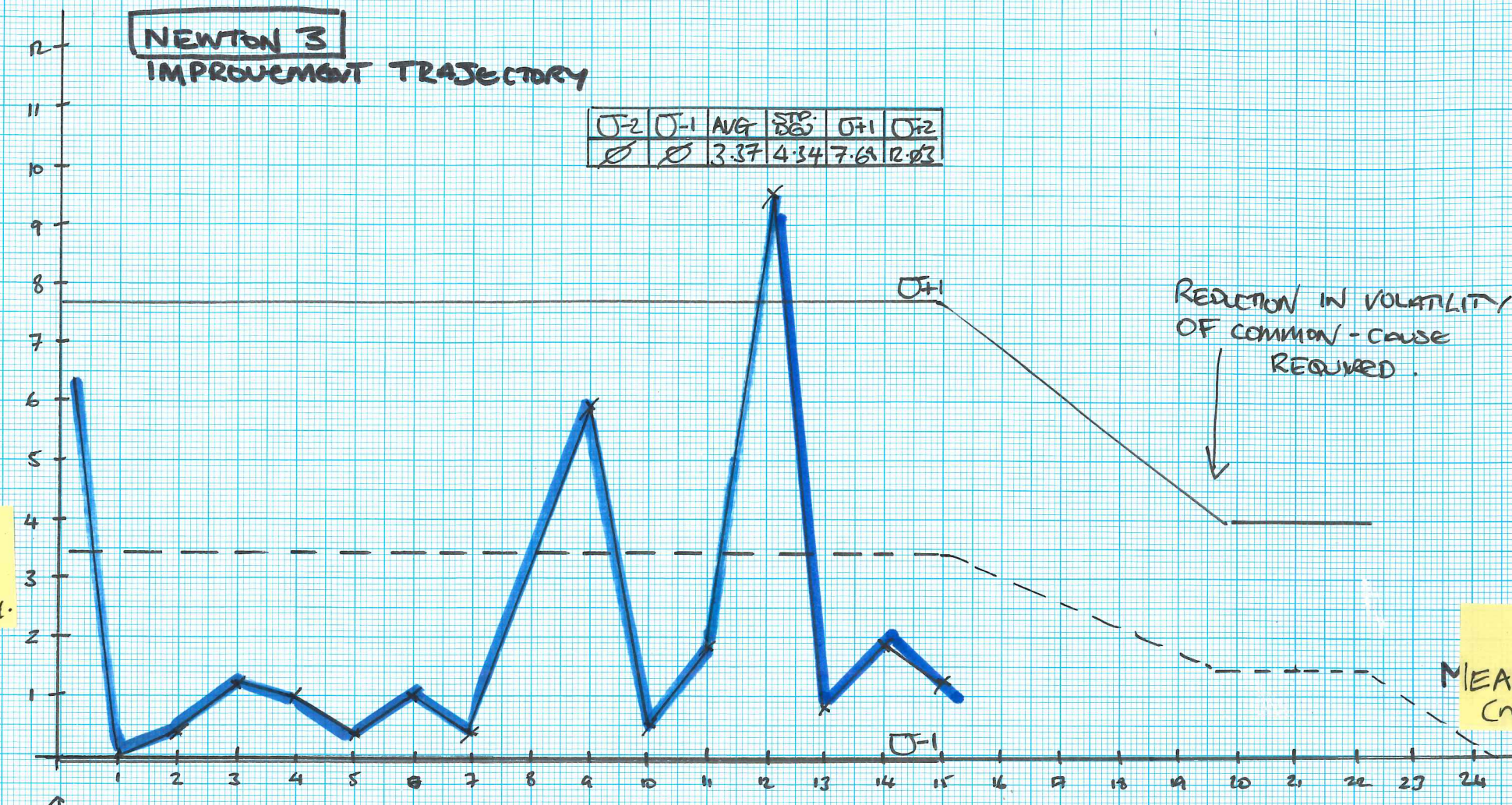
σ-2	σ-1	AVG	STD DEV	σ+1	σ+2
1	2·955	4·91	1·955	6·86	8·82



SAFETY PLAN

NEWTON 3
IMPROVEMENT TRAJECTORY

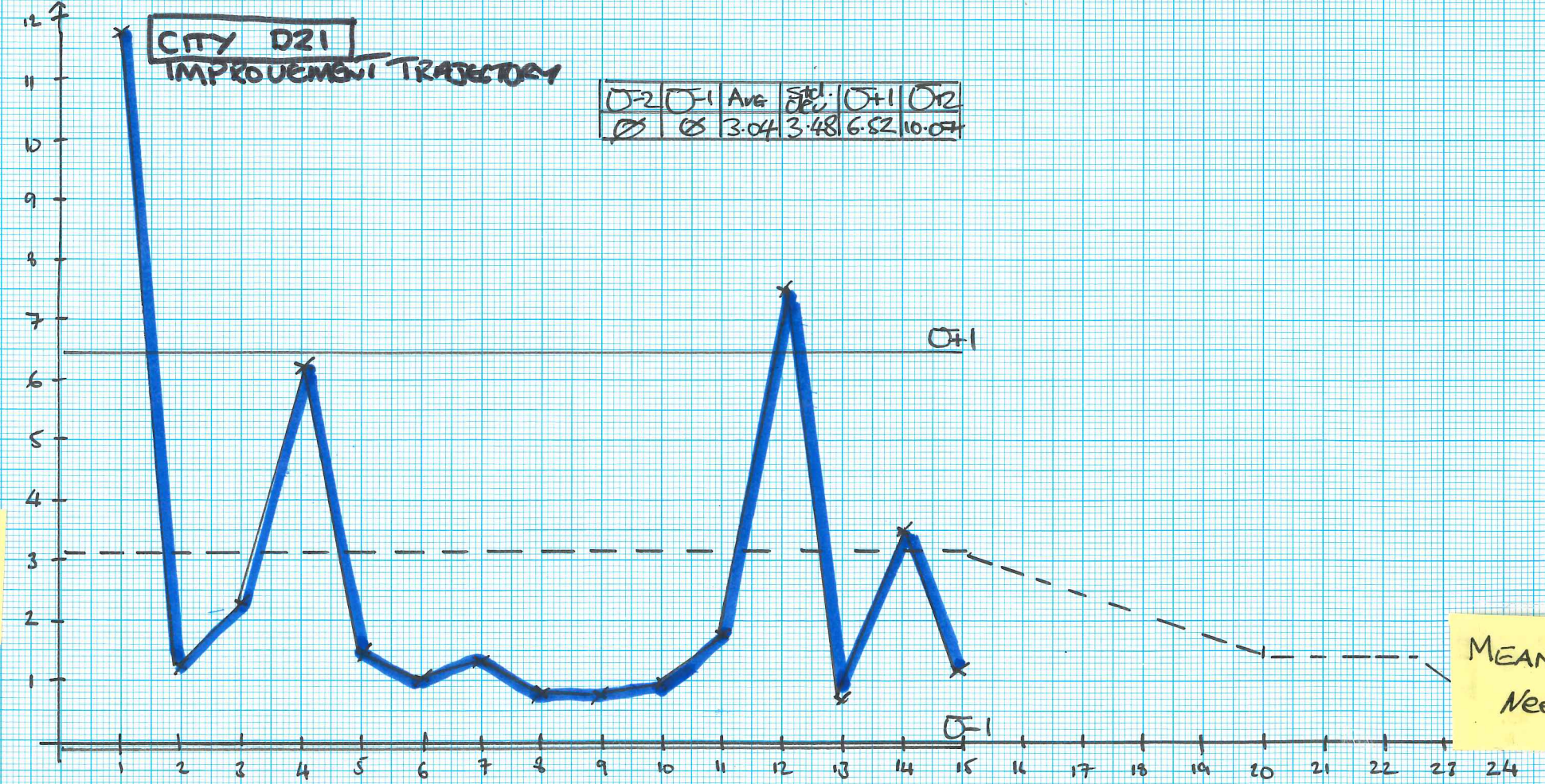
σ-2	σ-1	AVG	STD DEV	σ+1	σ+2
∅	∅	3.37	4.34	7.69	12.03



MEAN (current) = 3.37 per day.

CITY D21
IMPROVEMENT TRAJECTORY

σ-2	σ-1	Avg	Std. Dev.	σ+1	σ+2
∅	∅	3.04	3.48	6.52	10.04



Mean (current) = 3.04 per day

per day.

SAFETY PLAN

NEWTON 3
IMPROVEMENT TRAJECTORY

σ-2	σ-1	AVG	STD DEV	σ+1	σ+2
∅	∅	3.37	4.34	7.69	12.03

σ+1

σ-1

REDUCTION IN VOLATILITY OF COMMON-CAUSE REQUIRED.

MEAN (current) = 3.37 per day.

MEAN = 1.5 per day, IMPROVE BY 1.5 per day. (new)

FINAL TARGET OF ZERO NON-COMPLIANT CHECKS.

CITY D21
IMPROVEMENT TRAJECTORY

σ-2	σ-1	Avg	Std. dev.	σ+1	σ+2
∅	∅	3.04	3.48	6.52	10.04

σ+1

σ-1

Mean (current) = 3.04 per day

MEAN (new target) = 1.5 per day.
Needed (improvement) = 1.5 per day.

per day.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Annual Report on the Implementation of Medical Appraisal
SPONSOR (EXECUTIVE DIRECTOR):	Dr Roger Stedman, Medical Director
AUTHOR:	Philip Andrew, Head of Medical Staffing and Heather Matthews, Directorate Manager for the Medical Director
DATE OF MEETING:	6th July 2017

EXECUTIVE SUMMARY:

The Medical Director acting as the Responsible Officer (RO) has a statutory duty to ensure that the requirements of revalidation are met. To be revalidated a doctor has to demonstrate that they have been participating in annual appraisal (assessed against the requirements of the GMC's Good Medical Practice) and have undertaken at least one patient and colleague multisource feedback exercise prior to their revalidation date.

This report provides a summary of the medical appraisal and revalidation activity within the Trust in the period 1st April 2016 to 31 March 2017. It includes information on the number of doctors that the RO is responsible for, the number of appraisals undertaken and the number of revalidation recommendations made.

As of 28th June 2017 there are 27 doctors with a prescribed connection to SWBH that have not had an appraisal in 16/17 or Q1 of 17/18. It is anticipated this will have dropped to 25 by 1/7/2017. All these doctors are non-training junior medical grades – Specialty doctors, Clinical fellows, typically short term contract (12 months or less).

The report sets out the governance arrangements around revalidation, provides details on how the performance of doctors is monitored and how concerns with doctors are responded to. The report seeks to assure the Board that the Trust is compliant with the requirements of medical revalidation.

REPORT RECOMMENDATION:

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

To approve the `statement of compliance' confirming that the Trust, as a designated body, is in compliance with the regulations (see Appendix 4).

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

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

Accept	Approve the recommendation	Discuss
	X	

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

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

Comments:

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

PREVIOUS CONSIDERATION:

FOR DECISION

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Annual Report on the Implementation of Medical Appraisal

Report to Trust Board on 6th July 2017

1 EXECUTIVE SUMMARY

1.1 Medical Revalidation has been in place since December 2012 and is well established within the Trust. Approximately 420 doctors have now been through the revalidation process. The Medical Director acting as the Responsible Officer (RO) has a statutory duty to ensure that the requirements of revalidation are met. To be revalidated a doctor has to demonstrate that they have been participating in annual appraisal (assessed against the requirements of the GMC's Good Medical Practice) and have undertaken at least one patient and colleague multisource feedback exercise prior to their revalidation date.

1.2 This report provides a summary of the medical appraisal and revalidation activity within the Trust in the period 1st April 2016 to 31 March 2017. It includes information on the number of doctors that the RO is responsible for (447), the number of appraisals undertaken (379) and the number of revalidation recommendations made (17).

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

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

2 BACKGROUND

2.1 Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Previous Board Reports on Medical Revalidation were presented to the Trust Board and this is the sixth annual board report.

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

- monitoring the frequency and quality of medical appraisals in their organisations;

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

3 GOVERNANCE ARRANGEMENTS

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

3.2 The medical appraisal and revalidation process is clearly set out in the Trust Appraisal Policy for Career Grade Medical Staff which was implemented in 2012 and further revised in October 2013. This policy has been revised and updated (which was one of the recommendations of the NHS England and Baker Tilly reports) and will become an appendix of the Trust PDR policy when this is implemented.

3.3 An IT system, PReP, was acquired in 2012 that fully documents the appraisal process. The doctor completes their appraisal input form on PReP with the necessary supporting information uploaded for each domain under the GMC's Good Medical Practice document. The appraiser then has access to the input form on PReP and can reject the form in advance of the appraisal meeting if it is felt that that the input form does not meet the necessary requirements. The PDP and Output form is completed as part of and after the appraisal meeting and signed off on PReP by both appraiser and appraisee. The PReP system provides the RO with access to all the appraisal input and output information for all the doctors he has responsibility for. There is also an RO dashboard and a suite of reports available on the system.

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

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

3.6 The ROs have established a regional network to share concerns about doctors who work in their Trust. The SWBH RO has also set up meetings with the main private healthcare

providers to ensure that any concerns that might have been flagged in private practice are fedback to the Trust.

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

4 MEDICAL APPRAISAL

4.1 Appraisal and Revalidation Performance data

As at 31st March 2017 the Trust had a prescribed connection with 447 doctors (316 Consultants, 78 SAS Doctors, 49 Temporary or short term contract holders and 4 other doctor with a prescribed connection to this designated body).

In the period 1 April 2016 to 31st March 2017 the number of completed appraisals was 379 (290 Consultants, 58 SAS Doctors, 30 Temporary or short term contract holders and 1 other doctor with a prescribed connection to this designated body). A summary of the reasons for missed or incomplete appraisals is contained in *Appendix 1.* Other doctor reasons' account for all of missed appraisals and the vast majority of those would best be described as `underestimation of preparation and workload involved in appraisal process leading to delay in appraisal'. For the others there were some mitigating factors where they hadn't been added to PReP in a timely fashion or their contractual status changed from short term locum to a longer term position which would require a PReP appraisal.

In the period 1 April 2016 to 31st March 2017 there were 6 doctors in remediation and/or disciplinary processes. There were no GMC referrals made by the Trust during this period.

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

4.2 Appraisers

As at 31st March 2017 there are 101 medical appraisers within the Trust, all of whom have undertaken strengthened appraisal training. In the period 1st April 2016 to 31st March 2017 88 of those trained appraisers undertook at least one appraisal. This training is a one day training session that the Trust has commissioned.

The objectives of the training include:

- Be familiar with SWBH appraisal policy for medical staff

- Understand the purpose of the medical appraisal and how it relates to other management and regulatory processes
- Be aware of the General Medical Council (GMC), British Medical Association (BMA) and Department of Health's guidance on appraisals in line with Good Medical Practice
- Understand the role of the appraisal in the revalidation process, based on the most current information from the Revalidation Support Team (RST) and the Trust
- Understand what preparatory work needs to be done by the appraiser and appraisee before the appraisal interview and the timescales
- Have examined the appraisal process and what supporting information should be included under each section in terms of evidence
- Have explored the role of the appraiser and the skills required to conduct an effective appraisal interview
- Know how to complete the summary of appraisal form and PDP sections with the appraisee, using SMART objectives
- Be able to handle difficult appraisals which may include: performance or capability issues; inadequate evidence; reluctance to agree the need for further development; health and probity issues and who to communicate concerns to within the Trust
- Have practised the skills required to carry out appraisals by appraising a colleague(s) during the workshop.

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

The Appraiser forum was held last year with a refresher opportunity for the appraisers. This also included providing Trust data on appraisals and selected anonymised examples. Practical constraints have restricted the achievement of mandatory attendance at these forums, hence, alternative approaches such as direct feedback are being explored by Dr Kannan.

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

4.3 **Quality Assurance**

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

For the appraisal portfolio an audit of anonymised input forms and output forms for 39 randomly selected doctors has been undertaken by Dr Kannan the Medical Appraisal Lead . This audit reviewed electronic appraisal folders on PReP to provide assurance that the appraisal inputs (pre- appraisal declarations, scope of work and supporting information) provided is available and appropriate, hat the appraisal outputs (Personal Development Plan (PDP), summary and signoffs) are complete and to an appropriate standard and any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs.

The summary of the audit is contained in Appendix 2.

Dr Kannan will be contacting each of the appraiser and appraisee (from these 78 forms) to provide feedback on the areas they did well and also where they could do better. From November 2016, Dr Kannan has been auditing a randomly chosen output form for each appraiser and scoring them against a recommended template. This was then fed back to the appraiser. The aim is to audit at least one form for each appraiser every year. Dr Kannan has received positive feedback from the appraisers for this and we hope that this will translate into improved practice.

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

The mean duration of the appraisal meeting was 1.6 hours (excludes preparation time of reviewing the input form and submitted supporting evidence). Maximum duration of appraisal meeting was 2.75 hours. Minimum was 1 hour.

Appraiser feedback scores were provided by appraisees under 9 domains including the appraisal process, the appraiser's preparedness, conducting the appraisal etc. Mean score for all appraisers across all domains was 4.41 (out of maximum of 5).

4.4 **Access, security and confidentiality**

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

4.5 **Clinical Governance**

There is an expectation that individual Consultants, SAS Doctors and other doctors should already be aware of the complaints and Serious Untoward Incidents (SUIs) that they have been involved in and that reflection on these should not be left until appraisal. Their SUI information is available to them via a self-service report in Safeguard system. If doctors need any further information on complaints or incidents they can obtain it from the relevant governance department.

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

5 REVALIDATION RECOMMENDATIONS

5.1 During the period 1st April 2016 to 31st March 2017 there were 30 revalidation recommendations made to the GMC by the Trust. All of the recommendations were made on time. There were *17* positive recommendations, *13* deferral requests and *0* non engagement notifications.

5.2 The revalidation recommendations are made promptly and there is a robust process managed by the Directorate Manager for the Medical Director to ensure timescales are always kept to. The Head of Medical Staffing and the Directorate Manager for the Medical Director work together to action the recommendations jointly on behalf of the RO. The Head of Medical Staffing and/or the Directorate Manager for the Medical Director escalate any concerns to the RO as required.

6 RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

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

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

7 MONITORING PERFORMANCE

7.1 The RO and Head of Medical Staffing meet regularly and as part of that meeting issues relating to doctors performance are routinely discussed. There is also a monthly Medical Director Decision Making Group (MDDMG) which is attended by the RO, Deputy Medical

Director, Deputy Director of Workforce, Deputy Director of Governance, Head of Medical Staffing and Directorate Manager for the Medical Director where a summary of current concerns is presented. There is a detailed discussion of the approach being taken in each case and challenge is encouraged to ensure the RO is managing the issues appropriately. New concerns or issues are also raised at this meeting. The Deputy Director of Governance has the opportunity to bring to the group's attention any issues with complaints data, SUI data, trends etc that might indicate poor practice or learning and development needs of individual doctors and/or teams. The Directorate Manager for the Medical Director presents a summary of those doctors with revalidation dates in the next period and confirms whether they are revalidation ready or not, getting the RO and other members of the MDDMG to input their views.

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

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

8 RESPONDING TO CONCERNS AND REMEDIATION

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

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

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

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

9 Improvements in the last year

An educational appraisal check list has been introduced in the electronic system as an aid memoire for appraisees and appraisers. The guidance also highlights the relevant acceptable documentation against each domain.

Feedback to individual appraisee and appraiser has been started this year where one randomly chosen appraisal documentation is assessed against recommended criteria and scored. The score is passed on to the individual along with constructive comments in terms of improvement. Informal feedback on this approach has been very positive. The aim is to analyse at least one appraisal form for each appraiser and appraisee every year.

Compliance rate of individual departments is now fed back to the relevant Clinical Directors to maximise involvement of all staff.

10 DEVELOPMENTS REQUIRED/ NEXT STEPS

10.1 The medical appraisal and revalidation systems within the Trust have worked effectively over a number of years. We will shortly be revalidating doctors for their second 5 year revalidation cycle. The main areas to be developed now are:

- Develop processes for remediation, re-skilling and rehabilitation of doctors within the Trust;
- Increase awareness amongst SAS Doctors and other non-consultant grades regarding appraisal and revalidation. This will be taken forward with Director of Medical Education and SAS Clinical Tutor.

11 RECOMMENDATIONS

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

11.2 To approve the `statement of compliance' confirming that the Trust, as a designated body, is in compliance with the regulations (see Appendix 4).

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

[Dr Roger Stedman, Executive Lead]
[Medical Director/Responsible Officer]
[22 June 2017]

APPENDICES:

Appendix 1 – Summary of Missed or Incomplete appraisals 2016-17

Appendix 2 – Quality assurance audit of appraisal inputs and outputs 2016-17

Appendix 3 – Audit of revalidation recommendations 2016-17

Appendix 4 – Statement of Compliance

Appendix 1 Summary of missed or incomplete appraisals 2016-17

Audit of all missed or incomplete appraisal in period 1 April 2016 -31 March 2017

Doctor factors [total]	**Number**
Maternity leave during the majority of the 'appraisal due window'	0
Sickness absence during the majority of the 'appraisal due window'	0
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window'	0
New starter within the 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by the doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	68
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors [describe]	0
[describe]	
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors [describe]	0
Total	**68**

Appendix 2 – Quality assurance audit of appraisal inputs and outputs

	Number fulfilling criteria	**%**
Appraisal inputs (out of 39)		
Scope of work: has a full scope of practice been described.	32	82 %
Continuing Professional Development [CPD]: Is **CPD** compliant with GMC requirement?	35	90 %
Quality improvement activity: Is quality improvement activity compliant with GMC requirement?	32	82 %
Patient feedback exercise: Has a patient feedback exercise been completed?	39	100 %
Colleague feedback exercise: Has a colleague feedback exercise been completed?	39	100 %
Review of **complaints**: Have all complaints been included?	39	100 %
Review of **significant events**/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	38	97 %
Is there sufficient supporting information from all the doctor's role and places of work?	37	95 %
No patient identifiable evidence been submitted	34	87 %
Is the **portfolio sufficiently complete**d for the stage of the revalidation cycle year [year 1 to year 4]	38	97 %
Appraisal Outputs (out of 39)		
Descriptive Summary present	31	79 %
Objective **statements** about quality of statements	27	69 %
PDP (3- 6 targets set)	29	74 %
PDP contains **SMART** objectives	36	92 %

Audit of revalidation recommendations

Revalidation recommendation between 1 April 2016 to 31 March 2017	**Number**
Recommendations completed on time [within the GMC recommendation window].	30
Late recommendations [completed, but after the GMC recommendation window closed]	0
Missed recommendations [not completed]	0
TOTAL	30
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified.	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resource or support for the responsible officer role	0
Other	0
Describe other	
TOTAL [sum of [late] + [missed]	0

Appendix 4 – Statement of Compliance

Designated Body Statement of Compliance

The board/executive management team –[delete as applicable] of [Insert official name of designated body] has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments:

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments:

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments:

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

[1]Doctors with a prescribed connection to the designated body on the date of reporting.

Comments:

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments:

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments:

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

[2]Doctors with a prescribed connection to the designated body on the date of reporting.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Patient stories to the Board – wider learning
SPONSOR (EXECUTIVE DIRECTOR):	Elaine Newell – Chief Nurse
AUTHOR:	Elaine Newell
DATE OF MEETING:	30 June 2017

EXECUTIVE SUMMARY:

Patient stories have been a regular feature of the Trust Board agenda for a number of years facilitating rich discussion and learning amongst Board members and key group staff. To date however, it is acknowledged that there has been limited sharing of either the learning or the actions taken to address key concerns or issues identified. The attached plan sets out:

1. Actions taken to establish a repository for patient stories in order that thematic trends can be identified and shared learning / actions can be evidenced.
2. Methods by which patient stories with associated learning and actions can be disseminated / shared with a wider audience.

The plan incorporates the use of existing communications platforms thereby reaching a wide audience base and cross sectional audience base thereby raising the profile and value of the patient story.

REPORT RECOMMENDATION:

The committee are asked to approve the suggested plan

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

Comments:

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

PREVIOUS CONSIDERATION:

Quality & Safety Committee

Patient stories – shared learning process plan

	Action	Led by	Date	Status
1	Develop schedule for monthly patient stories by group	KD	Feb 17	complete
2	Develop template for capturing key learning	EN	Feb 17	Complete
3	Establish database to enable capture of patient stories / key learning themes / evidence of dissemination	RW	July 17	
4	Agree the following methods by which patient stories and learning actions can be shared: • Monthly release of patient story video Via CEO Friday message • Consider publicising link to videos / key learning / actions as part of Hot Topics • Patient story with key learning messages / actions to be included as regular feature in Hot Topics • Establish section on Connect with all patient story videos and 'you said, we did'	EN	July 17	
5	Chief Nurse to provide annual report on thematic trends / learning / actions	EN	Dec 17	

Patient Story presentations at Trust Board meetings
Appendix 1: schedule of participation – patient stories.

Background

Each month a different patient story is presented to the public Trust Board meeting. These stories provide board members with an opportunity to hear directly from patients or carers about their experiences so that the Trust can identify learnings that can be shared across the organisation. The patient stories take a variety of formats, from patients or their relatives attending in person to films or audio recordings. On occasions a SWBH employee has attending to talk about their experiences of caring for a particular patient or group of patients.

Identifying patient stories

In order to hear from a range of different experiences, Group leaders are asked to identify a patient story to present at the Board meeting according to the schedule below. The patients must be asked their consent and if they would like to attend. If they prefer, arrangements can be made to film their experiences so that they are not at the meeting in person. Group leaders should consider different services, pathways or conditions that the board would be interested in hearing about. The experiences can be positive or negative, but should always identify opportunities for learning.

Schedule of patient stories Date	**Group**
June	Surgical Services
July	Medicine
August	Community & Therapies
September	Women & Child Health
October	Imaging
November	Corporate (eg outpatients, dementia, pharmacy, discharge)
December	Pathology
January	Surgical Services
February	Medicine
March	Community & Therapies
April	Women & Child Health
May	Imaging

Appendix 2

Patient / Carer Stories to Trust Board

Checklist for completion by Group lead

Patient Name (if applicable)	RXK (if applicable)	Group	Specialty
What is the source for the patient / carer story (i.e. complaint / incident / derived from introduction of new project)?			
Have you requested consent from the patient / carer to share their story? Yes □ No □			
Date of Trust Board:			
Has the patient / carer agreed to : • Attend Trust Board in Person □ • Speak to video camera □ • Speak to audio tape □ • Provide a written submission □			
Does the patient / carer require an interpreter? Yes □ No □ If Yes – language required: Date booked:			
Has a member of staff been identified to support patient / carer: Yes □ No □ Name Contact details: Telephone…… Email address…….			

What are the key messages you wish the Trust Board to consider / discuss?

1.
2.
3.
4.

What are the key lessons / themes to emerge from this story?

How will the themes lessons be shared across the wider organisation?

Where applicable, has the member of staff been provided with feedback from an exec member?

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Production Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Rachel Barlow – Chief Operating Officer**
DATE OF MEETING:	**6th July 2017**

EXECUTIVE SUMMARY:

As of the 27th June, the Trust forecast a deficit of c£200K in Q1 from a total production plan of £27.1 million. This is made up from an over-performance to plan in April and May, offset by an under-delivery to plan in June.

The main area to the deficit in June, contributing to the Q1 deficit is the un-forecast slippage in ophthalmology OP booking and DNA rates. The speciality had a 65% utilisation rate in June and remedial action is being taken with the specialty team.

The paper summarise main points of deficit in June as 4 key reasons

- Deficit in booking in ophthalmology
- Case mix change in T&O – activity and finances rephrased in year
- In month workforce related capacity deficits – will be recovered in year
- Demand changes – are small scale and need replacing with other activity from our waiting lists

Governance and oversight is in place to ensure ongoing delivery of the production plan after a good start to the year. The scale of forecast delivery in June is comparative to July's plan, those 2 months being the highest monthly plans this year which should give the Trust Board some assurance in terms of scale of delivery going forward. July's forecast is currently breakeven based on available capacity.

REPORT RECOMMENDATION:

The Trust Board are asked to discuss the Q1 forecast position

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:

Safe and sustainable services, financial plan

PREVIOUS CONSIDERATION:

Production Plan Assurance

Quarter 1 forecast outturn

As of the 27th June, the Trust forecast a deficit of c£200k in Q1 from a total production plan of £27.1 million. This is made up from an over-performance to plan in April and May, offset by an under-delivery to plan in June.

The main area to the deficit in June, contributing to the Q1 deficit is the un-forecast slippage in ophthalmology OP booking and DNA rates. The speciality had a 65% utilisation rate in June and remedial action is being taken with the specialty team.

Forecast outturn for June vs plan

The forecast for June month is a c£820K deficit against a plan of £11,046,625 with 4 key reasons:

- Deficit in booking in ophthalmology – un-forecast and the main contributor to Q1 forecast deficit
- Case mix change – T&O related in day case and in patients identified in May / June - plan recovered by rephrasing of activity and finances
- Workforce related capacity deficits – this is part of day to day running the business and is relatively small scale at individual speciality level. This deficit was unforecast at beginning of year, has been escalated at weekly PMO as quantified issues with staff turnover or unscheduled absence. Specialities will revise plans to be recovered in year.
- Demand changes - due to treatment / pathway changes and isolated to 2 specialties anticoagulation and diabetes, both of which we anticipate an ongoing activity decrease and this will be replaced within clinical groups

The table below identifies services which forecast a deficit to June plan.

Speciality	June Month Deficit forecast	Reason / mitigation
Opthalmology	-£250K	Un-forecast under delivery in OP due to booking deficit and DNA rate
Trauma and orthopaedics	-£200K	Requested rephrasing due to case mix change for day case and out patient
Cardiology	-£45K	Workforce deficit Re-profiled plan in line with new workforce assumptions
Respiratory	-£12K	Workforce deficit Seeking locum and anticipate to correct in July
Rheumatology	-£27K	Workforce deficit due to sickness – will recover activity in Q2
Breast surgery	-£40K	Workforce issue – will confirm plan to re-profile into Q3
ENT	-£30K	14% DNA rate in day cases / IP mainly paediatric. Contact centre to call ahead of appointment. SMS messaging already in place.

General surgery	-£70K	Workforce due to vacancy; successful recruitment and will recover in Q3.
Oral surgery	-£30K	New SLA due to be agreed start July and will recover in Q2.
Urology	-£35K	Workforce deficit and case mix change
Paediatric	-£45K	Workforce deficit – Clinical group over performing over all in Q1
Diabetes	-£32K	Decrease in demand – will profile activity at directorate review
Anticoagulant service	-£35K	Treatment change in practice resulting in decreasing FU activity – initial assessment show 9% activity decrease. Will look to replace activity

Look ahead to reminder of year

The Production Plans were developed in March 2017 in line with IMAS demand and capacity modelling. It considers group level knowledge; including any changes to workforce throughout the year, changes in point of delivery and bases monthly out turn on the number of working days in each month.

There has been a subsequent review based on the lack of assurance from T&O to be able to deliver their admitted care plan. The rest of the Trust Production Plan has had no significant changes apart from some re-phasing of the same levels of activity as explained below.

The **Production plan for T&O** has now been amended from an activity basis from Q2 onwards due to a change in the case mix. This has come about as a result of the removal of Procedures of Low Clinical Value (PLCV) from waiting lists in April 2017. However, this is merely a switch from 'minor' procedures to 'Major' procedures so the activity levels have dropped (reduction of 1,177 cases) but the bottom line finances do not alter, as we have factored a proportional level of income being achieved through increased levels of 'major' cases. This is evident in the income produced in April & May and projections for June at a HRG level and by a reduction of 150 OP referrals per month for the first two months of this year.

Ophthalmology, Cardiology have re-phased their profiles to smooth their admitted activity from Q2 onwards. This was due to the following reasons:

- Cardiology – recruitment issue and a switch of a procedure from elective to day case, following best practice guidance, resulting in a small reduction in EL (109)overall, but higher price in DC offsetting this reduction.
- Ophthalmology profiles smoothed over the year in line with, greater theatre protection during EPR roll out and on-going theatre efficiency work.

This will ensure that all specialities can deliver their plans within financial control totals, ensuring all theatre sessions are used and that theatres are protected, where possible, during EPR rollout. The Phasing is modelled in line with the number of working days in each month and the recruitment of clinical staff.

Appendix 1 summarises the activity and financial rephrasing profiles of the 3 specialities against the monthly Trust planned care income plan.

The scale of forecast delivery in June is comparative to July's plan, those 2 months being the highest monthly plans this year. July's forecast is currently breakeven based on available capacity.

Governance and oversight

- A weekly Planned Care PMO reviews a 6 week forecast of activity and financial delivery, this is chaired by the COO and attended by the DCOO of planned care, Head of Performance, Director of Operations and operational representatives.
- A monthly review of the entire year plans at specialty level is scheduled to account for any recovery required, for example aligning with workforce plans to ensure capacity is fully validated month on month.
- Following Q1 a 'rolling forecast' will be produced to reflect Q1 actual activity & income + 9 months' worth of required levels of output to deliver full year plan (3+9 Forecast).
- A review of the Production Plan costing model is also scheduled for July, after Q1 income is fully coded, to ensure the unit price assumptions are valid based on activity delivered and waiting lists. This will ensure that a most accurate production plan model is used to estimate outputs.

Appendix 1 – Movements to Admitted Care as part of the re-phasing exercise

Phasing Impact Analysis - Activity:	Apr-17 PLAN	May-17 PLAN	Jun-17 PLAN	Jul-17 PLAN	Aug-17 PLAN	Sep-17 PLAN	Oct-17 PLAN	Nov-17 PLAN	Dec-17 PLAN	Jan-18 PLAN	Feb-18 PLAN	Mar-18 PLAN	TOTAL
Cardiology													
Original PLAN	140	173	185	183	187	180	192	192	148	183	174	174	2,111
Re-Phased PLAN	154	177	169	162	177	161	169	166	150	181	174	162	2,002
Total Movement	14	4	-16	-22	-10	-19	-23	-26	2	-2	0	-12	-109
Opthalmology													
Original PLAN	528	694	948	929	801	771	774	695	637	786	749	749	9,062
Re-Phased PLAN	692	798	769	735	801	734	770	769	727	801	700	766	9,062
Total Movement	164	104	-179	-194	0	-37	-4	74	90	15	-49	17	**0**
T&O													
Original PLAN	236	312	431	422	361	348	348	311	287	355	338	338	4,088
Re-Phased PLAN	224	258	246	235	258	235	246	246	235	258	224	246	2,911
Total Movement	-12	-54	-185	-187	-103	-113	-102	-65	-52	-97	-114	-92	-1,177
Admitted Plan (Original)	**2,915**	**3,692**	**4,369**	**4,307**	**4,095**	**3,941**	**4,106**	**3,949**	**3,252**	**4,017**	**3,826**	**3,826**	**46,295**
Movements	166	55	-380	-403	-113	-169	-129	-17	40	-84	-163	-87	-1,286
Total Admitted Plan (Rephased)	**3,081**	**3,747**	**3,989**	**3,904**	**3,981**	**3,772**	**3,977**	**3,932**	**3,291**	**3,933**	**3,663**	**3,739**	**45,008**
Grand Total Production Plan (Original)	**43,725**	**50,427**	**68,155**	**69,536**	**59,930**	**57,689**	**57,854**	**51,957**	**47,607**	**58,809**	**56,009**	**56,009**	**677,709**
Movements	166	55	-380	-403	-113	-169	-129	-17	40	-84	-163	-87	-1,286
Grand Total Production Plan (Rephased)	**43,891**	**50,482**	**67,775**	**69,133**	**59,817**	**57,520**	**57,725**	**51,940**	**47,647**	**58,725**	**55,846**	**55,922**	**676,423**
Phasing Impact Analysis - Income :													
Grand Total Production Plan (Original)	£7,327,907	£8,769,807	£11,046,625	£11,092,136	£9,842,976	£9,474,473	£9,615,547	£8,828,717	£7,518,398	£9,458,444	£9,128,518	£9,198,518	**£111,302,064**
Grand Total Production Plan (Rephased)	£7,327,907	£8,769,807	£11,046,625	£10,640,896	£9,784,402	£9,378,166	£9,574,755	£8,882,169	£8,001,855	£9,540,213	£9,112,746	£9,242,497	**£111,302,039**
Rolling Forecast :	**Actual**	**Actual**	**FCST**	**FCST**	**FCST**	**FCST**	**FCST**	**FCST**	**FCST**	**FCST**	**FCST**	**FCST**	
Actual YTD Delivery + Forecast	£7,604,194	£9,112,853	£10,226,625	£10,640,896	£9,784,402	£9,378,166	£9,574,755	£8,963,169	£8,001,855	£9,690,213	£9,112,746	£9,212,497	**£111,302,371**
Q1 YTD Delivery	£26,943,671												
Q1 YTD Plan	£27,144,339												
Q1 Variance to Plan	-200,668												

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Performance Report – P02 May 2017
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Finance Director
AUTHOR:	Yasmina Gainer, Head Performance Management & Costing
DATE OF MEETING:	6 July 2017

EXECUTIVE SUMMARY:

IPR – Summary Scorecard for May 2017 (In-Month)

Summary Scorecard

Section	Red Rated	Green Rated	None	Total
Infection Control	1	5	0	**6**
Harm Free Care	9	4	9	**22**
Obstetrics	1	6	6	**13**
Mortality and Readmissions	1	1	11	**13**
Stroke and Cardiology	1	10	0	**11**
Cancer	0	10	5	**15**
FFT. MSA, Complaints	14	2	5	**21**
Cancellations	5	3	0	**8**
Emergency Care & Patient Flow	10	4	4	**18**
RTT	7	1	6	**14**
Data Completeness	2	8	9	**19**
Workforce	5	1	13	**19**
SQPR	9	0	1	**10**
Total	**65**	**55**	**69**	**189**

Persistent 'reds' are being reviewed and prioritised for remediation by the Exec Group through PMC and with necessary remedial action plans in development.

- **Formal Recovery Action Plans (RAI raised by CCG**:
- Community Gynae referral to 1st OP within 4 weeks
- Safeguarding training – Children level 3 below agreed trajectory as is adult advanced - RAP agreed, but will show as not achieving
- Dementia and Falls Assessments (Community)
- RAP for A&E, RTT and Diagnostics to be discussed during April contract review meeting

Key targets – May Delivery

× **ED 4 hour** performance for May was 81.57% (84.95%), non-compliant with 95% national target; 3549 breaches in the month

× **Never Event** reported in May due to 'wrong side block'.

✓ **RTT** May delivery at 93.79% against the national standard of 92%. Waiting list at 32,663, patient backlog of patients at 2,024 down by c200 patients from April. There were 3x 52 week incomplete breaches. June tracking projections to deliver standard, internal forecast for 93.5%.

✓ **Acute Diagnostic waiting times** within 6 weeks as at May 99.4% recovering to compliance of 99%; 46 breaches were declared for the month of which echos were at 30, which was due to cardiology capacity issues. Plan for June is to deliver 99% with echo breaches fully recovering in July.

✓ **62 day cancer** compliant at 85.6% at April vs. target of 85%; all other cancer targets continue to deliver. May delivery is anticipated to deliver to standards. Whilst performance is consistently good, cancer delivery requires increased 'effort'.

× **Neutropenic sepsis** considerable improvement on prior months, but remains below 100% standard [6/37 (16%) patients did not receive treatment within the required 1hr timeframe]. 6 patients missed the standard, all in ED.

- ✖ **Elective Operations Cancellations** consistently under-delivering and at 1.5% against 0.8% target in May; cancellations are the highest for a number of months at 67 on day cancellations of which 27 were validated as avoidable; No 28 Day Guarantee or urgent cancellations during May.
- ✖ **Hip fractures** best practice tariff performance in month improved from last month to 65% but remains below 85% standard and with consequent failure to recover additional tariff income
- ✖ **Sickness rates** cumulatively are at 4.48% against the Trust target of 2.5%. Short-term sickness cases worsening to last month from 415 to 445, long term sickness remaining flat at 415.
- ✖ **Mortality reviews** 64% in March showing only modest improvement and remains significantly below 90% standard; key mortality rate indicators remain within confidence limits.
- ✖ **MSA Breaches** x7 were incurred in May; cause due to capacity issues.
- ✓ **VTE** delivers full year to national standard at 95.8% in May with 346 patients missing the assessment.
- ✓ **MRSA** – no cases year to date
- ✓ **CDiff** – x3 cases year to date against a target of 5.
- ✓ **Readmissions** at 7.2% in May (7.1%). The Trust now tracks better than peer group.

Requiring attention – action for improvement :

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

- A PMC review is under-going to establish the priority in which to address
- Robust plans are expected to then flow through based on this and will be monitored as per agreed improvement plans

Cancelled operations

- We continue to see high levels of cancellations which impact patient experience as well as contractual obligations
- 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.

Neutropenic Sepsis

- Shows improvement but stubborn to further reduction to secure 100% local 'always event' compliance standard. MD to action improvement. 6 patients missed it in May (17 year to date).

Complaints

- Rate of complaints and timeliness of response in Q4 contrary to recent track record of excellent performance; Governance team to review for hotspots and to remedy. 79% of complaints have not met to agreed deadlines in March improving to 29% in May (percentage indicates where responses have been reported beyond agreed target time)

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 is improving in line with trajectories as at May.
2. Safeguarding training – Children level 2 and Adult Advanced training is below the agreed trajectory and will require an exception plan to support recovery. Failure to get improvement back on track may result in suspended fine being payable for last year (175k)
3. Dementia and Falls Assessments (Community); falls are failing improvement trajectory but dementia assessments are on target. Data Quality improvements ongoing for these indicators.
4. Two Maternity indicators which are have failed to deliver improvement trajectory.

Persistent red rated indicators

These are the subject of attention through the executive PMC as follows:

1. To challenge and confirm the view of relative priority for remediation [now/soon/later]
2. To obtain relevant remediation plans and to form a view as to the credibility of the plan [to be then be challenged / confirmed by PMC]
3. To establish trajectories for improvement / milestone date for full remedy of each KPI [to detail in Gantt chart format for tracking of delivery through PMC]
4. To assess confidence in delivery of the plans / trajectories [deliberate distinction here between having a good plan – which does the right things – and confidence in capacity & capability to deliver that plan which may be different] [to be then be challenged / confirmed by PMC]

PMC on 24 July to review the above.

CQUINs 2017/18

The trust has 9 National CQUINs to deliver in-year of which some are continuations from last year and will also carry on into 18/19. There will be no local CQUINs for the next two year plans. Q1 reporting is due mid-July.

	Scheme	Services Applicable to	Exec Lead	Clinical Lead	Operational Lead
1	NHS Staff Health & Well Being	Acute & Community	Raffaela Goodby	Dr T Radford	Jenny Wright, Steve Clarke
2	Reducing the Impact of Serious Infections	Acute	Elaine Newall	Dr Stedman	Dr Ratnaraja, Dr WicKramasinghe, Dr J Conor
3	Improving services for people with Mental Health needs who present to A&E	Acute	Rachel Barlow	Dr P John	Phil Holland, Deputy COO Emergency Care
4	Offering advice and Guidance (A&G)	Acute	Rachel Barlow	Mr A Sharma	Liam Kennedy, Deputy COO Planned Care
5	NHS e-Referrals CQUIN	Acute	Rachel Barlow	Mr Sharma	Liam Kennedy, Deputy COO Planned Care
6	Proactive and Safe Discharge	Acute & Community	Rachel Barlow	Dr J C Agwu	Amanda Geary, Phil Holland
7	Preventing ill health by risky behaviours – alcohol and tobacco	Acute & Community	Dr Stedman	Dr. Hatem Abusriwil-Tobacco; Dr Sally Bradberry - Alcohol	Jenny Wright,
8	Improving the assessment of wounds	Community	Elaine Newall	Paul Hooten / Debbie Talbot	Lesley McDonagh / Tammy Davies
9	Personalised Care / support planning	Community	Elaine Newall	Paul Hooten	Tammy Davies

Specialised Commissioning CQUINs

1	Haemoglobinopathy Improving Pathways through Operational Delivery Networks			Dr Shivan Pancham	
2	Activation System for Patients with Long Term Conditions			SIVARAM, Muralidhar	Amanda Geary
3	Paediatric Networked Care to Reduce Recourse to Critical Care Distant from Home				Amanda Geary

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Operational Management Committee, Performance Management Committee, CLE

Sandwell and West Birmingham Hospitals NHS Trust

SWBTB (07/17) 020a

Integrated Quality & Performance Report

Month Reported: May 2017

Reported as at: 27/06/2017

TRUST BOARD

Contents

May 2017

Infection Control

2x C. Diff cases reported during the month of May;
3x cases year to date against a target of 5.
An annual trajectory of 30 has been agreed with the CCG for 17/18.
On track.

Nil cases of MRSA Bacteraemia were reported in May;
zero cases on a year to date basis.
Annual target set at zero.
On track.

MRSA Screening - May month:
- Non-elective patients screening 92.3%
- Elective patients screening 89.5%
both indicators are compliant with 80% target in-month and year to date

Elective screening is compliant with standard at a whole trust level;
Scheduled Care within Medicine Group is at 14% and persistently under-achieving - escalation to CNO to ensure effective remedial action within the group.

MSSA Bacteraemia (expressed per 100,000 bed days) for the month of May at 9.8 against a tolerance rate of 9.42.
7/12 months elevated levels.
Escalated to CNO and Infection Control clinical lead for review & assurance

Harm Free Care

95.5% reported for May against NHS Safety Thermometer against the target 95%;

x70 [x69] falls reported in May with x1 [x0] fall resulting in serious injury.
21 falls within community and 49 in acute setting.
Falls remain subject to ongoing CNO scrutiny.

x10 [x13] avoidable, hospital acquired pressure sores reported in May of which 8x grade 2; 2x grade 3;
x10 [x6] separate cases reported within the DN caseload.

x4 [x4] serious incidents reported in May; routine collective review in place and reported to the Q&S Cttee.

- x1 never event was reported in May; the incident involved 'wrong side block'
- WHO Safer Surgery performance consistently below 100% standard for a prolonged period of time, this is subject to MD review and re-positioning of target with CCG upon which the IPR will reflect any relevant changes.

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

x14 (x15) DOLS have been raised in May of which 14 were 7-day urgents;

Venous Thromboembolism (VTE) Assessments in May at 95.8% compliant with 95% standard across all Groups except Medicine & EC.

Missing 346 assessments in May . Stubborn number of assessments missed - escalated to MD to resolve.

Obstetrics

The overall Caesarean Section rate for May is 22.9% and delivers the standard of 25% after several months of elevated levels. 24.5% year to date against the 25% target
Elective and non-elective rates are 8.2% and 14.6% 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 May is 7.63 [4.1] within the threshold levels of 8.
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 5.91 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.

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 May the delivery is 77.3%; however, performance is consistently delivering to nationally specified definitions (80%) in large part due to significant excess of registrations over births in the Trust, so not a fully reflective indicator as such.
- Deliveries, reducing to last month and still continue to be below registrations.

Breastfeeding initiation performance reports quarterly, and as at March quarter is at 73.7% just below the target of 74.0%.

Mortality & Readmissions

The Trust overall RAMI for most recent 12-mth cumulative period is 105 (latest available data is as at February)
RAMI for weekday and weekend each at 102 and 113 respectively. Reassurance is required from MD on the levels reported.

SHMI measure which includes deaths 30-days after hospital discharge is at 104 for the month of January (latest available data).

- Deaths in Low Risk Diagnosis Groups (RAMI) - month of February is 72. This indicator measures in-month expected versus actual deaths so subject to larger month on month variations.
- Crude in-month mortality rate for April is 1.2 [1.0] slightly increased to last month;
- The rolling crude year to date mortality rate remains consistent at 1.3 and consistent with last year same period at this stage.
- There were x105 [x100] deaths in our hospitals in the month of April; significantly lower than last year same period.

Mortality review rate in March at 64% worsening to previous monthly trends,
Remains subject to MDO attention for remedy.

Readmissions (in-hospital) reported at 7.2% in April (7.1% in Mar) showing a slight increase to last month but remaining low.

7.1% rolling 12 mths. The equivalent peer group rate is at 7.8% increasing significantly in the last months.

Stroke Care & Cardiology

Stroke data for May indicates that 95.0% of patients are spending >90% of their time on a stroke ward which is compliant with the 90% operational threshold.

May admittance to an acute stroke unit within 4 hours is at 87.5% being below local target of 90%.
National target of 80% is consistently met.

Pts receiving CT Scan within 1 hour of presentation is at 71.4%[87.2%] in May being compliant with 50% standard consistently;

Pts receiving CT Scan within 24 hrs of presentation delivery in month at 97.1% [95.8%] meeting the 95% standard in month

May performance for thrombolysis is 50% [100%] vs the 85% target; subject to validation.

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

RACP performance for May is at 100% [100%] exceeding the 98% target for over 15 consecutive mths

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

Cancer Care

- April performance delivery across all cancer targets including 62 Days at 85.6%
- May cancer performance expected to deliver to targets.
- June being currently validated.

April validated position is that :
- x8 [x8] patients waited longer than the 62 days.
- x5 [x5] patients waited more than 104 days at the end of April
-The longest waiting patient as at the end of April was at 140 days [162 days]

- (6/37 patients) neutropenic sepsis April cases failed to receive treatment within prescribed period (less than 1hr). Delivery still below the 100% target.
- 50% of Tertiary referrals were met within 38 days by the Trust for the month of March - the consistent failure to meet this target requires attention and escalated to GDO for review & assurance.

Patient Experience - MSA & Complaints

There were 7 MSA breaches in May consistent with capacity issues.
All instances approved by COO and advised to CCG.

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

The number of complaints received for the month of May is 94 with 2.9 formal complaints per 1000 bed days.
100% have been acknowledged within target timeframes (3 days).
28% of responses have been reported beyond agreed target time, showing improvement to last month but still on the high side.

Patient Experience - Cancelled Operations

- 65 [47] sitrep declared late (on day) cancelations were reported in May of which avoidable were at the highest level for a number of months.
- Of 65 patients who were cancelled, 27 were validated as avoidable in May.
- The proportion of elective operations cancelled at the last minute for non-clinical reasons was 1.5% for May (rising since Jun16 when at 0.7%) failing the tolerance of 0.8% consistently.
11/12 months failure to achieve standard

- There were nobreches of the 28 days guarantee in May
- No urgent cancellations took place during the month of May

Theatre utilisation is consistently below the target of 85% at a Trust average of 71.9% in May.
The theatre capacity and performance is subject to Theatre Improvement Project overseen by the Theatres Board

Emergency Care

- The Trust's performance against the 4-hour ED wait target in May was 81.57% [84.95%] against the 95% national target
- 3,549 breaches were incurred in May; (2,814 Apr, 2,875 Mar, 3,046 Feb, 2,821 Jan, 3,324 Dec, 3,237 Nov, 2,676 Oct, 2,051 Sept, 1,884 Aug) .

- ED quarterly performance trend for 16/17 : Q1 at 91.9%, Q2 at 89.2%, Q3 at 83.64% and Q4 at 84.0% ;
- **Full Year 16/17 performance at 87.22%;**

- WMAS fineable 30 - 60 minutes delayed handovers at 159 in May (110).
- x12 [x0] cases were > 60 minutes delayed handovers in May
- Handovers >60mins (against all conveyances) 0.27% in May exceeding the target of 0.02%.

Fractured Neck of Femur Best Practice Tariff delivery for May is 65% [41.4%] showing an improvement on previous month, but still below the national target of 85%.
Consistently below target.

DTOCs accounted for 501[546] bed days in May; of which 258 [324] beds were fineable to BCC.
Sustained elevated levels of DTOCs with no obvious system plan for resolution.

Referral To Treatment

- RTT incomplete pathway for May is at 93.79%% [92.76%]; 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

- The RTT backlog for May is at 2,024 patients being a 15% reduction on April and 35% reduction in 2017

- The total waiting list has remained fairly static for the last three months stabilising at 32,000-33,600 patients (Sept16 high at 37,380)
- June performance is expected to deliver the national standard of 92%

3x Incomplete Breaches of 52 Weeks have been incurred in May; 2x Dermatology and 1x Urology, for which RCAs have been received. RTT Training has commenced within the trust, due to roll out to all consultant and admin staff involved in patient list management.

- Diagnostics performance has delivered at 99.2% in May (46 breaches at month end)
- June performance is expected at the same levels as for May

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, <u>without future activity</u>, hence not on a waiting list, stand at 115,000 as at May showing an increasing trend again as administration/IT processes persistently do not close down as appropriate. We will be investigating the impact of recently identified Partial Booking issues on open referrals. (Note: these open referral numbers 'exclude' patients on the RTT pathway and waiting list). 50% of open referrals are generated in outpatients cohort and we are now pursuing a specific line of enquiry in respect of PB. Low patient risk rated (green risk) amount to c15,000 which are part of the 115,000, are subject to auto-closures since Jan2016.

Staff

PDR overall compliance as at the end of May is at 88.5% against the 95% target.
Medical Appraisal at 85.1% (performance indicates appraisals 'validated' not 'carried out').

In-month sickness for May is at 4.71% (4.40%) increasing slightly to last month and below the 2.5% target ; the number of short term sickness 445 cases increasing to last month reported cases of 415; long term 214 cases remain static to last month. The cumulative sickness rate is at 4.48%. RTW is at 79.1% in month

The Trust annualised turnover rate is at 11.5% in May.
Specifically, nursing turnover in May is at 11.7% . Both are still well above trust aspirations in respect of turnover rate, and remain fairly static now for the last year.

Mandatory Training at the end of May is at 87% overall against target of 95%;
Health & Safety related training is above the 95% target at 95.6% in May.
Safeguarding training recovery plans failing at 2 levels, with a further exception report extending delivery further out.

CQUINs, Local Quality Requirements 2017/18

The Trust has been funded to support 9x national CQUINs and 3x Specialised Commissioning schemes. The funding value is c£8.5m. Quarter 1 reporting commences at the end of July and we have engaged in the delivery of the schemes, some of which are continuations from the previous year.

Local Quality Requirements 2017/18 are monitored by CCG and there is no confirmation at this stage how Key Access Targets (A&E, RTT, Diagnostics and Cancer) will be treated this year in relation to STF criteria. Last year these were excluded directly from CCG fines.
Last year the Trust failed to deliver across a number of indicators and these have been subject to formal RAPs (recovery action plans) which continue into 17/18:
- Safeguarding training for which the performance notice action plan has been accepted, but failing to deliver trajectory (the trust may be liable to repay the full fine c£200k)
- Community falls & dementia
- On the Day Cancellations • Gynae 4 week community clinics
- A&E including morning discharges.
- A new IPR page has been added to highlight and monitor areas of non-compliance (Local Quality Requirements page).
- The Trust received confirmation that RAPs (recovery plans) provided in April for the above have been accepted. It is the responsibility of the Groups to monitor and deliver the required improvements. The SQPR page in the IPR provides insight into the failing performance on page 17.

STF Criteria & NHSI Single Oversight Framework

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.

To secure the Q1 ED funding [£236k] requires improvement to 85.3% P12 March 2017 performance. This cannot now be achieved.

Balance of STF [c£7.4m] related to achievement of financial plan.
PO2 financial performance reported as being on plan but supported by c£2.0m of non-recurrent measures.

Summary Scorecard - April (In-Month)

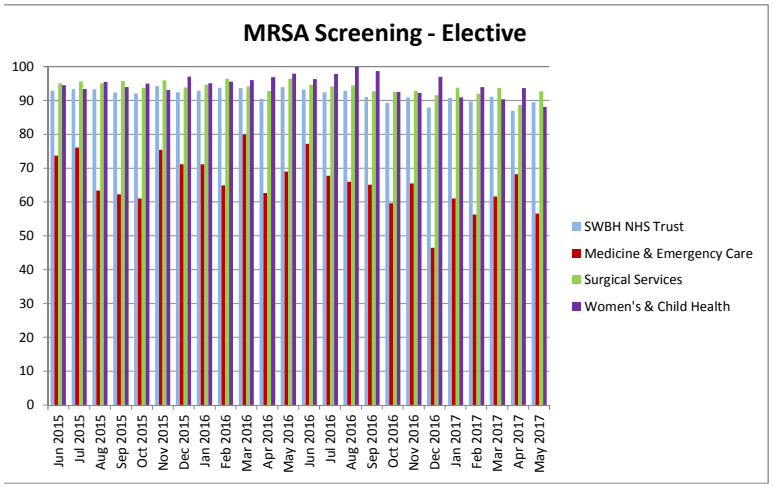
Summary Scorecard

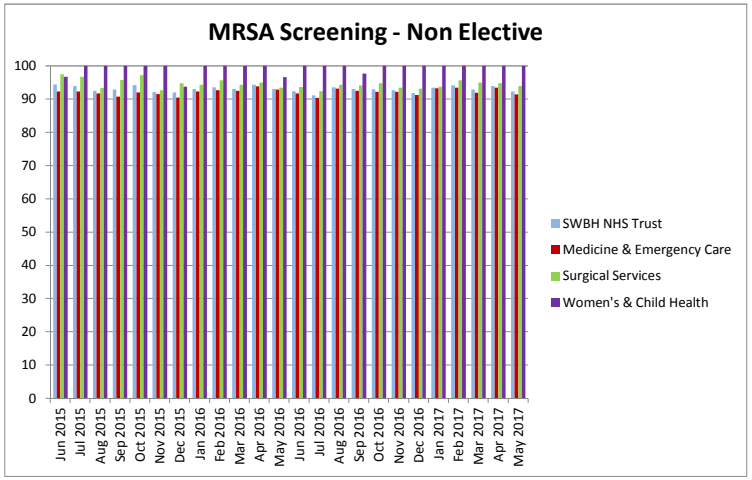
Section	Red Rated	Green Rated	None	Total
Infection Control	1	5	0	6
Harm Free Care	9	4	9	22
Obstetrics	1	6	6	13
Mortality and Readmissions	1	1	11	13
Stroke and Cardiology	1	10	0	11
Cancer	0	10	5	15
FFT, MSA, Complaints	14	2	5	21
Cancellations	5	3	0	8
Emergency Care & Patient Flow	10	4	4	18
RTT	7	1	6	14
Data Completeness	2	8	9	19
Workforce	5	1	13	19
SQPR	9	0	1	10
Total	65	55	69	189

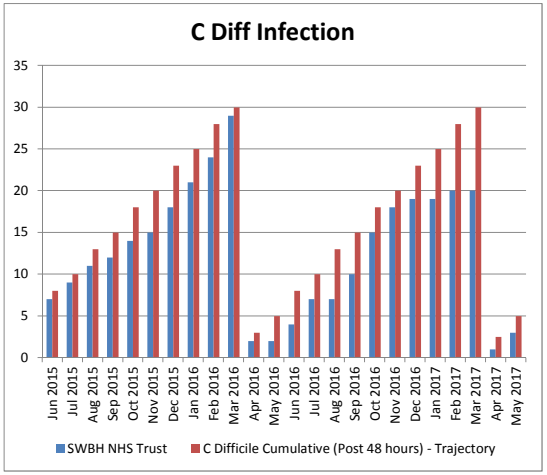
CCG Performance Notices :
- Cancelled Operations: on-day cancelled operations
- Community Gynae referral to 1st OP within 4 weeks
- RAP for Dementia & Falls Assessment not delivering and exception report was submitted
- Safeguarding training RAP – Children level 3 below agreed trajectory as is adult advanced training - exception report required
- RAP for A&E, RTT and Diagnostics to be specifically discussed during April

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Dec 2015) D J F M A M J J A S O N D J F M A M	Data Period	Group M	Group SS	Group W	Group P	Group I	Group C	Group CO	Month	Year To Date	Trend
4			C. Difficile	<= No	30	2.5		May 2017	1	1	0					2	3	
4			MRSA Bacteraemia	<= No	0	0		May 2017	0	0	0					0	0	
4			MSSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9.42		May 2017								9.8	15.2	
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	94.9	94.9		May 2017								14.7	7.6	
3			MRSA Screening - Elective	=> %	80	80		May 2017	57	93	88					89.5	88.4	
3			MRSA Screening - Non Elective	=> %	80	80		May 2017	92	94	100					92.3	93.1	

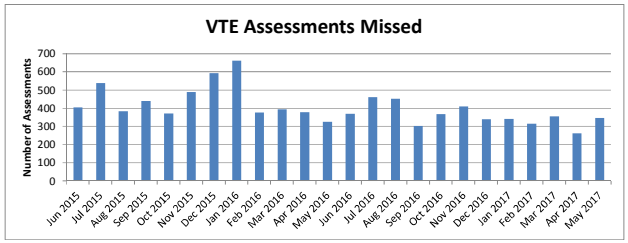


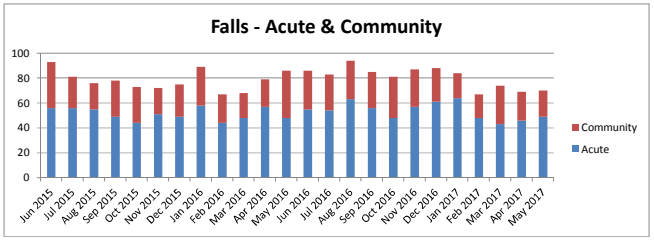


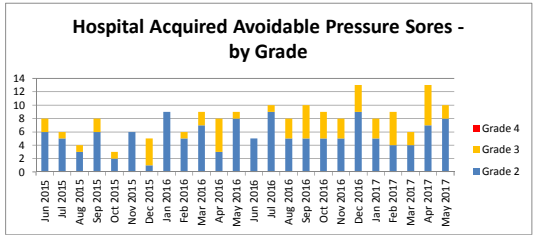


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	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																			May 2017								95.5	94.6	
8		d	Patient Safety Thermometer - Catheters & UTIs	%			7.00	4.00	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	May 2017								0.17	0.22	
	NEW		Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	-	-	25	22	15	14	23	15	14	May 2017	7	3	0	-	-	4		14	29	
	NEW		Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	-	-	25	22	14	14	23	15	14	May 2017	7	3	0	-	-	4		14	29	
	NEW		Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	-	-	6	0	0	0	0	0	0	May 2017	0	0	0	-	-	0		0	0	
	NEW		Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	-	-	4	15	14	8	8	15	12	May 2017	6	4	0	-	-	2		12	27	
	NEW		Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	-	-	6	6	2	11	6	3	11	May 2017	6	3	0	-	-	2		11	14	
	NEW		Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	-	-	1	0	1	1	0	1	0	May 2017	0	0	0	-	-	0		0	1	
	NEW		Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	-	-	-	-	-	-	5	2	1	0	0	3	1	May 2017	1	0	0	-	-	0		1	4	
8			Falls	<= No	804	67	75	89	67	68	79	86	86	83	94	85	81	87	88	84	67	74	69	70	May 2017	39	7	3	0	0	21		70	139	
9			Falls with a serious injury	<= No	0	0	1	2	2	2	1	0	4	1	3	3	1	2	3	3	1	2	1	1	May 2017	1	0	0		0	0		1	2	
8			Grade 2,3 or 4 Pressure Ulcers (Hospital Aquired Avoidable)	<= No	0	0	5	9	6	9	8	9	5	10	8	5	9	8	13	8	9	6	13	10	May 2017	6	3	0			1		10	23	
	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	6	10	May 2017						10		10	16	
3		d	Venous Thromboembolism (VTE) Assessments	=> %	95	95																			May 2017	93.7	98.1	96.1					95.8	96.1	
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	100	100																			May 2017	100.0	99.9	99.7		0.0			99.9	99.9	
3			WHO Safer Surgery - brief (% lists where complete)	=> %	100	100																			May 2017	99	100	100		0			99.5	99.5	
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	100																			May 2017	96	100	100		0			98.4	98.4	
9		d	Never Events	<= No	0	0	0	0	1	0	0	0	1	1	0	0	0	1	0	0	1	0	0	1	May 2017	0	1	0	0	0	0		1	1	
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	May 2017	0	0	0	-	0	0		0	0	
9		d	Serious Incidents	<= No	0	0	2	12	8	5	2	1	10	5	6	4	6	5	10	5	6	5	4	4	May 2017	1	3	0	0	0	0	0	4	8	
9			Open Central Alert System (CAS) Alerts	<= No			9	7	6	5	1	13	3	11	12	12	14	10	8	6	5	4	8	9	May 2017								9	17	
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	No	0	0	0	2	1	2	0	0	0	0	1	1	2	1	2	0	1	0	0	0	May 2017								0	0	

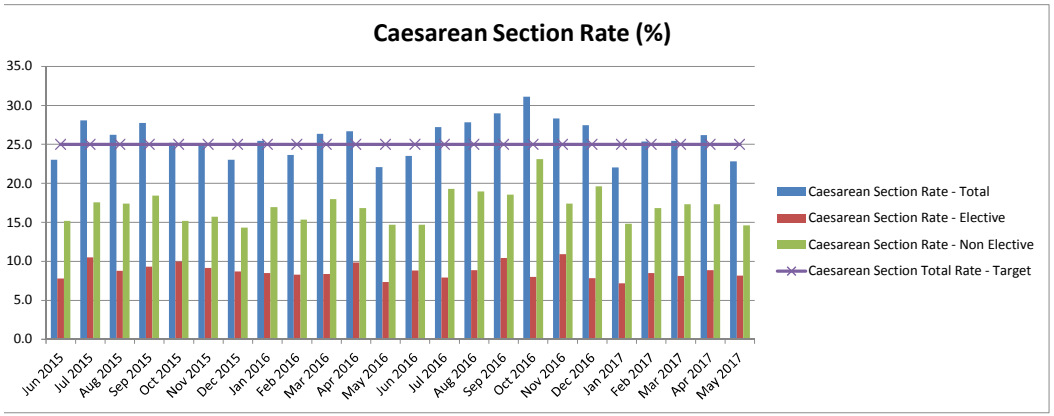


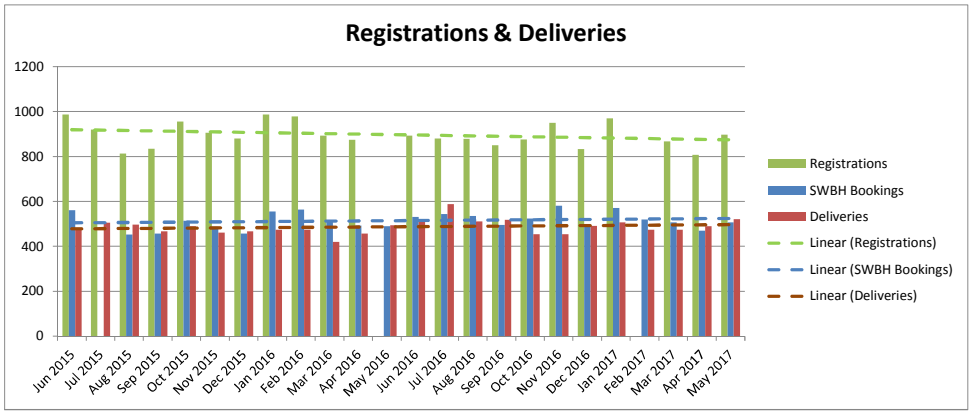




Patient Safety - Obstetrics

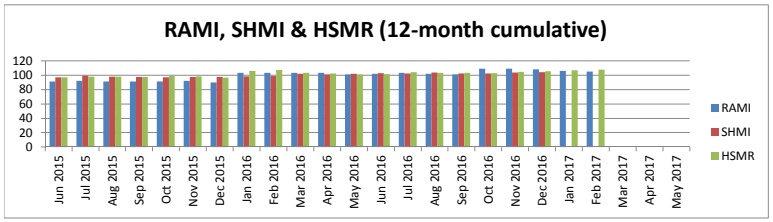
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory 2016-2017 Year	Trajectory 2016-2017 Month	Previous Months Trend (since Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Month	Year To Date	Trend
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			May 2017	22.9	24.5	
3			Caesarean Section Rate - Elective	<= %			9	8	8	8	10	7	9	8	9	10	8	11	8	7	9	8	9	8	May 2017	8.2	8.5	
3			Caesarean Section Rate - Non Elective	<= %			14	17	15	18	17	15	15	19	19	19	23	17	20	15	17	17	17	15	May 2017	14.6	16.0	
2		d	Maternal Deaths	<= No	0	0																			May 2017	0	0	
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			May 2017	3	4	
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																			May 2017	1.73	1.78	
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			May 2017	7.63	5.91	
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	90.0	90.0																			May 2017	77.3	79.0	
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																			May 2017	134.5	134.3	
2			Breast Feeding Initiation (Quarterly)	=> %	74.0	74.0		-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		-->	-->	May 2017	-	-	
2			Puerperal Sepsis and other puerperal infections (variation 1 - ICD10 O85 or O86) (%) -	<= %			1.3	0.7	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	May 2017	2.53	3.46	
2			Puerperal Sepsis and other puerperal infections (variation 2 - ICD10 O85 or O86 Not O864) (%)	<= %			0.3	-	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	May 2017	1.61	2.30	
2			Puerperal Sepsis and other puerperal infections (variation 3 - ICD10 O85) (%)	<= %			0.0	-	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	May 2017	1.38	1.84	

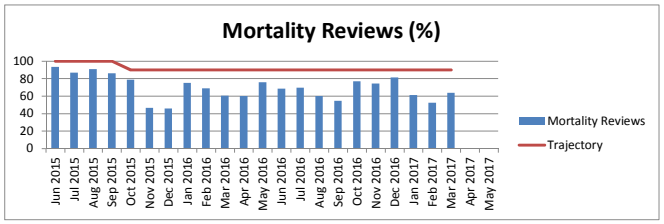


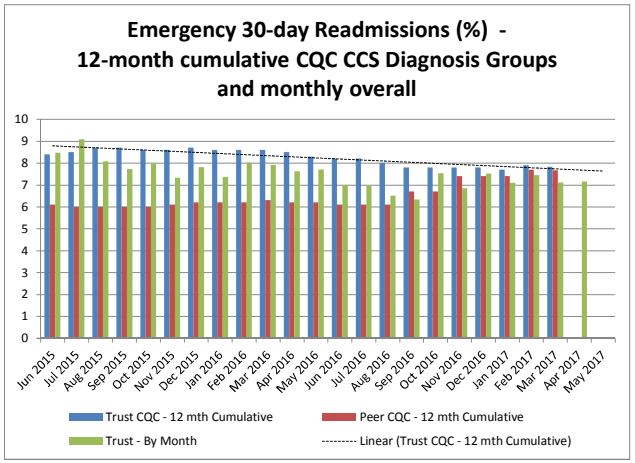


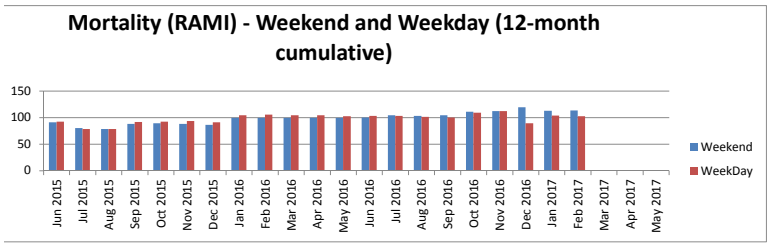
Clinical Effectiveness - Mortality & Readmissions

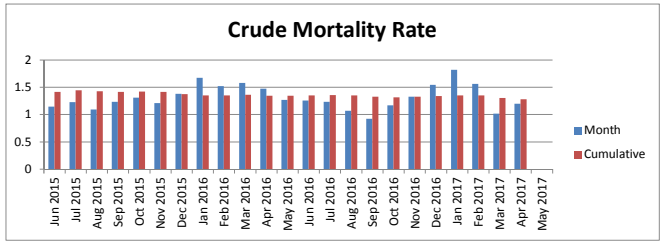
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	90	103	103	103	103	101	102	103	102	101	109	109	108	106	105	-	-	-	Feb 2017									1149	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	91	104	105	104	104	102	103	103	101	100	109	112	89	104	102	-	-	-	Feb 2017									1129	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	86	99	99	99	99	99	100	104	103	104	111	112	119	112	113	-	-	-	Feb 2017									1176	
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	98	98	99	102	101	102	103	102	104	102	102	104	104	-	-	-	-	-	Dec 2016									924	
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			97	106	107	103	102	101	101	104	103	103	103	105	106	107	108	-	-	-	Feb 2017									1142.1	
5		C	Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	40	68	113	82	103	50	3	103	43	56	94	139	84	105	72	-	-	-	Feb 2017								72		
3			Mortality Reviews within 42 working days	=> %	90	90	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	-	-	Mar 2017	63	71	0					64	67	
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.4	1.7	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	-	Apr 2017								1.20		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.4	1.4	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	-	Apr 2017									1.28	
	NEW		Deaths in the Trust	No			135	163	146	158	142	121	123	119	102	87	108	129	143	172	139	100	105	-	Apr 2017								105	105	
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			7.8	7.4	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	-	Apr 2017								7.15		
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			8.3	8.2	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	-	Apr 2017									7.09	
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			8.7	8.6	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	-	-	-						7.83	





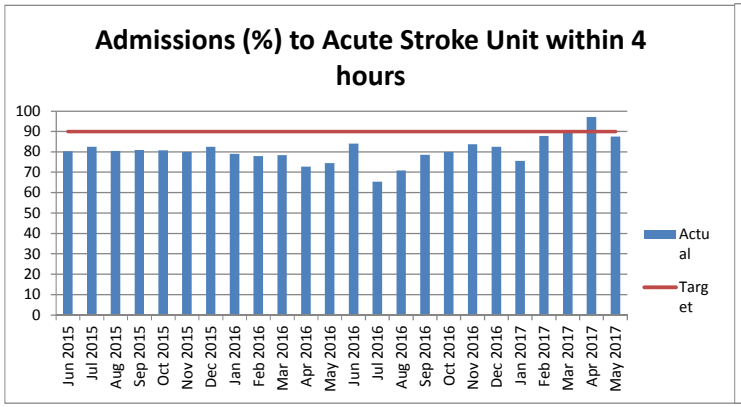


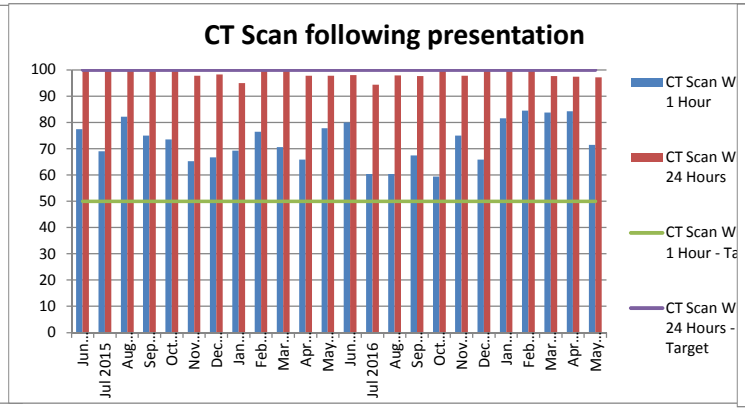


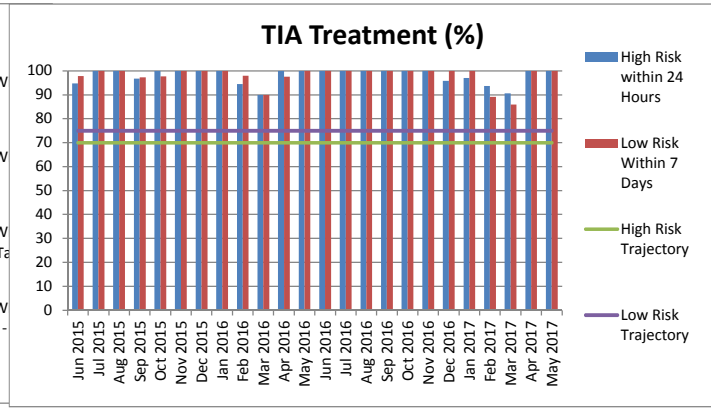


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Month	Year To Date	Trend
3			Pts spending >90% stay on Acute Stroke Unit	=> %	90.0	90.0																			May 2017	95.0	94.5	
3			Pts admitted to Acute Stroke Unit within 4 hrs	=> %	90.0	90.0																			May 2017	87.5	92.4	
3			Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0																			May 2017	71.4	78.1	
3			Pts receiving CT Scan within 24 hrs of presentation	=> %	95.0	95.0																			May 2017	97.1	97.3	
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			May 2017	50.0	66.7	
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0																			May 2017	106.7	103.3	
3			TIA (High Risk) Treatment <24 Hours from receipt of referral	=> %	70.0	70.0																			May 2017	100.0	100.0	
3			TIA (Low Risk) Treatment <7 days from receipt of referral	=> %	75.0	75.0																			May 2017	100.0	100.0	
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0																			May 2017	100.0	96.4	
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0																			May 2017	100.0	96.2	
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0																			May 2017	100.0	100.0	



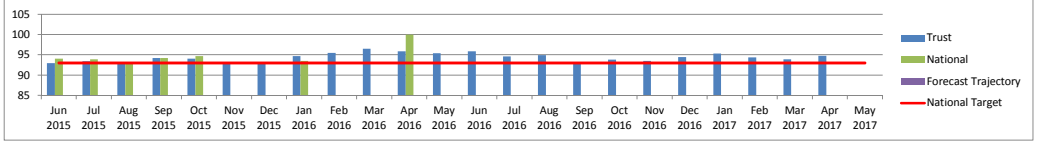




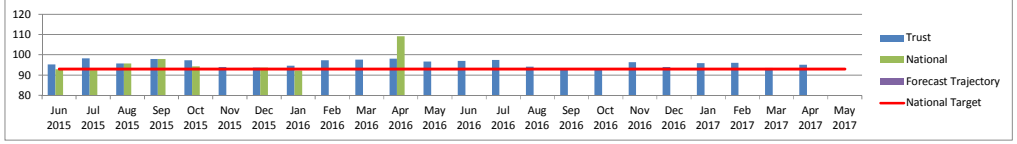
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
1			2 weeks	=> %	93.0	93.0																		-	Apr 2017	93.1	95.6	96.1					94.8	94.8	
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		-	Apr 2017		-						95.2	95.2	
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Apr 2017	100.0	100.0	95.5					99.2	99.2	
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0																		-	Apr 2017								100.0	100.0	
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																		-	Apr 2017								100.0	100.0	
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																		-	Apr 2017								-	0.0	
1			62 Day (urgent GP referral to treatment) Excluding Rare Cancer	=> %	85.0	85.0																		-	Apr 2017	86.2	94.7	50.0					85.6	85.6	
1	NEW		62 Day (urgent GP referral to treatment) Including Rare Cancer	=> %	85.0	85.0																		-	Apr 2017	86.2	94.9	50.0					85.8	85.8	
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																		-	Apr 2017	0.0	100.0	0.0					100.0	100.0	
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																		-	Apr 2017	100.0	100.0	100.0					100.0	100.0	
1			Cancer - Patients Waiting over 62 days	No			8	6	10	6	9	11	7	7	12	8	10	11	10	8	15	8	8	-	Apr 2017	2.0	1.5	4.5					8.0	8.0	
1			Cancer - Patients Waiting over 104 days	No			4	0.0	4.5	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	-	Apr 2017	1.0	1.0	3.0					5.0	5.0	
1			Cancer - Longest Waiter in days	No			167	98	154	98	175	95	130	113	131	140	133	77	107	120	150	162	140	-	Apr 2017	140	119	126					140		
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	May 2017	6	0	0					6	17	
	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	-	Apr 2017	-	-	-					0	0	

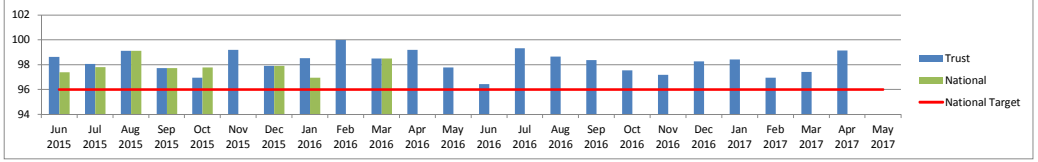
2-week wait from Referral to Date First Seen



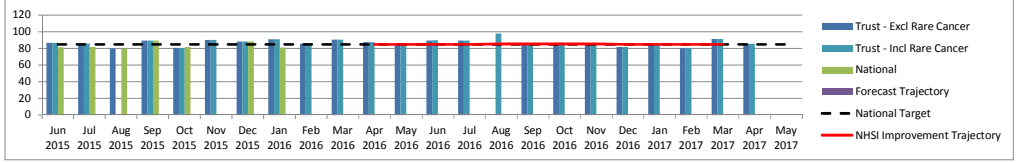
2-week wait from Breast Symptomatic Patients



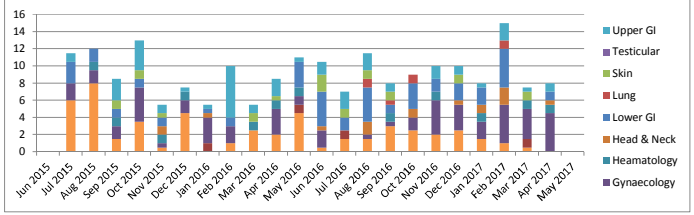
31-day Diagnosis to First Treatment



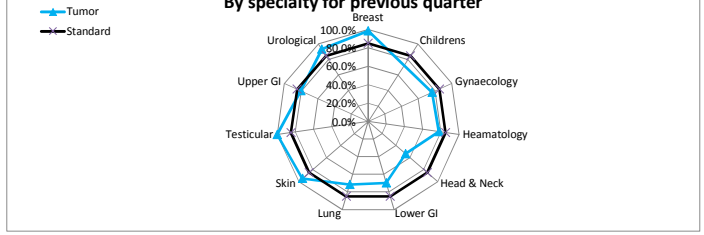
62-day Urgent GP Referral to First Treatment



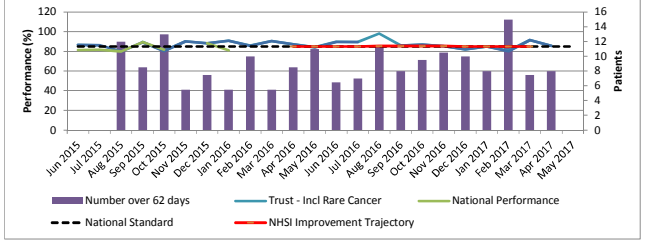
62-day Urgent GP Referral to First Treatment Breach- By Tumour Site



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

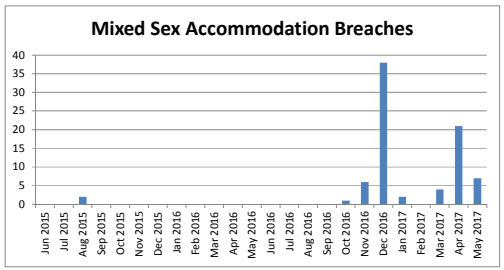


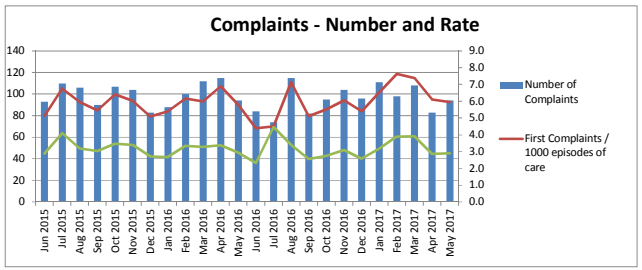
62-day Urgent GP Referral to First Treatment

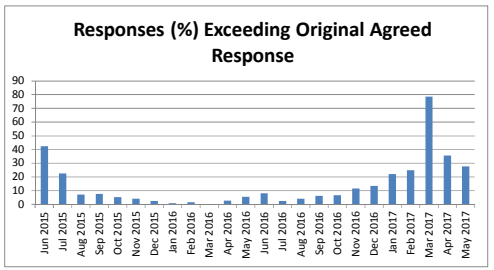


Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	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	15	15	14	17	16	17	17	13	20	22	17	10	15	9.7	7.9	9.27	11	May 2017								11	10	
8		a	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95.0	95.0	96	96	95	95	96	90	83	86	83	86	88	94	97	97	95	96	94.8	92	May 2017								92		
8		b	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50.0	50.0	5.7	6.3	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	May 2017	3.8							3.8	4.6	
8		a	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95.0	95.0	81	79	74	74	78	85	87	86	83	78	73	75	73	77	76	73	75.2	71	May 2017	71							71		
8			FFT Response Rate: Type 3 WiU Emergency Department	=> %	50.0	50.0	0.1	1.5	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	0.11	0	May 2017	-							0.0	0.1	
8			FFT Score - Adult and Children Emergency Department (type 3 WiU)	=> No	95.0	95.0	50	85	0	0	100	96	50	95	100	86	64	100	100	65	0	0	0.04	0	May 2017	-							0		
8			FFT Score - Outpatients	=> No	95.0	95.0	86	90	88	87	87	88	88	86	89	88	88	89	90	88	88	90	89.7	89	May 2017								89		
8	NEW		FFT Score - Maternity Antenatal	=> No	95.0	95.0	100	96	100	95	100	91	100	94	86	79	86	90	86	97	11	95	87.5	90	May 2017								90		
8	NEW		FFT Score - Maternity Postnatal Ward	=> No	95.0	95.0	97	95	91	91	97	100	100	100	100	74	81	93	90	91	29	83	91.4	86	May 2017								86		
8	NEW		FFT Score - Maternity Community	=> No	95.0	95.0	98	96	99	99	99	99	100	98	96	91	100	100	50	0	0	80	100	100	May 2017								100		
8			FFT Score - Maternity Birth	=> No	95.0	95.0	82	90	94	93	92	90	0	0	100	87	71	88	90	88	23	92	82	83	May 2017								83		
8			FFT Response Rate - Maternity Birth	=> %	50.0	50.0	14	23	15	10	12	9	0	0	1.4	15	5.9	17	13	8.2	5.4	21	8.91	11	May 2017								11	10	
13		a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	0	0	0	0	0	0	0	0	0	1	6	38	2	0	4	21	7	May 2017	7	0	0		0	0		7	28	
9	NEW		No. of Complaints Received (formal and link)	No			83	88	100	112	115	94	84	74	115	82	95	104	96	111	98	108	83	94	May 2017	42	29	8	1	2	3	9	94	177	
9			No. of Active Complaints in the System (formal and link)	No			121	113	128	147	154	144	147	127	143	144	152	148	157	176	177	194	205	184	May 2017	79	61	12	2	3	10	17	184		
9		a	No. of First Formal Complaints received / 1000 bed days	Rate1			2.7	2.7	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	May 2017	2.5	5.2	1.8					2.89	2.88	
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			5.1	5.4	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	May 2017	6.3	7.3	3.2			0		5.96	6.03	
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	=> %	100	100	100	100	100	100	100	100	100	96	100	100	99	100	100	99	98	94	100	100	May 2017	100	100	100	100	100	100	100	100	100	
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	<= %	0	0	2.5	0.9	1.6	0	2.6	5.6	8.2	2.4	4.2	6.3	6.6	11	13	22	25	79	35.6	28	May 2017	30	35	0	0	0	20	24	28	32	
9			No. of responses sent out	No			98	69	81	84	98	81	103	103	80	110	87	79	79	76	95	84	67	106	May 2017	41	37	18	1	0	3	6	106	173	
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	N	N	N	N	N	N	N	No		

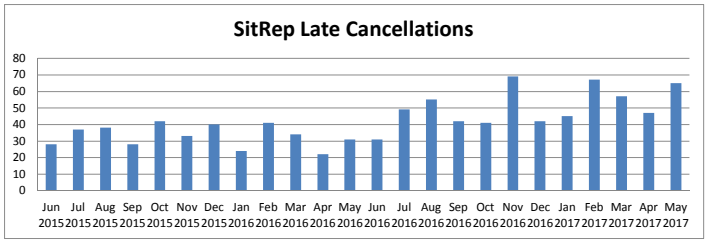


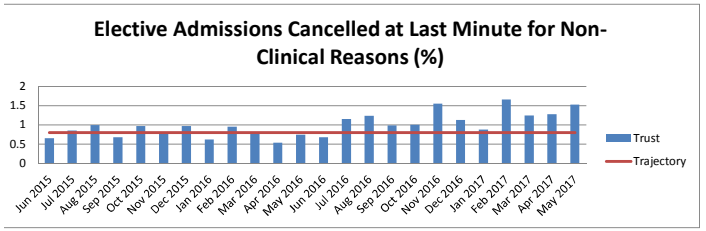


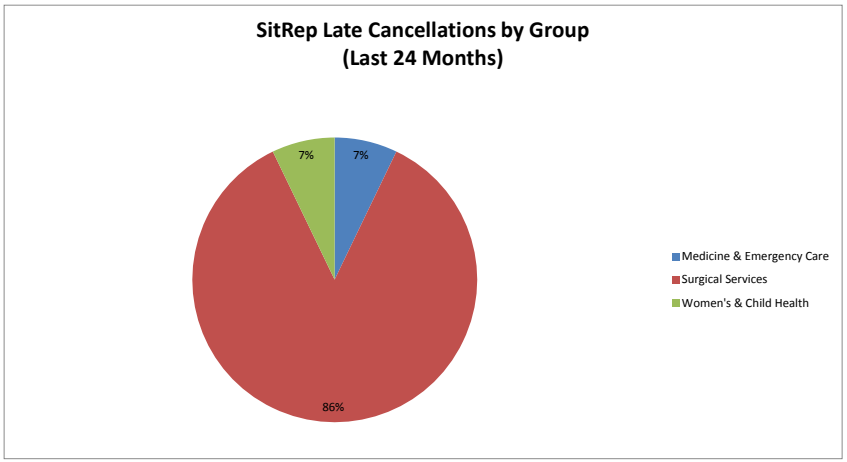


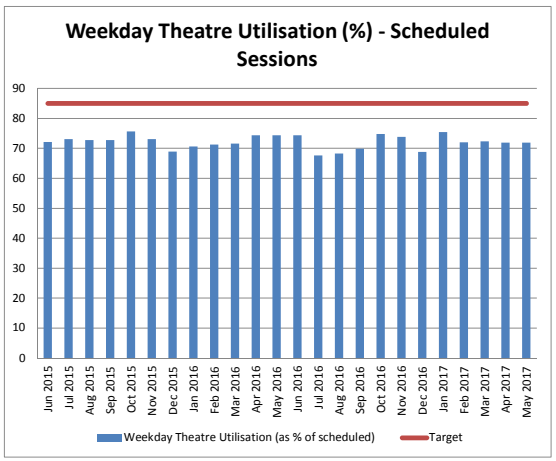
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	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	40	24	41	34	22	31	31	49	55	42	41	69	43	45	67	57	47	65	May 2017	11	49	5					65	112	
2	NEW		No. of Sitrep Declared Late Cancellations - Avoidable	No			-	-	-	-	6	9	11	9	9	15	17	28	19	13	19	17	24	27	May 2017	6	20	1					27	51	
2	NEW		No. of Sitrep Declared Late Cancellations - Unavoidable	No			-	-	-	-	16	22	19	40	43	27	22	41	18	29	48	37	23	37	May 2017	5	28	4					37	60	
2			Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	0.8	0.8																			May 2017	0.61	2.24	1.79					1.5	1.4	
2			Number of 28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	1	0	3	6	0	0	1	0	May 2017	0	0	0					0	1	
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	May 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	May 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	0	0	1	2	0	0	1	3	4	0	3	0	3	1	May 2017	0	1	0					1	4	
			Multiple Hospital Cancellations experienced by same patient (all cancellations)	<= No	0	0	39	63	56	57	79	63	43	56	51	60	49	50	63	61	62	67	51	45	May 2017	4	37	4					45	96	
3			All Hospital Cancellations, with 7 or less days notice	<= No	0	0	194	210	228	223	229	257	229	241	223	258	234	273	272	269	284	257	219	230	May 2017	44	161	25					230	449	
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0																			May 2017	35.3	75.8	81.6					71.9	71.9	



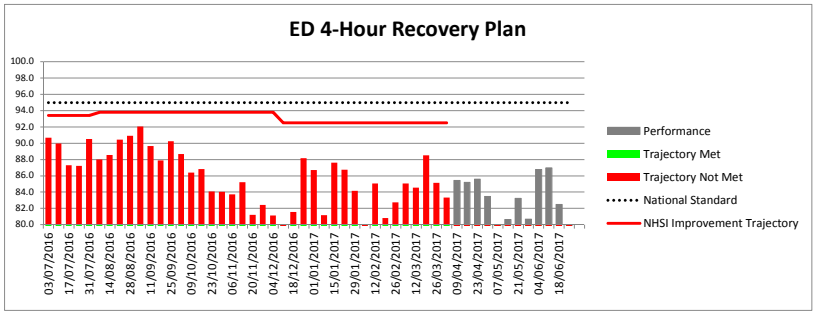


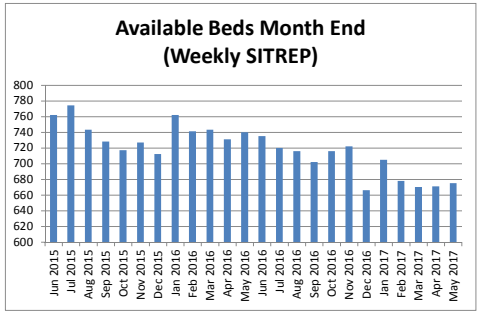


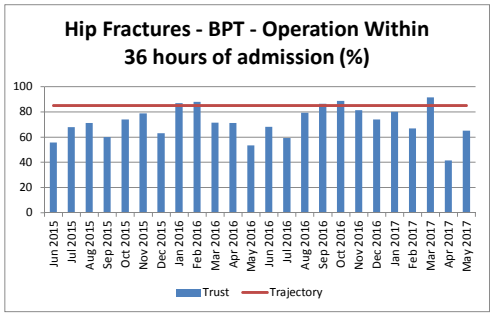


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend
2			Emergency Care 4-hour waits	=> %	95.00	95.00																			May 2017	78.7	82.2	96.8	81.57	83.23	
2			Emergency Care 4-hour breach (numbers)	No			1715	1757	1956	2342	1608	1451	1625	2168	1884	2051	2676	3237	3324	2821	3046	2875	2814	3549	May 2017	1821	1689	39	3549	6363	
2			Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			May 2017	0	0		0	0	
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			May 2017	15	14	14	15	15	
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			May 2017	73	64	97	70	67	
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			May 2017	8.18	8.40	2.97	7.90	7.76	
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			May 2017	5.45	7.66	2.39	6.28	5.60	
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	121	116	97	117	81	65	70	122	112	135	112	162	193	162	129	107	110	159	May 2017	107	52		159	269	
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	8	10	6	9	2	0	1	8	6	9	16	21	19	11	13	5	0	12	May 2017	11	1		12	12	
11			WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			May 2017	0.51	0.04		0.27	0.14	
11			WMAS - Emergency Conveyances (total)	No			4573	4679	3961	4513	4115	4604	4099	4363	4204	4138	4233	4261	4622	4410	4034	4206	4137	4376	May 2017	2150	2226		4376	8513	
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																			May 2017	0.7	3.8		1.9	2	
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	<10 per site	<10 per site																			May 2017	2.5	9		12		
2			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	<= No	0	0	498	318	426	397	454	494	588	617	530	483	509	503	674	629	512	583	546	501	May 2017				501	1047	
2			Delayed Transfers of Care (Acute) - Finable Bed Days (Birmingham LA only)	<= No	0	0	267	185	198	232	234	228	251	245	287	215	266	272	449	435	309	375	324	258	May 2017				258	582	
2			Patient Bed Moves (10pm - 6am) (No.) -ALL	No			540	632	543	546	563	498	451	578	533	525	546	679	666	682	633	586	584	651	May 2017				651	1235	
2			Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units	No			236	320	269	232	255	222	204	268	246	248	219	273	251	249	228	221	229	234	May 2017				234	463	
			Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85.0	85.0																			May 2017				65	51.0	

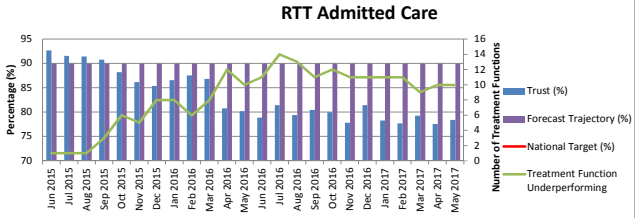


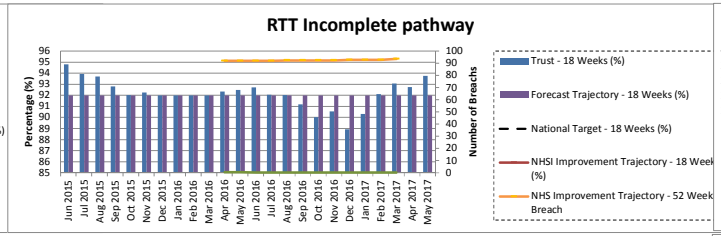


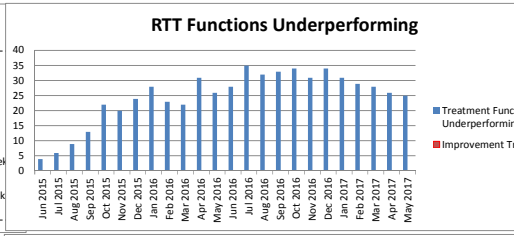


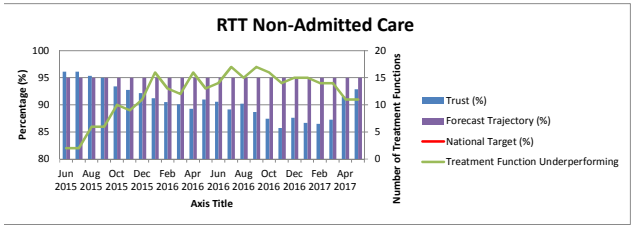
Referral To Treatment

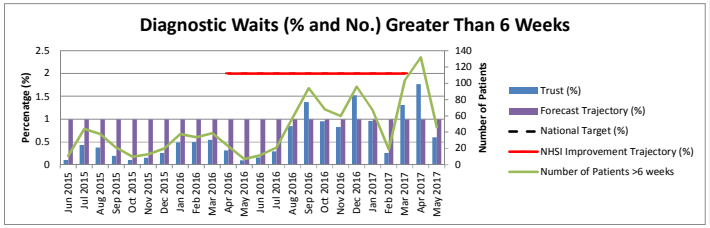
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
2			RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			May 2017	85.2	74.5	72.1					78.43		
2			RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			May 2017	85.0	93.3	95.3					92.88		
2			RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			May 2017	93.4	92.8	94.7					93.79		
	NEW		RTT - Backlog	No			2463	2468	2423	2557	2566	2561	2515	2870	2968	3289	3728	3417	3908	3204	2578	2214	2327	2024	May 2017	479	1204	81					2024		
2			Patients Waiting >52 weeks	<= No	0	0	2	4	5	8	3	2	4	4	0	1	4	3	2	0	3	6	5	3	May 2017	2	1	0					3	8	
2	NEW		Patients Waiting >52 weeks (Incomplete)	<= No	0	0	0	3	3	2	0	2	2	0	0	1	2	2	2	1	3	2	3	3	May 2017	2	1	0					3	6	
2			Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	<= No	0	0	24	28	23	22	31	26	28	35	32	33	34	31	34	31	29	28	26	25	May 2017	7	16	1.0					25		
			Treatment Functions Underperforming (Incomplete)	<= No	0	0	5	4	4	2	3	3	3	4	4	5	6	6	8	5	4	5	5	4	May 2017	1	3	0					4		
2			Acute Diagnostic Waits in Excess of 6-weeks (End of Month Census)	<= %	1.0	1.0																			May 2017	1.4	0.5	0.0		0.3			0.61		
			Acute Diagnostic Waits in Excess of 6-weeks (In Month Waiters)	No			1593	1250	273	281	542	480	419	502	470	500	711	817	498	902	387	577	942	931	May 2017	377	214	-		340			931		

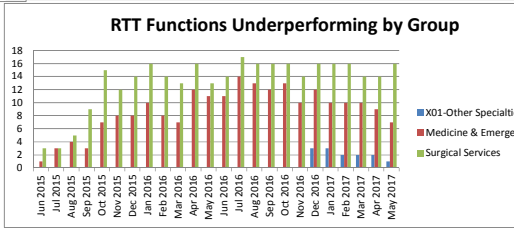


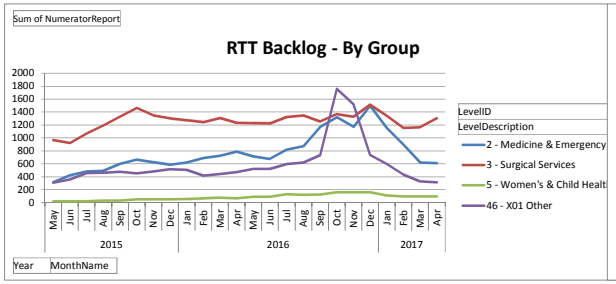


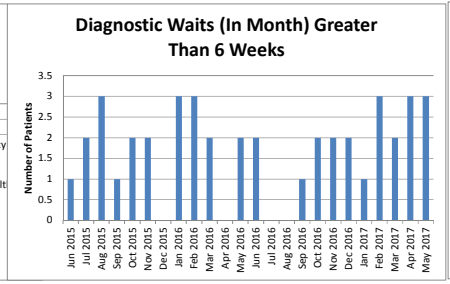


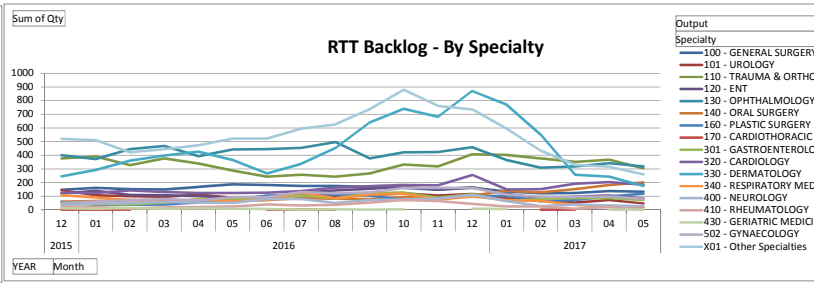






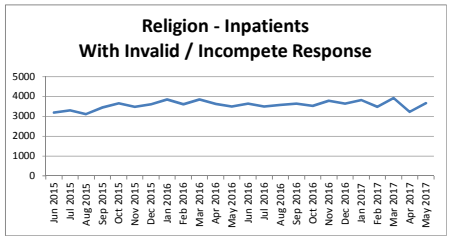


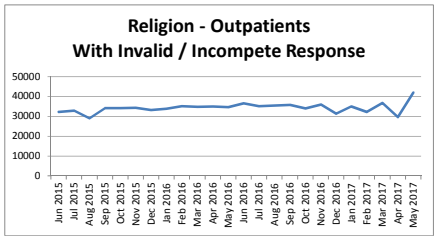


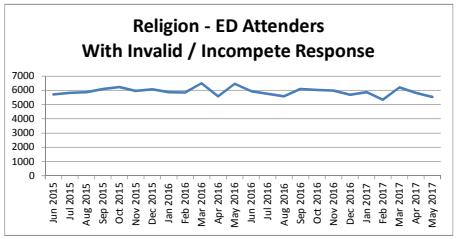


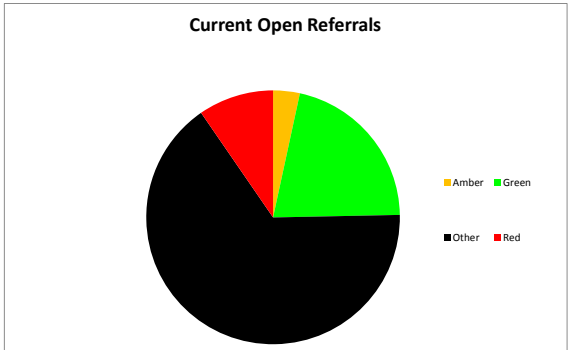
Data Completeness

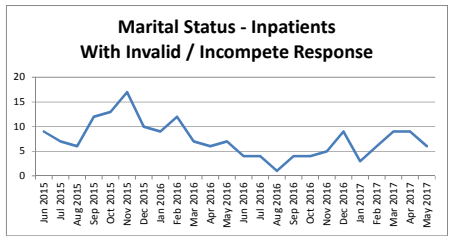
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
14			Data Completeness Community Services	=> %	50.0	50.0																		-	Apr 2017							61.2	61.2		
2			Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																	-	-	Mar 2017								99.5		
2			Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																	-	-	Mar 2017								99.2		
2			Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																	-	-	Mar 2017								99.3		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=> %	99.0	99.0	97.0	97.5	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	May 2017								98.3	98.2	
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	=> %	99.0	99.0	99.5	99.5	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	May 2017								99.5	99.5	
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=> %	95.0	95.0	96.8	97.3	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	May 2017								97.4	97.3	
2			Ethnicity Coding - percentage of inpatients with recorded response	=> %	90.0	90.0																			May 2017								90.4	90.5	
	NEW		Ethnicity Coding - percentage of outpatients with recorded response	=> %	90.0	90.0																			May 2017								89.7	89.6	
	NEW		Protected Characteristic - Religion - INPATIENTS with recorded response	%			70.8	68.9	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	May 2017								70.6	70.5	
	NEW		Protected Characteristic - Religion - OUTPATIENTS with recorded response	%			59.3	59.3	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	May 2017								52.9	54.6	
	NEW		Protected Characteristic - Religion - ED patients with recorded response	%			62.0	63.9	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	May 2017								67.2	65.9	
	NEW		Protected Characteristic - Marital Status - INPATIENTS with recorded response	%			99.9	99.9	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	May 2017								100.0	99.9	
	NEW		Protected Characteristic - Marital Status - OUTPATIENTS with recorded response	%			40.7	40.8	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	May 2017								41.1	41.2	
	NEW		Protected Characteristic - Marital Status - ED patients with recorded response	%			41.5	41.7	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	May 2017								42.7	41.3	
2			Maternity - Percentage of invalid fields completed in SUS submission	<= %	15.0	15.0																			May 2017								5.9	6.0	
2			Open Referrals	No			228,862	192,989	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	May 2017	79,971	126,992	30,838	6,770	532	57		245,160		
	NEW		of which: Open Referrals - Not on the Waiting List (no future appt)	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	May 2017	36,822	55,792	15,849	2,956	474	2,614		115133		

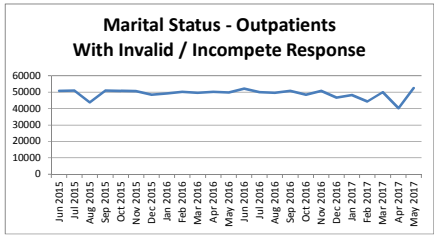


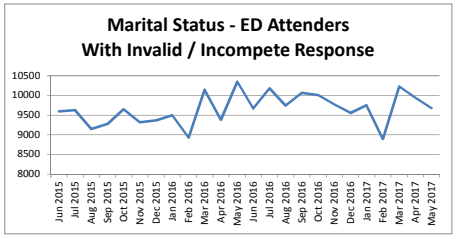






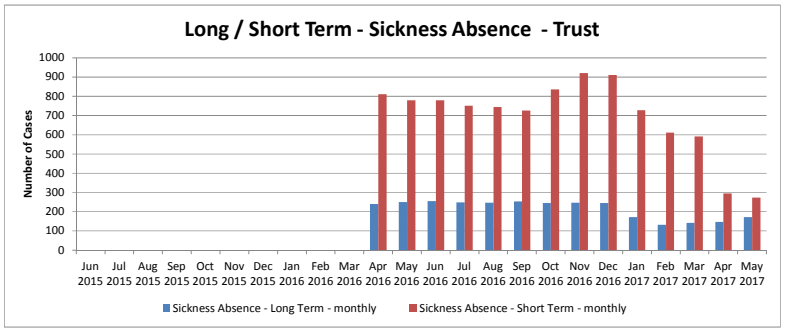


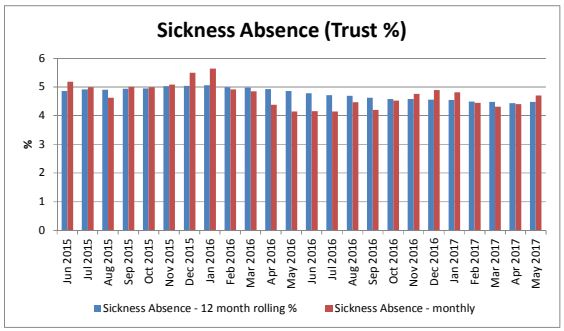




Workforce

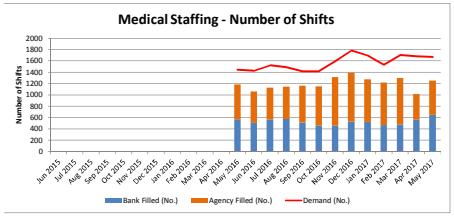
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
3			PDRs - 12 month rolling	=> %	95.0	95.0																			May 2017	83.1	87.6	91.2	95.4	91.4	92.2	89.0		88.5	
7			Medical Appraisal	=> %	95.0	95.0																			May 2017	85.7	81.9	93.0	75.0	93.3	141.2	50.0	88.4	85.1	
3			Sickness Absence (Rolling 12 Months)	<= %	3.15	3.15																			May 2017	4.7	4.7	4.6	3.9	4.3	4.0	4.5	4.48	4.46	
3	NEW		Sickness Absence (Monthly)	<= %	3.15	3.15																			May 2017	5.4	4.7	5.1	2.6	4.9	3.7	4.9	4.71	4.56	
3	NEW		Sickness Absence - Long Term (Monthly)	No			-	-	-	-	240	250	256	249	247	253	245	247	246	253	205	213	214	241	May 2017	59	41	36	6	10	19	1	241	455	
3	NEW		Sickness Absence - Short Term (Monthly)	No			-	-	-	-	812	779	780	752	745	727	837	922	911	956	808	785	414	445	May 2017	68	50	41	30	22	60	2	445	859	
3			Return to Work Interviews following Sickness Absence	=> %	100.0	100.0																			May 2017	71.9	82.9	84.3	85.5	71.1	79.1	80.5	79.1	79.2	
3			Mandatory Training	=> %	95.0	95.0																			May 2017	81.5	86.0	88.0	90.0	87.7	86.4	87.8		87.0	
3			Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-		-	
3			Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0																			May 2017	92.0	0.0	93.7	95.8	95.1	0.0	97.8		95.6	
7			Employee Turnover (rolling 12 months)	<= %	10.0	10.0																			May 2017								11.5	11.5	
	NEW		Nursing Turnover	%			14.6	14.7	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	May 2017								11.7	12	
7			New Investigations in Month	No			2	5	12	9	6	4	3	8	4	4	3	0	3	4	3	9	14	1	May 2017	0	0	1	0	0	0	0	1		
7			Vacancy Time to Fill	Weeks			23	24	26	23	26	25	23	24	24	21	25	21	21	21	22	21	20	21	May 2017								21		
7			Professional Registration Lapses	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	May 2017	0	0	0	0	0	0	0	0	0	
7			Qualified Nursing Variance (FIMS) (FTE)	No			293	272	274	293	292	315	317	339	343	341	313	293	305	268	246	257	256	276	May 2017								276		
15			Your Voice - Response Rate	No			12.6	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	16.0	-->	-->	-->	-->	Jan 2017	8	30	13	22	20	29	18	16		
15			Your Voice - Overall Score	No			3.57	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.70	-->	-->	-->	-->	Jan 2017	3.68	3.79	3.66	3.82	3.58	3.83	3.64	3.7		

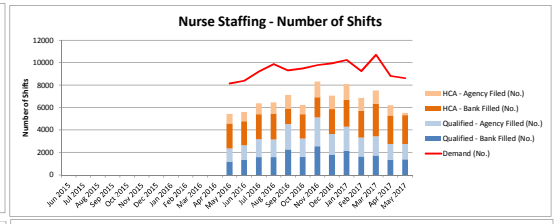


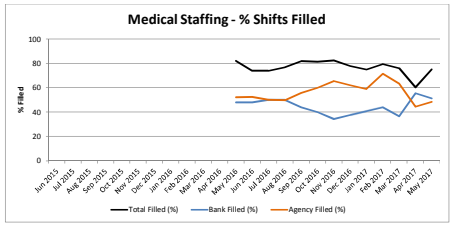


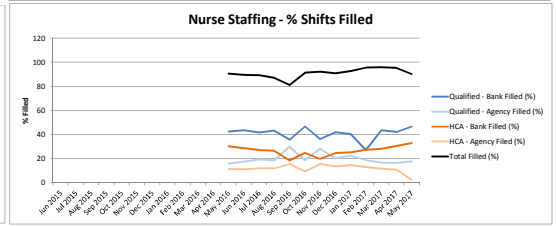
Temporary Workforce

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
			Medical Staffing - Number of instances when junior rotas not fully filled	<= %	0	0	-	-	-	-	-	4906	5343	5097	5015	5291	5005	5478	4777	5133	4965	5610	4506	5124	May 2017	-	-	-	-	-	-	-	100	100	
			Medical Staffing - Demand	No			-	-	-	-	-	1443	1429	1523	1491	1419	1419	1596	1786	1699	1534	1703	1682	1669	May 2017	1064	410	181	0	14	0	0	1669	3351.0	
			Medical Staffing - Total Filled	%			-	-	-	-	-	81.98	74.04	74.06	76.93	81.89	81.25	82.46	77.94	74.93	79.4	76.101	60.4	75.07	May 2017	72.18	84.63	71.27	0	64.29	0	0	75	67.7	
			Medical Staffing - Bank Filled	%			-	-	-	-	-	47.84	47.92	50	50.13	44.06	40.07	34.42	37.79	40.93	44.12	36.651	55.51	51.48	May 2017	37.37	75.79	66.67	0	100	0	0	51	53.3	
			Medical Staffing - Agency Filled	%			-	-	-	-	-	52.16	52.36	50	49.87	55.94	59.93	65.58	62.21	59.07	71.44	63.349	44.49	48.52	May 2017	62.63	24.21	33.33	0	0	0	0	49	46.7	
			Medical Staffing - Filled Shifts - Snr Consultant	No			-	-	-	-	-	114	110	107	137	177	243	237	187	152	217	270	120	214	May 2017	134	55	25	0	0	0	0	214	334.0	
			Medical Staffing - Filled Shifts - Jnr Doctor	No			-	-	-	-	-	1089	951	1021	1010	998	951	1108	1196	1144	1001	1026	896	394	May 2017	347	29	18	0	0	0	0	394	1290.0	
			Nursing - Demand	No			-	-	-	-	-	8158	8413	9220	9887	9312	9476	9802	9935	10261	9268	10708	8825	8616	May 2017	4381	1857	911	0	57	1187	223	8616	17441	
			Nursing - Total Filled	%			-	-	-	-	-	90.44	89.33	89.21	86.98	81.13	91.18	92.03	90.68	92.75	95.55	95.798	95.29	90.2	May 2017	90.8	88.64	85.4	0	98.25	92.17	99.1	90	92.8	
			Nursing - Qualified - Bank Filled	%			-	-	-	-	-	42.3	43.4	41.7	43.1	35.8	46.8	36.3	41.8	40.3	27.1	43.5	42.1	46.7	May 2017	40.5	43.99	69.28	0	23.21	59.51	40.72	47	44.3	
			Nursing - Qualified - Agency Filled	%			-	-	-	-	-	16.0	17.6	19.3	18.4	30.0	18.8	28.4	20.2	22.5	18.7	16.8	16.3	17.8	May 2017	22.17	21.75	2.96	0	75	6.95	0	18	17.0	
			Nursing - HCA - Bank Filled	%			-	-	-	-	-	30.2	28.6	27.0	26.6	18.6	25.0	19.8	24.6	25.3	27.2	28.1	30.4	33.1	May 2017	34.57	30.8	27.63	0	1.79	31.08	59.28	33	31.7	
			Nursing - HCA - Agency Filled	%			-	-	-	-	-	11.39	11.07	12.01	11.92	15.62	9.444	15.49	13.48	14.48	12.91	11.591	10.74	2.5	May 2017	2.77	3.46	0.13	0	0	2.47	0	3	6.8	
			AHPs - Radiography - Demand (Shifts)	No			-	-	-	-	-	138	97	79	55	269	332	321	290	526	332	525	332	372	May 2017	0	0	0	0	372	0	0	372	704	
			AHPs - Radiography - Filled (Shifts)	No			-	-	-	-	-	138	97	73	55	249	324	299	256	496	302	502	329	359	May 2017	0	0	0	0	359	0	0	359	688	
			AHPs - Physiotherapy - Demand (Shifts)	No			-	-	-	-	-	191	156	192	55	63	38	190	186	276	478	356	180	242	May 2017	0	0	0	0	0	242	0	242	422	
			AHPs - Physiotherapy - Filled (Shifts)	No			-	-	-	-	-	191	156	192	55	63	38	190	186	274	478	346	180	242	May 2017	0	0	0	0	0	242	0	242	422	
			AHPs - Other - Demand (Shifts)	No			-	-	-	-	-	301	336	289	66	96	139	96	567	413	530	1009	459	527	May 2017	185	28	34	59	15	130	76	527	986	
			AHPs - Other - Filled (Shifts)	No			-	-	-	-	-	301	336	288	55	95	95	200	567	412	527	885	457	527	May 2017	185	28	34	59	15	130	76	527	984	
			Admin - Demand (Shifts)	No			-	-	-	-	-	1994	1954	1902	2147	2765	2839	2479	2442	2381	4128	5135	4198	4228	May 2017	1055	667	256	293	89	135	1733	4228	8426	
			Admin - Filled (Shifts)	No			-	-	-	-	-	1988	1937	1855	2061	2450	2589	2452	2405	2348	4026	5079	4162	4184	May 2017	1026	662	256	293	81	135	1731	4184	8346	
			Facilities - Demand (Shifts)	No			-	-	-	-	-	1903	1947	1442	1451	2160	2185	1997	2172	2066	1971	2485	1795	2031	May 2017	25	56	20	0	1	0	1929	2031	3826	
			Facilities - Filled (Shifts)	No			-	-	-	-	-	1898	1933	1405	1397	1942	2135	1969	2107	1992	1926	2425	1737	1999	May 2017	24	56	20	0	1	0	1898	1999	3736	
			Interpreters - Demand (Shifts)	No			-	-	-	-	-	4925	5358	5110	5034	5321	5026	5508	4803	5159	4983	5634	4511	5139	May 2017	-	-	-	-	-	-	-	5139	9650.0	
			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	May 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	78.5	May 2017	-	-	-	-	-	-	-	78	77.9	
			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	May 2017	-	-	-	-	-	-	-	22	22.1	
			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	May 2017	-	-	-	-	-	-	-	0	0.2	









SQPR : Local Quality Indicators

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	RAP	Previous Months Trend (From Dec 2015) D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
			Safeguarding Adults Advanced Training	=> %	85	85	☒	-	-	-	-	-	-	-	-	-	80	80	81	81	80	79	81	81	81	May 2017								80.976	80.98	
			Safeguarding Children Level 2 Training	=> %	85	85	☒	-	-	-	-	74	73	73	72	73	71	71	73	75	76	77	77	78	79	May 2017								78.7	78.2	
			Safeguarding Children Level 3 Training	=> %	85	85	√	-	-	-	-	71	72	72	75	74	73	73	75	78	78	81	84	85	88	May 2017								88.0	86.5	
			WHO Safer Surgery - Audit - brief and debrief (% lists w	=> %	100	100	n/a	-	-	-	-	99	99	99	100	99	100	98	97	95	97	99	99	98	98	May 2017	96.3	99.7	100					98.4	98.4	
			Morning Discharges (00:00 to 12:00) - SQPR	=> %	27	27	n/a	-	-	-	-	16	15	17	17	13	16	16	17	17	20	17	16	16	15	May 2017	14.5	11.4	23.7					15.4	15.6	
			ED Diagnosis Coding (Mental Health CQUIN) - SQPR	=> %	90	90	n/a	-	-	-	-	88	88	87	87	87	87	85	86	86	86	86	87	86	86	May 2017								86.2	85.9	
			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	May 2017								79.6	78.8	
			CO Monitoring by 12+6 weeks of pregnancy - SQPR	=> %	90	90	☒	-	-	-	-	79	80	81	82	82	75	76	76	75	73	78	79	76	74.6	May 2017								74.6	75.1	
			Community - Screening For Dementia - SQPR	=> %	100	100	☒	-	-	-	-	40	37	53	30	37	data quality issue - will be populated								55											37.2	38.4	
			Community - HV Falls Risk Assessment - SQPR	=> %	100	100	☒	-	-	-	-	61	67	56	61	55	data quality issue - will be populated								69											54.8	60.0	

A number of the LQRs are subject to Recovery Action Plans (RAPs) with the SWBCCG : The RAP field above indicates whether the improvement trajectory has been met in the month.

Performance in-month against the RAP:

Safeguarding Training - some recovery, but slightly behind 2x training sets as at May

- Children Level 3 Training is hitting the trajectory and target and now needs to be sustained
- Children Level 2 Training is below the 80% trajectory for May reporting at 79%
- Adults Advanced Training is below the 83% trajectory for May reporting at 81%

Exception reports have been asked of the Training & Development team to consider approach to bookings.

Maternity

- BMI recording reported at 79.6% in May against a trajectory of 81.4%
- CO Monitoring reported at 74.6% in May against a trajectory of 81.4%

Exception reports have been requested from Maternity

Community HV & Dementia Screening

- Due to data quality issues the reporting for these has to resume shortly. Data is collected from System, but has been coupled with other information so not reportable separately. This issue will be resolved shortly.
- Dementia assessment trajectory for April was 50% against performance in the same month of 55%. No May data available as yet.
- Falls assessment trajectory for April was 75% against delivery in the same month of 69%

Exception reports are required to confirm why the trajectory is not delivering.

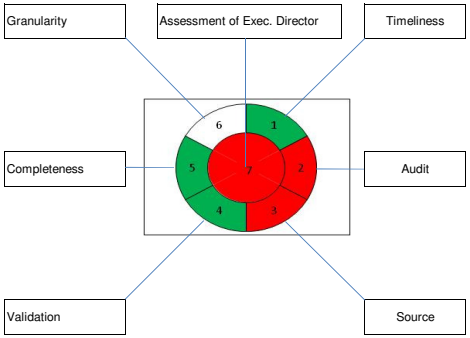
Legend

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

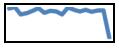
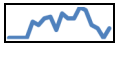
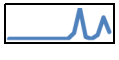
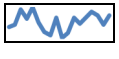
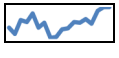
Medicine Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate EC	AC	SC	Month	Year To Date	Trend
Patient Safety - Inf Control	C. Difficile	<= No	30	3																			May 2017	1	0	0	1	1	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			May 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective (%)	=> %	80	80																			May 2017	79	84	14	56.7		
Patient Safety - Inf Control	MRSA Screening - Non Elective (%)	=> %	80	80																			May 2017	91	94	91	91.5		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	-	-	19	20	14	14	16	9	7	May 2017	1	6	0	7	16	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	-	-	19	20	12	14	16	9	7	May 2017	1	6	0	7	16	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	-	-	4	0	0	0	0	0	0	May 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	-	-	3	14	12	8	8	11	6	May 2017	0	6	0	6	17	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	-	-	5	6	2	11	5	1	6	May 2017	0	6	0	6	7	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	-	-	1	0	1	1	0	0	0	May 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	-	-	-	-	-	-	5	2	1	0	0	1	1	May 2017	0	1	0	1	-	
Patient Safety - Harm Free Care	Falls	<= No	0	0	35	40	35	32	44	37	47	39	47	44	34	41	47	50	38	34	36	39	May 2017	11	24	4	39	75	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	1	1	0	0	2	1	2	2	0	2	3	3	1	2	1	1	May 2017	0	1	0	1	2	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	4	4	6	4	4	3	3	5	5	4	5	7	9	5	5	4	6	6	May 2017	0	6	0	6	12	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			May 2017	91.4	88.1	97.7	93.7		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			May 2017	100.0	100.0	100.0	100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			May 2017	99	98	0	99.2		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			May 2017	99	87	0	96.3		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			May 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	May 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			May 2017	0	1	0	1	4	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98																	-	-	Mar 2017	54	72	58	63		

Medicine Group

Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			9.3	9.2	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	-	Apr 2017				9.5		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			10.3	10.1	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	-	Apr 2017					9.4	

Medicine Group

Section	Indicator		Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate EC	AC	SC	Month	Year To Date	
Clinical Effect - Stroke & Card	Pts spending >90% stay on Acute Stroke Unit (%)	=> %	90.0	90.0																	-	-	Mar 2017		95.0		95.0	94.5	
Clinical Effect - Stroke & Card	Pts admitted to Acute Stroke Unit within 4 hrs (%)	=> %	90.0	90.0																			May 2017		87.5		87.5	92.4	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			May 2017		71.4		71.4	78.1	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.0																			May 2017		97.1		97.1	97.3	
Clinical Effect - Stroke & Card	Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			May 2017		50.0		50.0	66.7	
Clinical Effect - Stroke & Card	Stroke Admissions - Swallowing assessments (<24h) (%)	=> %	98.0	98.0																			May 2017		106.7		106.7	103.3	
Clinical Effect - Stroke & Card	TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=> %	70.0	70.0																			May 2017		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=> %	75.0	75.0																			May 2017		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=> %	80.0	80.0																			May 2017		100.0		100.0	96.4	
Clinical Effect - Stroke & Card	Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			May 2017		100.0		100.0	96.2	
Clinical Effect - Stroke & Card	Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			May 2017		100.0		100.0	100.0	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																	-		Apr 2017			93.1	93.1		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																	-		Apr 2017			100.0	100.0		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																	-		Apr 2017			86.2	86.2		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			1.5	0.5	6	3	3.5	1.5	3.5	3	4	3.5	1	2.5	2	1.5	3	2.5	2	-	Apr 2017	-	-	2.00	2.00	2	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	0	4.5	0	2	0	1	2	1.5	2	0	0	1	1	1	1	1	-	Apr 2017	-	-	1.00	1.00	1	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			104	98	154	98	175	95	130	113	107	140	75	71	107	111	135	105	140	-	Apr 2017	-	-	140	140		
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	May 2017	-	-	6	6	6	
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	6	30	2	0	4	21	7	May 2017	7	0	0	7	28	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			32	34	47	39	49	36	28	25	40	23	27	40	35	40	45	42	34	42	May 2017	17	20	5	42	76	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			57	50	65	63	72	57	62	46	47	55	56	63	62	66	61	75	79	79	May 2017	40	32	7	79		

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		EC	AC	SC			
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			May 2017	-	3.36	0.37	0.61		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	May 2017	0.0	0.0	0.0	0	1	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	0	2	1	1	0	3	0	0	6	1	0	6	2	4	6	2	3	11	May 2017	0.0	5.0	6.0	11	14	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	32	34	32	31	58	56	54	28	32	28	57	44	29	51	37	41	28	35	May 2017	0.0	0.0	35.3	35.3		
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	May 2017	0.00	0.00	0.00	0.00	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95.0	95.0																			May 2017	78.7	82.2	Site S/C	80.5	81.9	
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	May 2017	1566	1	175	1742	3404	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0																			May 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	-	-																	May 2017	15.0	14.0	Site S/C	15	15	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60.0	60.0	-	-																	May 2017	73.0	64.0	Site S/C	69	64	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			May 2017	8.2	8.4	Site S/C	8.3	8.3	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			May 2017	5.5	7.7	Site S/C	6.6	6.0	
Emergency Care & Pt. Flow	WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	121	116	97	117	81	65	70	122	112	135	112	162	193	162	129	107	110	159	May 2017	107	52		159	269	
Emergency Care & Pt. Flow	WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	8	10	6	9	2	0	1	8	6	9	16	21	19	11	13	5	0	12	May 2017	11	1		12	12	
Emergency Care & Pt. Flow	WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			May 2017	0.51	0.04		0.27	0.14	
Emergency Care & Pt. Flow	WMAS - Emergency Conveyances (total)	No			4573	4679	3961	4513	4115	4604	4099	4363	4204	4138	4233	4261	4622	4410	4034	4206	4137	4376	May 2017	2150	2226		4376	8513	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			May 2017	0.0	92.1	82.6	85.2		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			May 2017	0.0	70.6	91.5	85.0		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			May 2017	0.0	93.5	93.4	93.4		
RTT	RTT - Backlog	<= No	0	0	587	623	689	725	789	716	674	821	873	1172	1319	1168	1500	1154	897	622	610	479	May 2017	0	212	267	479		
RTT	Patients Waiting >52 weeks	<= No	0	0	1	1	3	4	0	0	0	1	0	0	1	2	1	0	0	1	1	2	May 2017	0	0	2	2		
RTT	Treatment Functions Underperforming	<= No	0	0	8	10	8	7	12	11	11	14	13	12	13	10	12	10	10	10	9	7	May 2017	0	2	5	7		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			May 2017	0	1.67	0.24	1.37		

Medicine Group

Medicine Group

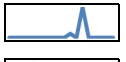
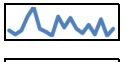
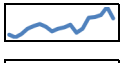
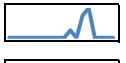
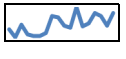
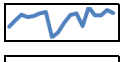
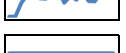
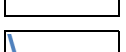
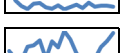
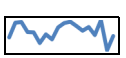
Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		EC	AC	SC			
Data Completeness	Open Referrals	No			80,663	67,608	65,055	65,979	67,205	68,646	70,876	69,993	70,424	72,581	74,142	75,046	75,926	75,925	76,880	78,278	78,984	79,971	May 2017	14,062	23,444	42,465	79971		
Data Completeness	Open Referrals - Awaiting Management	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	May 2017	10,147	12,071	14,604	36822		
Workforce	WTE - Actual versus Plan	No			208	204	201	219	220	207	213	220	229	231	229	231	244	202	194	208	205	199	May 2017	112.9	79.95	0	199		
Workforce	PDRs - 12 month rolling (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	84.75	81.99	0		82.6	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	69.57	93.62	0		86.4	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	4.50	4.77	0.00	4.65	4.66	
Workforce	Sickness Absence - In month	<= No	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	5.10	5.64	0.00	5.42	5.39	
Workforce	Sickness Absence - Long Term - In month	No			-	-	-	-	57	62	60	49	47	43	45	40	39	39	33	40	53	59	May 2017	24	22	13	59	112	
Workforce	Sickness Absence - Short Term - In month	No			-	-	-	-	212	186	195	180	179	162	194	206	243	223	207	182	66	68	May 2017	21	22	24	68	134	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	65.4	77.1	0.0		71.84	
Workforce	Mandatory Training (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	81.93	81.47	80.06		82.1	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			1	1	6	4	1	0	0	1	1	0	0	0	0	0	1	2	3	0	May 2017	0	0	0	0		
Workforce	Nurse Bank Fill Rate %	=> %	100	100	3654	3001	3002	4159	3992	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016				85		
Workforce	Nurse Bank Shifts Not Filled (number)	<= No	0	0	749	925	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			6	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	8	-->	-->	-->	-->	Jan 2017	6.0	7.0	16.0	8.0		
Workforce	Your Voice - Overall Score	No			3.37	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	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 D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate GS	SS	TH	An	O	Month	Year To Date	Trend
Patient Safety - Inf Control	C. Difficile	<= No	7	1	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	1	0	0	0	0	1	2	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	96.17	96.48	0	0	53.19	92.7		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	93.39	95.58	0	100	92.11	94.0		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	-	-	4	0	0	0	2	1	3	May 2017	0	0	0	3	0	3	4	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	-	-	4	0	0	0	2	1	3	May 2017	0	0	0	3	0	3	4	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	May 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	May 2017	0	0	0	4	0	4	5	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	-	-	0	0	0	0	1	0	3	May 2017	0	0	0	3	0	3	3	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	1	0	May 2017	0	0	0	0	0	0	1	
Patient Safety - Harm Free Care	Falls	<= No	0	0	12	14	7	12	8	9	4	12	12	9	10	12	13	8	6	6	10	7	May 2017	2	5	0	0	0	7	17	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	0	May 2017	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	1	2	0	1	2	2	0	2	2	0	4	0	1	1	2	1	1	3	May 2017	1	2	0	0	0	3	4	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	98.08	97.71	0	99.19	98.17	98.1		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	99.87	99.77	0	100	100	99.9		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	100	100	99.34	0	100	99.7		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	100	100	99.34	0	100	99.7		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	0	0	1	0	0	0	0	1	0	0	0	1	0	0	0	0	0	1	May 2017	0	0	0	1	0	1	1	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	May 2017	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0	2	0	1	0	3	3	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	-	Mar 2017	100	33	0	0	0	71.4		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			8.2	6.5	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	-	Apr 2017						6.2		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.92	6.94	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	-	Apr 2017							5.8	

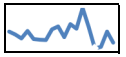
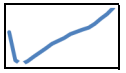
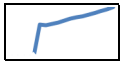
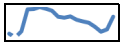
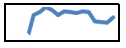
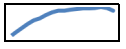
Surgical Services Group

Surgical Services Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate GS	SS	TH	An	O	Month	Year To Date	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2017	95.6	-	0.0	-	-	95.57		
Clinical Effect - Cancer	2 weeks (Breast Symptomatic)	=> %	93.0	93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2017	95.2	-	-	-	-	95.19		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2017	100.0	-	0.0	-	-	100		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	Apr 2017	94.7	-	0.0	-	-	94.74		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			5	2	2	3	2	9	1	4	7	4	7	4	5	5	8	2	2	-	Apr 2017	-	-	-	-	-	1.5	2	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			4	0	0	1	0	1	0	1	2	2	2	2	2	0	2	1	1	-	Apr 2017	1	-	0	-	-	1	1	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			221	159	74	176	73	114	170	201	292	245	351	191	158	103	193	105	119	'	Apr 2017	119	-	0	-	-	119		
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	May 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	0	0	1	0	8	0	0	0	0	0	May 2017	0	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			28	25	28	38	45	29	27	24	38	30	37	29	26	32	25	36	24	29	May 2017	0	3	13	0	13	29	53	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			36	32	37	45	49	52	48	41	45	47	51	39	45	62	63	66	78	61	May 2017	0	7	25	6	23	61		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	1.68	1.56	0	2.08	3.38	2.24		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	1	0	3	4	0	0	0	0	May 2017	0	0	0	0	0	0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	27	16	33	20	18	18	22	45	43	32	29	57	31	35	49	45	32	49	May 2017	16	5	0	5	23	49	81	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	72.8	74.2	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	May 2017	75.1	76.7	0.0	77.8	75.7	75.79		
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	May 2017	0	0	0	0	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (%)	%	95.0	95.0	99.2	98.8	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	May 2017	-	-	-	-	96.84	-	-	
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	May 2017	46	22	0	2	39	109	246	
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	May 2017	-	-	-	-	0	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0	10.9	4.8	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	May 2017	-	-	-	-	2.97	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0	1.5	1.1	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	May 2017	-	-	-	-	2.39	-	-	
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	May 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	-	-	-	-	-	May 2017	-	-	-	-	97	-	-	
Emergency Care & Pt. Flow	Hip Fractures BPT (Operation < 36 hours of admissions	=> %	85.0	85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017						65.0	51.0	

Surgical Services Group

Surgical Services Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate GS	SS	TH	An	O	Month	Year To Date	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	79.7	57.6	0.0	0.0	75.9	74.5		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	91.1	93.2	0.0	0.0	95.4	93.3		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	94.0	86.1	0.0	0.0	94.6	92.8		
RTT	RTT - Backlog	<= No	0	0	1304	1276	1243	1308	1236	1231	1227	1324	1350	1254	1369	1328	1514	1344	1153	1167	1304	1204	May 2017	463	422	0	0	319	1204		
RTT	Patients Waiting >52 weeks	<= No	0	0	1	3	2	3	3	1	2	3	0	1	2	0	1	0	2	2	4	1	May 2017	1	0	0	0	0	1		
RTT	Treatment Functions Underperforming	<= No	0	0	14	16	14	13	16	13	14	17	16	16	16	14	16	16	16	14	14	16	May 2017	9	6	0	0	1	16		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0.4	0.0	0.9	0.0	0.0	0.48		
Data Completeness	Open Referrals	No			113,733	98,377	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	May 2017	44,237	15,307	0	4,504	62,944	126992		
Data Completeness	Open Referrals - Awaiting Management	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	May 2017	21,664	6,837	0	2,864	24,427	55792		
Workforce	WTE - Actual versus Plan	No			173	178	153	149	144	143	151	158	155	152	146	140	151	185	157	166	168	172	May 2017	51.71	35.05	28.06	19.91	32.61	172.12		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	86.7	81.7	94.9	83.9	91.0		84.6	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	83.33	88.89	0	78.57	80.77		79.0	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	4.7	5.5	7.0	4.2	2.2	4.7	4.7	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	4.5	5.1	7.5	5.4	1.8	4.7	4.6	
Workforce	Sickness Absence - Long Term - In Month	No			-	-	-	-	46	52	62	56	46	53	52	50	53	52	33	32	30	41	May 2017	13.0	7.0	12.0	9.0	0.0	41.0	71.0	
Workforce	Sickness Absence - Short Term - In Month	No			-	-	-	-	164	169	161	162	168	169	181	173	181	166	149	138	61	50	May 2017	17.0	6.0	15.0	11.0	0.0	50.0	111.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	86.9	77.3	88.6	70.1	85.3	82.9	83.6	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	84.7	85.1	89.8	86.2	84.4		86.3	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-		-	
Workforce	New Investigations in Month	No			0	1	1	2	0	0	0	2	0	1	3	0	0	2	1	2	2	0	May 2017	0	0	0	0	0	0		
Workforce	Nurse Bank Fill Rate	=> %	100.0	100.0	84.5	83	64.9	86.3	88	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016						88.03	88	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	255	280	216	233	238	'	'	'	'	'	'	'	'	'	'	'	'	'	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			22	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	30	-->	-->	-->	-->	Jan 2017	12	7	7	11	13	**30**	
Workforce	Your Voice - Response Score	%			6.94	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.79	-->	-->	-->	-->	Jan 2017	3.53	3.29	3.85	3.6	3.69	**3.79**	

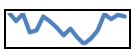
Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		G	M	P			
Patient Safety - Inf Control	C. Difficile	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.00	80.00	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	88.1			88.1		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80.00	80.00	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0	100		100.0		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	1	0	May 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	May 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	May 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	May 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	May 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	May 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	Jan-00	0	0	0	0	0	
Patient Safety - Harm Free Care	Falls	<= No	0	0	0	2	0	1	0	1	2	1	1	2	3	1	1	2	1	1	0	3	May 2017	2	1	0	3	3	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	May 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	May 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	99.7	94.1		96.1		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	100	99.3		99.7		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	100	100		100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	100	100		100.0		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0	0	0	0	1	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate G	M	P	Month	Year To Date	
Patient Safety - Obstetrics	Caesarean Section Rate - Total	<= %	25.0	25.0																			May 2017		22.9		22.9	24.5	
Patient Safety - Obstetrics	Caesarean Section Rate - Elective	%			9	8	8	8	10	7	9	8	9	10	8	11	8	7	9	8	9	8	May 2017		8.2		8.2	8.5	
Patient Safety - Obstetrics	Caesarean Section Rate - Non Elective	%			14	17	15	18	17	15	15	19	19	19	23	17	20	15	17	17	17	15	May 2017		14.7		14.7	16.0	
Patient Safety - Obstetrics	Maternal Deaths	<= No	0	0																			May 2017		0		0	0	
Patient Safety - Obstetrics	Post Partum Haemorrhage (>2000ml)	<= No	48	4																			May 2017		3		3	4	
Patient Safety - Obstetrics	Admissions to Neonatal Intensive Care	<= %	10.0	10.0																			May 2017		1.73		1.7	1.8	
Patient Safety - Obstetrics	Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			May 2017		7.63		7.6		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	90.0	90.0																			May 2017		77.3		77.3		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0																			May 2017		135		134.5		
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100.0	97.0	N/A		N/A					N/A		N/A						N/A	-	-	Mar 2017	0	0	0	0.0		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			4.8	4.7	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	-	Apr 2017				4.6		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.3	6.1	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	-	Apr 2017					4.8	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0												#DIV/0!						-	Apr 2017	96.1		0	96.1		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Apr 2017	95.5			95.5		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Apr 2017	50			50.0		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			1.5	3	2	0	3	1	2	0	0.5	0.5	1.5	4	3	2	4.5	3.5	4.5	-	Apr 2017	4.5	-	0	4.5	4.5	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	0	0	0	1	0	1	0	0	0	0	0	0	0.5	1.5	3.5	3	-	Apr 2017	3	-	0	3	3	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			71	104	97	62	149	86	176	62	70	97	76	98	98	120	150	162	126	-	Apr 2017	126	-	0	126		
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	May 2017	0	-	0	0	0	

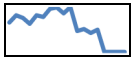
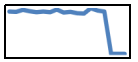
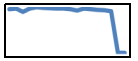
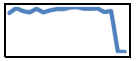
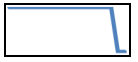
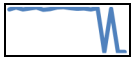
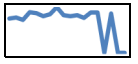
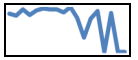
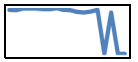
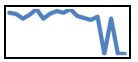
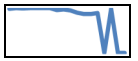
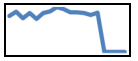
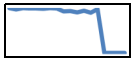
Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate G	M	P	Month	Year To Date	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	May 2017	0			0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			15	17	4	13	5	10	9	15	15	15	12	9	12	14	14	12	13	8	May 2017	3	2	3	8	21	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			14	20	6	17	9	13	10	19	21	23	23	16	21	24	24	22	19	12	May 2017	0	0	0	12		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	2.5		-	1.8		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	May 2017	0			0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	13	6	7	13	4	10	9	4	6	9	12	6	10	6	12	10	12	5	May 2017	5			5	17	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	72	74	71	78	76	73	74	76	76	76	79	79	71	80	83	81	83	82	May 2017	81.6	-		81.6		
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	May 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	May 2017	2	0	8	10	19	
RTT	RTT - Admittted Care (18-weeks)	=> %	90.0	90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	72.1			72.1		
RTT	RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	95.3			95.3		
RTT	RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	94.7			94.7		
RTT	RTT - Backlog	<= No	0	0	52	60	70	80	69	92	93	130	121	129	161	161	160	111	96	96	98	81	May 2017	81			81		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	May 2017	0			0		
RTT	Treatment Functions Underperforming	<= No	0	0	1	1	0	1	1	0	1	2	2	2	2	3	3	2	1	2	1	1	May 2017	1			1		
RTT	Acute Diagnostic Waits in Excess of 6-weeks	<= %	0.1	0.1	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0			0.0		

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate G	M	P	Month	Year To Date	
Data Completeness	Open Referrals	No			30,745	23,372	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	May 2017	8,277	15,028	7,533	30838		
Data Completeness	Open Referrals - Awaiting Management	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	May 2017	4,558	9,225	2,066	15849		
Workforce	WTE - Actual versus Plan	No			98.9	96.9	94.7	91.8	87.3	101	99.2	97.1	118	116	107	109	126	119	111	116	119	124	May 2017	3.99	82.5	37.6	124.1		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	93.8	89.2	94.4		90.5	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	93.8	86.7	100		85.1	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	4.59	5.21	3.09	4.6	4.6	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	3.26	6.5	2.72	5.1	4.8	
Workforce	Sickness Absence - Long Term - in month	No			-	-	-	-	40	36	34	39	43	44	43	43	30	30	23	29	27	36	May 2017	2	28	6	36.0	63.0	
Workforce	Sickness Absence - Short Term - in month	No			-	-	-	-	99	105	94	111	96	106	113	125	114	142	83	105	50	41	May 2017	5	29	7	41.0	91.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	90.1	84.3	81.8	84.34	84.3	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	84.9	88.9	87.8		88.5	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	1	0	1	0	0	1	1	0	0	0	0	0	0	1	3	1	May 2017	1	0	0	1		
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			11	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	13	-->	-->	-->	-->	Jan 2017	17	10	20	13		
Workforce	Your Voice - Overall Score	No			3.63	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.66	-->	-->	-->	-->	Jan 2017	3.54	3.72	3.6	3.7		

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate G	M	P	Month	Year To Date	
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			167	207	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	88.2	87.6	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	%			8.82	7.69	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	91.9	97.5	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	%			96.2	99.8	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	94.5	95.8	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	%			80.5	90.2	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	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	93.9	97.9	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	91.9	98.6	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	%			36.8	37.9	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			353	335	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	97.2	96.3	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			376	366	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	98.2	99.7	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			316	352	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	92.4	89.6	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	

Women & Child Health Group

WCH Group Only	HV - movers into provider <1 year of age to be checked =<14 d following notification to HV service	No			51	42	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 D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate HA	HI	B	M	I	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			May 2017	0	0	0	0	0	0	0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2017	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2017	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2017	-	-	-	-	-	-		
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			0	2	4	2	3	4	2	1	2	1	2	3	2	4	1	2	1	1	May 2017	0	1	0	0	0	1	2	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			1	1	4	3	3	5	4	2	2	2	3	3	1	3	4	4	3	2	May 2017	1	1	0	0	0	2		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2017	-	-	-	-	-	-	-	
Data Completeness	Open Referrals	No			3,414	3,312	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	May 2017	1,947	0	2,255	0	2,568	6,770		
Data Completeness	Open Referrals - Awaiting Management	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	May 2017	962	0	1,054	0	940	2,956		
Workforce	WTE - Actual versus Plan	No			38.2	32.5	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	May 2017	9.85	4.79	7.75	4.58	-1.2	28		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			May 2017	100	94.4	95.1	93.1	88.5		95.53	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			May 2017	0	75	100	100	33.3		81.25	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			May 2017	3.19	3.76	5.01	2.88	2.75	3.93	3.99	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15																			May 2017	2.4	3.1	2.1	3.2	0.9	2.56	2.68	
Workforce	Sickness Absence - Long Term - In Month	No			-	-	-	-	10	12	14	14	15	13	12	14	6	5	6	8	6	6	May 2017	2.0	0.0	1.0	2.0	0.0	6	12	
Workforce	Sickness Absence - Short Term - In Month	No			-	-	-	-	47	45	38	35	36	30	43	49	41	36	35	45	30	30	May 2017	1.0	4.0	9.0	6.0	4.0	30	60	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			May 2017	88.7	94.1	75	97.8	96.7	85.5	84.7	
Workforce	Mandatory Training	=> %	95.0	95.0																			May 2017	90.2	91.4	88.9	89.7	98.5		91.4	
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	2	0	0	0	1	0	0	0	0	May 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			19	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	22	-->	-->	-->	-->	Jan 2017	24	21	17	27	55	22		
Workforce	Your Voice - Overall Score	No			3.79	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	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 D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate DR	IR	NM	BS	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			May 2017	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			May 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	-	1.0	2.0	-	2.0	1.0	2.0	1.0	3.0	1.0	-	2.0	2.0	1.0	-	1.0	1.0	-	Apr 2017					3.5		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	=> %	0	0	11.0	11.0	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	-	Apr 2017						4.29	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			May 2017			71.43		71.43	78.08	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.00																			May 2017			97.14		97.14	97.26	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2017	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2017	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 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	May 2017	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			1	3	6	5	2	0	1	1	2	1	1	4	5	4	1	1	4	2	May 2017	1	1	0	0	2	6	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			0	3	6	5	2	1	2	2	2	0	1	4	9	3	2	2	1	3	May 2017	2	1	0	0	3		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 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	May 2017	128	0	0	0	128	230	
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			May 2017	0.3				0.3		
Data Completeness	Open Referrals	No			248	259	271	286	288	298	325	342	361	376	399	428	438	461	481	498	512	532	May 2017	532	0	0	0	532		
Data Completeness	Open Referrals - Awaiting Management	No			-	-	-	-	-	287	267	299	315	331	346	373	386	403	421	438	454	474	May 2017	474	0	0	0	474		
Workforce	WTE - Actual versus Plan	No			40.1	43.9	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	May 2017	25.8	2.95	2.01	4	38.9		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			May 2017	77.3	90	94.4	94.6		89.5	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			May 2017	95.8	0	100	75		89.8	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			May 2017	3.4	8.3	2.7	4.3	4.27	4.21	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			May 2017	4.7	12.1	2.9	0.6	4.87	4.20	
Workforce	Sickness Absence - Long Term - in month	No			-	-	-	-	10	10	8	8	7	6	7	13	10	15	13	9	6	10	May 2017	5.0	1.0	0.0	0.0	10.00	16.00	
Workforce	Sickness Absence - Short Term - in month	No			-	-	-	-	33	39	38	31	23	26	29	41	40	53	36	32	29	22	May 2017	6.0	0.0	3.0	4.0	22.00	51.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			May 2017	69	42.9	86.1	65.2	71.1	70.9	
Workforce	Mandatory Training	=> %	95.0	95.0																			May 2017	82.5	94.1	91.5	96.3		87.7	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	May 2017					0		
Workforce	Your Voice - Response Rate	No			21	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	20	-->	-->	-->	-->	Jan 2017	18	10	46	16	20		
Workforce	Your Voice - Overall Score	No			3.40	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	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	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		AT	IB	IC			
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.0	80.0																			May 2017	0	0	0	0		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	-	-	2	2	1	0	5	4	4	May 2017	0	4	0	4	8	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	-	-	2	2	2	0	5	4	4	May 2017	0	4	0	4	8	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	-	-	2	0	0	0	0	0	0	May 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	-	-	1	1	2	0	0	3	2	May 2017	0	2	0	2	5	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	-	-	1	0	0	0	0	2	2	May 2017	0	2	0	2	4	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	May 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	May 2017	0	0	0	0	2	
Patient Safety - Harm Free Care	Falls	<= No	0	0	26	31	23	20	22	38	31	29	31	29	33	30	27	20	19	31	23	21	May 2017	0	17	4	21	44	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	1	2	1	1	0	0	1	0	0	1	0	0	0	0	0	0	0	0	May 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	0	3	0	4	2	4	2	3	1	1	0	1	3	2	2	1	6	1	May 2017	-	1	-	1	7	
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			May 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			May 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			May 2017	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	May 2017	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			2	3	6	7	3	5	5	4	5	4	3	8	4	6	1	1	4	3	May 2017	1	1	1	3	7	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			5	3	6	7	11	7	9	8	9	7	5	5	6	6	6	6	9	10	May 2017	3	6	1	10		

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M		AT	IB	IC			
Workforce	WTE - Actual versus Plan	No			105	94.7	100	106	102	123	128	154	152	135	104	109	122	115	112	118	128	130	May 2017	30.1	62	38.3	130.37		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	92.6	92.1	92		94.3	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	3.15	4.74	4	4	4.01	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	2.69	5.1	3.07	3.66	3.77	
Workforce	Sickness Absence - Long Term - in month	No			-	-	-	-	26	25	26	24	27	29	22	23	29	32	24	24	24	19	May 2017	2	-	-	19	43	
Workforce	Sickness Absence - Short Term - in month	No			-	-	-	-	65	59	81	80	83	53	74	104	101	102	93	82	57	60	May 2017	7	22	30	60	117	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	70.1	81.5	82.3	79.13	78.89	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0	86.4	0		90.5	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	2	0	0	0	2	0	1	0	0	0	1	0	0	0	0	0	May 2017				0		
Workforce	Nurse Bank Fill Rate	=> %	100	100	88	88.4	78.3	89.3	87.9	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	87.87	87.87	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	78	90	78	86	87	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	87	87	
Workforce	Your Voice - Response Rate	No			21	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	29	-->	-->	-->	-->	Jan 2017	29	31	28	29		
Workforce	Your Voice - Overall Score	No			3.72	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.83	-->	-->	-->	-->	Jan 2017	3.72	3.72	3.96	3.83		

Community & Therapies Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate AT	IB	IC	Month	Year To Date
Community & Therapies Group Only	DVT numbers	=> No	730	61	24	47	65	51	53	55	74	-	-	-	-	-	-	-	-	-	-	-	Jun 2016				74	182
Community & Therapies Group Only	Adults Therapy DNA rate OP services	<= %	9	9	10.5	11.3	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	May 2017				8.2	8.3
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	2	1	1	0	0	2	0	0	2	1	1	0	0	0	0	0	0	May 2017				0	0
Community & Therapies Group Only	Green Stream Community Rehab response time for treatment (days)	<= No	11.0	11.0	17	16	24	24	23	17	17	-	-	-	-	-	-	-	-	-	-	-	Jun 2016				17	57
Community & Therapies Group Only	DNA/No Access Visits	%			1	1	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	-	Apr 2017				66.8	66.8
Community & Therapies Group Only	Falls Assessments - DN Intial Assessments only	%			46	52	55	54	61	161	70	61	55	65	42	77	69	60	62	58	69	-	Apr 2017				68.84	
Community & Therapies Group Only	Pressure Ulcer Assessment - DN Intial Assessments only	%			48	54	56	58	64	67	75	65	63	71	47	80	71	63	65	63	77	-	Apr 2017				76.73	
Community & Therapies Group Only	MUST Assessments - DN Intial Assessments only	%			26	28	32	32	37	35	40	36	32	37	26	52	46	48	36	46	58	-	Apr 2017				57.69	
Community & Therapies Group Only	Dementia Assessments - DN Intial Assessments only	%			29	28	31	21	40	37	11	30	37	45	14	53	53	52	62	44	55	-	Apr 2017				55	
Community & Therapies Group Only	48 hour inputting rate - DN Service Only	%			94	93	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	-	Apr 2017				66.39	66.39
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	6	10	May 2017				10	16
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	9	May 2017				9	14
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	1	1	May 2017				1	2
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	May 2017				0	0

Corporate Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	Data Period	Directorate SG	F	W	M	E	N	O	Month	Year To Date	Trend
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			5	4	5	8	8	10	12	4	13	8	13	11	12	11	11	14	3	9	May 2017	3	0	1	0	0	1	4	9	12	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			8	4	4	7	8	9	12	9	17	10	13	18	13	12	17	19	16	17	May 2017	4	0	1	0	0	6	6	17		
Workforce	WTE - Actual versus Plan	No			97.8	81.9	83.2	96.4	102	128	101	106	130	146	123	118	133	98.6	94.5	105	99.5	103	May 2017	8.68	1.29	-14.8	11.3	-5.84	31.3	71.4	103.4		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	81	76	91	90	94	96	90		90.8	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017			95					50.0	50	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	1.97	2.95	3.64	2.74	4.09	5.38	4.91	4.51	4.44	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0.15	2.65	4.45	2.72	4.22	6.44	4.78	4.93	4.62	
Workforce	Sickness Absence - Long Term - in month	No			-	-	-	-	51	53	52	59	62	65	64	64	79	0	1	0	2	1	May 2017	0.00	0.00	0.00	0.00	0.00	1.00	0.00	1.00	3.00	
Workforce	Sickness Absence - Short Term - in month	No			-	-	-	-	192	176	173	153	160	181	203	224	191	7	8	8	3	2	May 2017	2.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	5.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	87.3	78.8	71.3	77.2	75.3	83.4	79.5	80.5	80.8	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	May 2017	0	94	95	86	97	84	90	87.8	89	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	
Workforce	New Investigations in Month	No			1	2	2	2	4	4	1	4	1	1	0	0	2	1	1	4	6	0	May 2017	0	0	0	0	0	0	0	0		
Workforce	Your Voice - Response Rate	No			15	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	18	-->	-->	-->	-->	Jan 2017	51	45	39	30	19	6	17	18		
Workforce	Your Voice - Overall Score	No			3.58	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	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:	**Financial performance – P02 May 2017**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Finance Director**
AUTHOR:	**Tim Reardon – Associate Director of Finance**
DATE OF MEETING:	**6 July 2017**

EXECUTIVE SUMMARY:

Headlines

This report deals with the financial performance for P02 May 2017/18 and indications for the performance in relation to statutory duties for the full year.
The Board's attention is drawn to the following slides:

- 2 & 3 : summary of position & outlook
- 11 : cash flow forecast

Key messages:

- P02 year to date headline performance reported as plan but reliant on significant unplanned technical support. Requires remediation through delivery of cornerstone P&L improvement.
- Elements of technical support carry varying degrees of risk.
- Significant unidentified savings requirement requiring remediation through FIP2 process / asset sales.
- STF income assumed earned for P02 to date. Requires consistent P&L delivery to plan and ED 4hr remediation to 90% by July [NHSi to confirm] for performance component.
- Capex programme being pursued as plan. CRL remains to be confirmed by NHSi. Dialogue on-going.
- Cash borrowing requirements subject to routine assessment. NHSI indicated at loan review meeting that the Trust should rely on land sale cash receipt and creditor stretch before submitting any loan application. Lower BPPC performance has been tolerated by NHSI at other Trusts.
- Planned care activity exceeds plan with consequent income over-recovery on SLA income. Theatre efficiency remains biggest opportunity for improvement.
- Continued agency spend reduction through to P02 but remains above plan trajectory. Requires mobilisation & delivery of plan to secure first £10m of spend reduction.

Key actions:

- Confirmation and execution of step reduction in costs through focus on bed reduction, pay & workforce change & procurement cost savings. Delivery of demand & capacity plan to secure income
- Delivery of capital programme to time & revised plan consistent with enabling programme for MMH
- Monitoring and delivery of liquidity / cash improvement plan.
- Resolution of 2017.18 contract discussion with SWBCCG.
- Secure land sale to maximise H1 cash in-flow and profit on disposal.

Key numbers:

- Month deficit £(1.7)m being consistent with plan.
- Underlying YTD deficit £(6.8)m being £(2)m adverse to plan.
- STF of £1.0m assumed earned year to date
- Pay bill £26.4m (vs. £26.4m last month); Agency spend £1.4m (vs. £1.6m).
- Capital spend at £3.4m is £2.8m behind plan to date.
- Cash at 31st May £14.6m being above plan by £11.6m.

REPORT RECOMMENDATION:

The Board is recommended to note the report and to REQUIRE those actions necessary to secure the required plan out-turn for FY 2017/18.
Also to challenge and confirm the assumptions underpinning the deployment of technical support.

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:

FIC 30 June 2017

Finance Report

Period 02 2017/18
May 2017

Trust Board
6 July 2017

Contents

Finance Report

Summary & Recommendations

Period 02 2017/18

Statutory Financial Duties	Value	Outlook	Note
I&E control total deficit	£9.9m	TBC	1
Live within Capital Resource Limit	£46.6m	√	2
Live within External Finance Limit	£93.0m	√	3

1. Forecast surplus £9.9m 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 P02 return reports forecast surplus £9.9m as per agreed control total. Reliant on significant profit on disposal to cover recognised [CIP] risk.
- Achievement requires development of production planning and roster management as core competences.
- Required opex run rate change also depends on CIP delivery and additional efficiency delivery.
- Key risks to plan known and confirmed by external review. Phase 2 of FIP2 process concluding.

P02 key issues & remedial actions

- P02 YTD headline performance reported as plan but reliant on significant unplanned technical support. Requires remediation through delivery of cornerstone P&L improvement.
- Significant unidentified savings requirement requiring remediation through FIP2 process.
- STF income assumed earned to end of P02. Requires consistent P&L delivery to plan and ED 4hr remediation to 90% by July for performance component. At risk.
- 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. Likely revenue borrowing requirement pushed back to January 2018 on presumption of asset disposal receipt Q2.
- Planned care activity & income exceeds re-phased plan but aggregate SLA income under-recovery due to variance on emergency and other contract lines.
- Further month on month reduction in agency spend P02; mobilisation of plan to secure first £10m reduction.

Recommendation

- Challenge and confirm:
  - reported P02 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 02 2017/18

Financial Performance to Date

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

- Headline I&E deficit of £3,299k being consistent with plan;
- Underlying I&E deficit £6,864k being £2.0m adverse to plan
- Capital spend of £3,387k being £2,782k below plan;
- Cash at the end of May is £14,582 being £11,627k more than plan.

I&E

P02 year to date reported as delivering to plan but dependent on the benefits from £2.0m of unplanned contingencies and flexibility.

Patient Related Income and pay remain the drivers of I&E underperformance. Planned care income delivered to plan in P01 & P02 but faces a step up in P03 and Q2 which remains to be fully secured. Reliance on outpatient over performance is not sustainable and shortfalls in theatre productivity continue to impact DC and inpatient volumes. Key improvement opportunities remain:

- Theatre productivity
- Bed reduction
- Rostering discipline
- Recruitment & sickness
- Hours owed

P02 includes £1.0m STF income on a presumption that this will be secured. STF requires consistent delivery to headline financial plan and improvement in ED performance to key milestones.

Use of Resources Rating

Consistent with the downside scenario analysis the plan use of resources (UoR) rating for the Trust is 3 for the month and year.

Cash

The cash position is £11.6m above plan at 31st May. This is due to the I&E position being offset, and funded, by capital cash in the first two months of the financial year.

The key issue for the Trust is the impact of prior year underlying deficits on the cash position. Year to date financials and P03 lead measures 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 likely revenue borrowing requirement anticipated for July in the plan has pushed back to January 2018 on presumption of asset disposal proceeds receipt in Q2.

Better Payments Practice Code

Performance in May improved when measured by value and volume. However, this was 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.

Capital

Capital expenditure to date stands at £3.4m against a full year plan of £46.6m.

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.

Savings

Savings required in 2017/18 are £33m. Of this total £12.7m remain unidentified and there fore high risk. None of the schemes that are identified are reported as fully developed at P02; all remain classed as plans in progress. Actual delivery is reported as £1.5m at P02 which is above P02 plan by £0.2m.

A summary of the CIPs by group can be seen in slide 7.

Finance Report

I&E Performance – Full Year

Period 02 2017/18

Period 02	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	35,336	34,323	(1,013)	70,646	66,217	(4,429)	424,405	424,405	0
Other Income	3,882	4,936	1,054	7,781	9,905	2,124	59,706	59,706	0
Income total	**39,218**	**39,259**	**41**	**78,427**	**76,122**	**(2,305)**	**484,111**	**484,111**	**0**
Pay	(26,072)	(26,345)	(273)	(52,140)	(52,827)	(687)	(300,666)	(300,666)	0
Non-Pay	(12,721)	(12,411)	310	(25,434)	(22,366)	3,068	(148,580)	(148,580)	0
Expenditure total	**(38,793)**	**(38,756)**	**37**	**(77,574)**	**(75,193)**	**2,381**	**(449,246)**	**(449,246)**	**0**
EBITDA	**425**	**503**	**78**	**853**	**929**	**76**	**34,865**	**34,865**	**0**
Non-Operating Expenditure	(2,083)	(2,117)	(34)	(4,170)	(4,200)	(30)	(25,144)	(25,144)	0
Technical Adjustments	18	(47)	(65)	32	(28)	(60)	212	212	0
DH Surplus/(Deficit)	**(1,640)**	**(1,661)**	**(21)**	**(3,285)**	**(3,299)**	**(14)**	**9,933**	**9,933**	**0**
Add back STF	*(524)*	*(524)*	*0*	*(1,048)*	*(1,048)*	*0*	*(10,483)*	*(10,483)*	*0*
Adjusted position	***(2,164)***	***(2,185)***	***(21)***	***(4,333)***	***(4,347)***	***(14)***	***(550)***	***(550)***	***0***
Technical Support (inc. Taper Relief)	*(250)*	*(1,233)*	*(983)*	*(500)*	*(2,517)*	*(2,017)*	*(3,000)*	*(3,000)*	*0*
Underlying position	***(2,414)***	***(3,419)***	***(1,005)***	***(4,833)***	***(6,864)***	***(2,031)***	***(3,550)***	***(3,550)***	***0***

The trust reported a headline deficit for P02 YTD of £3.3m being consistent with plan.

This was reliant on the benefit of £2m of unplanned contingency and support.

The level of technical support utilised is £3.6m including STF accrued. This included £1.1m of taper relief funding against which there may be calls in future months.

The underlying deficit for P02 YTD is therefore recorded as £6.9m. This is £2m adverse compared with the NHSi plan underlying deficit of £4.8m.

Finance Report

Income Analysis

Period 02 2017/18

Year to Date Performance Against SLA by Patient Type								
	Activity			Finance				Straight
	Planned	Actual	Variance	Planned £000	Actual £000	Variance £000		Forecast £000
A&E	38,343	38,255	-89	£4,084	£4,184	£100		£25,106
Emergencies	7,530	7,479	-51	£14,426	£15,168	£742		£91,011
Emergency Short Stay	2,201	1,172	-1,028	£1,712	£891	-£821		£5,346
Excess bed days	2,251	2,092	-159	£624	£577	-£47		£3,460
Urgent Care				**£20,847**	**£20,820**	**-£26**		**£124,923**
OP New	24,603	30,026	5,423	£3,740	£4,483	£743		£26,897
OP Procedures	9,124	11,644	2,519	£1,542	£1,817	£275		£10,900
OP Review	57,231	56,888	-343	£4,089	£3,946	-£143		£23,677
OP Telephone	2,004	2,554	550	£46	£51	£5		£307
DC	6,252	5,946	-306	£5,026	£4,600	-£426		£27,599
EL	1,000	1,073	73	£2,524	£2,598	£73		£15,587
Planned Care				**£16,967**	**£17,495**	**£527**		**£104,968**
Maternity	3,311	3,120	-191	£3,133	£2,911	-£222		£17,467
Renal dialysis	82	90	8	£10	£11	£1		£65
Community	86,251	98,449	12,198	£5,365	£5,437	£73		£32,624
Cot days	2,063	2,299	236	£1,082	£1,147	£65		£6,883
Other contract lines	605,236	602,817	-2,419	£16,201	£15,315	-£885		£91,891
Unbundled activity	10,912	12,176	1,264	£1,364	£1,510	£147		£9,062
Other				**£27,154**	**£26,332**	**-£822**		**£157,993**
Grand Total				**£64,968**	**£64,647**	**-£321**		**£387,883**

This table shows the Trust's year to date SLA income performance by point of delivery as measured against the draft contract price & activity schedule.
The impact of the production plan work is evidenced with the favourable variance for planned care.
Outpatient activity was the main driver of this performance.
With the RTT backlog being mainly elective (>60%) theatre performance is critical to both the income and RTT targets that underpin the Trust's recovery trajectory.

The headline variance on total Patient Related Income to date is £4,429k adverse. The difference compared to SLA income shown above is a mix of phasing, pass through drugs and cancer drugs fund. Details are included in the finance report to FIC.

Finance Report

CIP achievement

Period 02 2017/18

Year to Date up to Period 2	17/18 In Year Target	In Year Actual and Forecast Delivery												In Year 17/18 F/Cast
		Apr Actual 1	May Actual 2	Jun F/Cast 3	Jul F/Cast 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	0	0	0	0	0	0	0	0	0	0	512
Surgical Services	8,327	130	92	0	0	0	0	0	0	0	0	0	0	222
Women and Child Health	2,519	35	52	0	0	0	0	0	0	0	0	0	0	86
Primary Care,Community and Therap	2,456	76	86	0	0	0	0	0	0	0	0	0	0	161
Pathology	640	49	78	0	0	0	0	0	0	0	0	0	0	127
Imaging	1,035	35	32	0	0	0	0	0	0	0	0	0	0	67
Sub-Total Clinical Groups	**20,902**	**562**	**613**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,175**
Strategy and Governance	344	14	14	0	0	0	0	0	0	0	0	0	0	28
Finance	392	24	24	0	0	0	0	0	0	0	0	0	0	47
Medical Director	418	34	34	0	0	0	0	0	0	0	0	0	0	67
Operations	524	0	0	0	0	0	0	0	0	0	0	0	0	0
Workforce	166	2	5	0	0	0	0	0	0	0	0	0	0	7
Estates and NHP	723	48	48	0	0	0	0	0	0	0	0	0	0	96
Corporate Nursing and Facilities	1,435	47	47	0	0	0	0	0	0	0	0	0	0	93
Sub-Total Corporate	**4,003**	**168**	**171**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**338**
Central	8,095	0	0	0	0	0	0	0	0	0	0	0	0	0
DH Surplus/(Deficit)	**33,000**	**730**	**784**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,513**
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		893	1,079	1,321	1,529	1,668	1,868	2,049	1,976	1,985	1,985	1,977	1,970	20,301
Planning gap		227	412	654	199	338	538	42	-31	-22	-676	-686	-13,696	-12,700
Delivery gap		-163	-296											-459

CIP delivery to date is reported as being £0.2m ahead of NHSi plan. This reflects schemes on TPRS with a plan value £0.6m better than NHSi plan but delivery of those schemes being £0.4m adverse to TPRS plan.
All schemes on TPRS together with those additional opportunities identified through the FIP process are currently subject to a review as to their status, value and delivery prospects.

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

Finance Report

Pay bill & Workforce

Period 02 2017/18

Paybill & Workforce

- Total workforce of 6,838 WTE [being 57 above plan] including 146 WTE of agency staff.
- Total pay costs (including agency workers) were £26.4m in May being £0.4m over 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 May. Shifts procured outside of this are subject to COO approval and is driven by strict commitment to maintaining safe staffing.
- The Trust continues to exceed the national agency rate caps. Trust implementation and compliance is subject to granular assurance that there is no compromise to securing safe staffing levels.
- Target have been set for locum spend reduction in FY 2017/18. For SWBH the target is a spend reduction of £544,770 compared to FY 2016/17.

Pay and Workforce	Current Period	Previous Period	Change in period Value	Change in period %
Pay - total spend	26,375	26,426	(51)	0%
Pay - substantive	22,267	22,102	165	1%
Pay - agency spend	1,372	1,605	(233)	-15%
Pay - bank (inc. locum) spend	2,736	2,719	17	1%
WTE - total	6,838	6,952	(114)	-2%
WTE - substantive	6,042	6,058	(16)	0%
WTE - agency	146	243	(97)	-40%
WTE - bank (inc. locum)	651	651	(0)	0%

Locum Target	£'000s
Spend 2016/17	6,852
Savings Target	545
Target 2017/18	**6,307**

Throughout 2016/17 NHSI monitored agency expenditure. Caps were introduced and they have reported savings. For 2017/18 a similar approach has been announced for Locum spend.

Based on the YTD locum spend the Trust is utilising locums at a rate in excess of that consistent with the 2017/18 target set by NHSI.

Finance Report

Prospective View – P02+10

Period 02 2017/18

Reported Position	Apr-16 Act £'000s	May-16 Act £'000s	Jun-16 Plan £'000s	Jul-16 Plan £'000s	Aug-16 Plan £'000s	Sep-16 Plan £'000s	Oct-16 Plan £'000s	Nov-16 Plan £'000s	Dec-16 Plan £'000s	Jan-17 Plan £'000s	Feb-17 Plan £'000s	Mar-17 Plan £'000s	2017/18 FY 2+10 £'000s
Patient Related Income	31,894	34,323	35,336	35,436	35,436	35,436	35,336	35,336	35,336	35,369	35,369	35,369	419,976
Other Income	4,969	4,936	3,882	4,057	4,057	4,057	4,406	4,406	4,406	4,581	4,581	13,492	61,830
Income total	**36,863**	**39,259**	**39,218**	**39,493**	**39,493**	**39,493**	**39,742**	**39,742**	**39,742**	**39,950**	**39,950**	**48,861**	**481,806**
Pay	(26,426)	(26,345)	(26,072)	(25,560)	(25,560)	(25,560)	(25,048)	(25,048)	(25,048)	(24,567)	(24,567)	(21,496)	(301,297)
Non-Pay	(10,011)	(12,411)	(12,721)	(12,566)	(12,567)	(12,567)	(12,398)	(12,398)	(12,398)	(12,184)	(12,184)	(11,164)	(145,568)
Expenditure total	**(36,437)**	**(38,756)**	**(38,793)**	**(38,126)**	**(38,127)**	**(38,127)**	**(37,446)**	**(37,446)**	**(37,446)**	**(36,751)**	**(36,751)**	**(32,660)**	**(446,865)**
EBITDA	**426**	**503**	**425**	**1,367**	**1,366**	**1,366**	**2,296**	**2,296**	**2,296**	**3,199**	**3,199**	**16,201**	**34,941**
Non-Operating Expenditure	(2,083)	(2,117)	(2,083)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(25,174)
Technical Adjustments	19	(47)	18	18	18	18	18	18	18	18	18	18	152
Reported DH Surplus/(Deficit)	**(1,638)**	**(1,661)**	**(1,640)**	**(714)**	**(715)**	**(715)**	**215**	**215**	**215**	**1,118**	**1,118**	**14,120**	**9,918**

The current I&E prospective view for FY 2017/18 at £9,918k is consistent with plan. The Trust forecast remains £9.9m for the full year. This is dependent on realisation of a significant profit on disposal of surplus assets and which remains to be confirmed.

This table combines the actual I&E position for May YTD and the plan I&E position for the coming months. This reflects the impact of the technical support utilised to date. It can be seen that there are key numbers within the plan I&E that need to change to deliver this plan.

Income levels are where the biggest increase is required based on the first two months. However, these months include a number of bank holidays and so, subject to theatre efficiency, increased income levels should follow.

Pay numbers need to reduce by £0.3m in June and a further £0.5m in July followed by a further £0.5m in October and a further £0.5m in January. Based on the bed numbers reported in May and previously referred to this outcome has some risk attached to it.

The Q1 plan developed to support this financial plan delivery is reported at appendix 1.

Finance Report

Capital

Period 02 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	3,671	2,687	(984)	*10,833*	20,624	20,624	20,624	0
Information	2,258	304	(1,954)	*1,899*	10,572	10,572	10,572	0
Medical equipment / Imaging	100	17	(83)	*7*	5,006	5,006	5,006	0
Contingency	0	0	0	*0*	0	0	0	0
Sub-Total	**6,029**	**3,008**	**(3,021)**	*12,739*	**36,202**	**36,202**	**36,202**	**0**
Technical schemes	126	313	187	*0*	10,386	10,386	10,386	0
Donated assets	14	66	52	*0*	84	84	84	0
Total Programme	**6,169**	**3,387**	**(2,782)**	*12,739*	**46,672**	**46,672**	**46,672**	**0**

The above table shows the status of the capital programme, analysed by category, at the end of Period 02.
The technical schemes include MES and BTC against which £0.02m and £0.01m items have been capitalised respectively.
In addition to the YTD spend £12.7m of commitments have been made. The £46.7m outlook reflects the capital element of the plan submitted to NHSI on 30th March 2017. Forecast capital spend is being reviewed having regard to MMH delay.

The £46,672k CRL includes £34,720k of anticipated adjustments NHSI have yet to confirm the full CRL with NHSi.

This reflects the re-phasing of the capital programme that was undertaken in 2016/17 and which moved £9m capex into 2017.18. This was managed without compromise to the critical path strategic investment plan. The cash review with NHSI included Capex consistent with the £46.7m plan programme. A reduced capital programme may be required if the outlook on I&E surpluses deteriorates or medium term cash remediation is compromised.

Finance Report

SOFP

Period 02 2017/18

Sandwell & West Birmingham Hospitals NHS Trust STATEMENT OF FINANCIAL POSITION 2016/17	Balance as at 31st March 2017	Balance as at 31st May 2017	TDA Planned Balance as at 31st May 2017	Variance to plan as at 31st May 2017	TDA 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	208,194	211,022	(2,828)	242,166	242,166
Intangible Assets	166	154	239	(85)	239	239
Trade and Other Receivables	43,017	48,423	52,731	(4,308)	92,045	92,045
Current Assets						
Inventories	5,268	5,268	4,179	1,089	4,177	4,177
Trade and Other Receivables	25,151	29,564	20,946	8,618	20,946	20,946
Cash and Cash Equivalents	23,902	14,582	2,955	11,627	309	309
Current Liabilities						
Trade and Other Payables	(68,516)	(62,440)	(55,612)	(6,828)	(38,646)	(38,646)
Provisions	(1,138)	(1,056)	(1,196)	140	(1,196)	(1,196)
Borrowings	(903)	(1,306)	(903)	(403)	(3,353)	(3,353)
DH Capital Loan	0	0	0	0	0	0
Non Current Liabilities						
Provisions	(3,404)	(3,370)	(2,955)	(415)	(3,012)	(3,012)
Borrowings	(33,954)	(34,072)	(27,207)	(6,865)	(50,077)	(50,077)
DH Capital Loan	0	0	0	0	0	0
	197,023	**203,941**	**204,199**	**(258)**	**263,598**	**263,598**
Financed By						
Taxpayers Equity						
Public Dividend Capital	205,362	215,550	215,550	0	252,540	252,540
Retained Earnings reserve	(24,972)	(28,242)	(28,033)	(209)	(5,822)	(5,822)
Revaluation Reserve	7,575	7,575	7,624	(49)	7,822	7,822
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	197,023	**203,941**	**204,199**	**(258)**	**263,598**	**263,598**

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

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 02 2017/18

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW 2017/18

PLAN, ACTUAL AND YEAR END FORECAST AT Q1 2017-18

ACTUAL/FORECAST	April Actual £000s	May Actual £000s	June Forecast £000s	July Forecast £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	22,603	22,603	22,603	22,603	22,603	22,603	22,603	22,603	22,603	22,603
Associates	6,278	6,675	6,466	6,466	6,466	6,466	6,466	6,466	6,466	6,466	6,466	6,466
Other NHS	1,980	750	742	1,319	602	1,912	1,131	866	795	1,161	1,428	1,806
Specialised Services	3,583	3,374	3,741	4,281	4,548	4,490	4,058	7,279	4,094	3,858	4,520	5,420
STF Funding and Taper Relief	0	0	1,753	1,716	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	4,405	0	0	4,405	0	0	4,405	0	0	4,405
Public Dividend Capital	5,050	5,138	0	3,651	3,528	3,656	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	1,375	1,375	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	41,085	41,412	57,922	46,656	41,348	47,000	45,439	39,299	39,690	46,863
Payments												
Payroll	13,431	13,789	13,755	13,504	13,504	13,504	13,504	13,504	13,253	13,504	13,504	13,504
Tax, NI and Pensions	9,910	10,133	9,930	9,930	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	10,312	13,115	13,515	13,515	13,110	13,310	13,015	13,515	13,015	13,015
Non Pay - Capital	11,368	4,422	3,045	3,697	3,240	2,403	5,148	1,863	2,487	1,925	2,068	1,544
MMH PFI	3,397	2,055	4,376	4,011	3,528	3,656	3,618	8,411	3,951	3,836	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	175	140	140	140	140	140	105	140	140	140
Total Payments	45,595	48,442	44,675	47,479	46,939	49,867	48,532	50,240	45,823	45,932	43,944	46,799
Cash Brought Forward	23,873	19,919	14,582	10,992	4,924	15,907	12,696	5,512	2,272	1,888	(4,745)	(8,999)
Net Receipts/(Payments)	(3,954)	(5,337)	(3,590)	(6,067)	10,983	(3,211)	(7,184)	(3,240)	(384)	(6,633)	(4,254)	64
Cash Carried Forward	19,919	14,582	10,992	4,924	15,907	12,696	5,512	2,272	1,888	(4,745)	(8,999)	(8,935)

This cash flow is based on actual cash flows for April and May. The future months forecast incorporates relevant insight from finance, operational and estates teams.

Consequently this cash flow statement reflects the latest collective view of cash flows, crucially the prospective land sale.

The impact of this is to defer to January 2018 the timing of the trust drawing down a revenue loan. This was originally planned for July 2017.

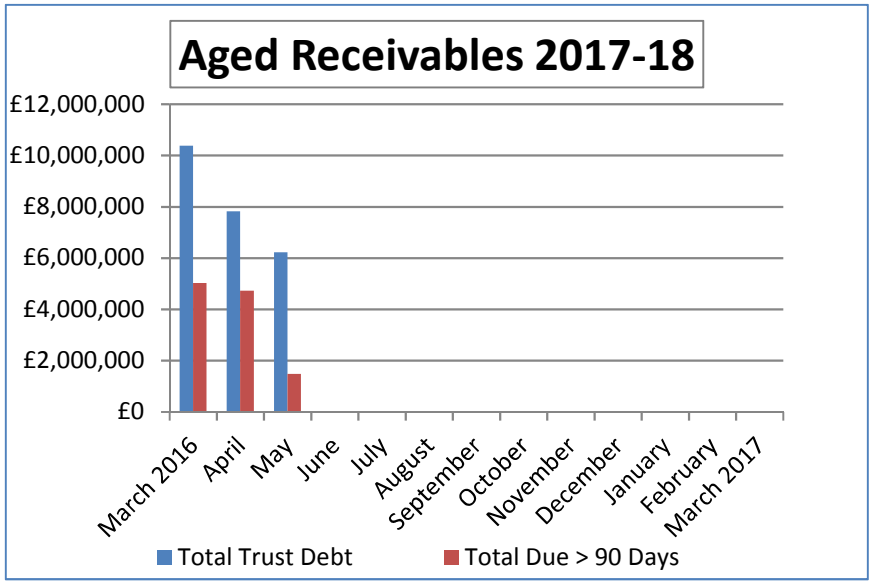
Work is continuing on the trust's cash remediation plan consistent with a return to sustainable finances in the medium term. That plan is being overseen by the FIC.

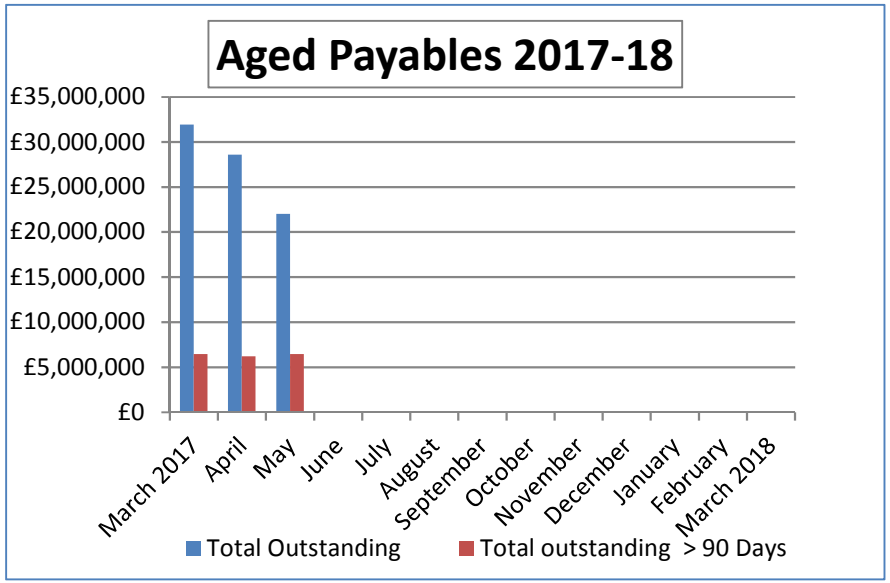
The trust continues to meet its obligations as they fall due and expects to continue to do so.

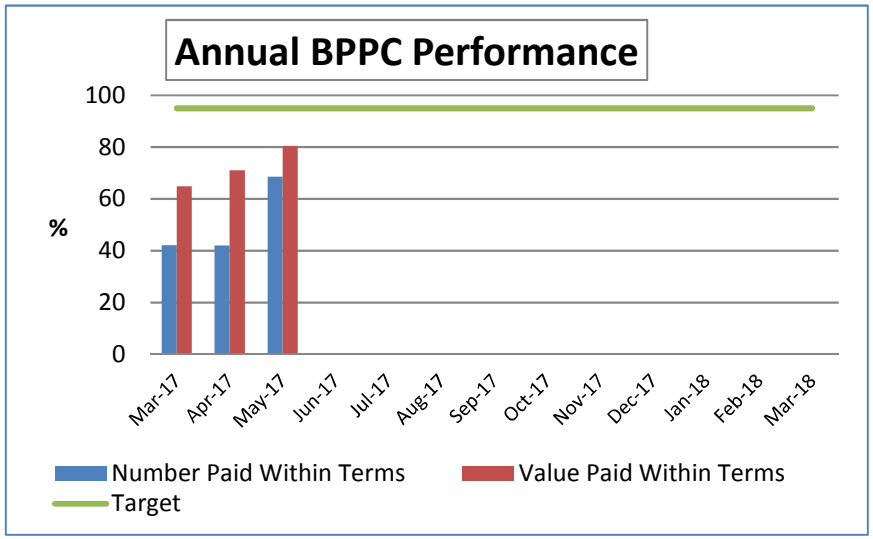
Finance Report

Aged Receivables, Aged Payables, BPPC and Cash Forecast

Period 02 2017/18







Note

- The May debt position reduced as aged NHS debt was recovered following the end of the year. However, the Non NHS debt and the over 90 Day element, increased as local government debt and Overseas Patient income aged further. The reduction in over 90 days debt includes £2.7m of credits raised in March to Commissioners that have not been taken.
- The overall Payables position has decreased during May as the Trust further utilised the cash balances from 31st March 2017 to settle debt. The overall levels remain high as the Trust continues to manage cash pressures and the overall level of over 90 days liability increased marginally.
- 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.

Finance Report

Appendix 1 – Group view P02

Period 02 2017/18

P02 May 2017			Current Month			Year to Date		
	WTE	WTE	£k	£k	£k	£k	£k	£k
Group	Budget	Actual	Budget	Actual	Variance	Budget	Actual	Variance
Medicine & Emergency Care	1,360	1,471	2,354	1,355	-1,000	3,391	2,102	-1,289
Surgical Services	1,397	1,361	1,276	1,273	-3	1,203	880	-323
Women's & Child Health	927	873	1,802	1,408	-394	3,514	3,142	-372
Primary Care, Community and Therapies	960	925	-20	178	198	616	-110	-726
Pathology	342	324	187	80	-107	477	290	-188
Imaging	280	258	260	145	-115	515	311	-204
	5,265	**5,212**	**5,859**	**4,439**	**-1,420**	**9,716**	**6,614**	**-3,102**
Corporate	1,603	1,626	-6,543	-6,487	55	-13,072	-12,678	394
Central	0		-975	322	1,296	36	2,793	2,757
	1,603	**1,626**	**-7,517**	**-6,166**	**1,352**	**-13,036**	**-9,885**	**3,151**
	6,867	**6,838**	**-1,658**	**-1,727**	**-68**	**-3,320**	**-3,271**	**49**

SWBTB (07/17) 022

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Application of the Trust Seal to Engrossment Leases
SPONSOR (EXECUTIVE DIRECTOR):	Alan Kenny – Director of Estates/New Hospital
AUTHOR:	Rob Banks – Deputy Director of Estates/New Hospital
DATE OF MEETING:	6th July 2017

EXECUTIVE SUMMARY:

In accordance with Trust practice the Trust Board is asked to approve the affixation of the Trust seal to the following documents:

Under Lease Plus Agreements (ULPAs) for:

Glebefields Health Centre
Whiteheath Health Centre
Oldbury Health Centre
Yew Tree Healthy Living Centre

The Key Terms and Points to Note are as follows:

- All Premises are used for the delivery of Community Based Services.
- All premises are LIFT Buildings under the control of Community Health Partnership (CHP) on behalf of Sandwell Lift Company.
- Rental and associated charges have been agreed between SWBH & CHP
- Break Rights - All Leases are coterminous with the service contracts for which the premises are used.
- Schedules of accommodation have been verified and certified as correct.
- Exclusion of section 24-28 of the Landlord & Tenant Act 1954

REPORT RECOMMENDATION:

The Board are recommended to:-

- Approve the application of the Trust Seal to the aforementioned documents

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		Communications & Media	
Business and market share	**X**	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:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC MEETING MINUTES

Venue: Anne Gibson Board Room, City Hospital **Date:** 1st June 2017, 0930 – 1300h

Members Present:		**In Attendance:**	
Mr R Samuda, Chair	(RS)	Mrs C Rickards	(CR)
Mr M Hoare	(MH)	Ms A Geary, Group Director of Operations – Women & Child Health	(AG)
Mr H Kang, Non-Executive Director	(HK)		
Cllr W Zaffar, Non-Executive Director	(WZ)		
Prof K Thomas, Non-Executive Director	(KT)	**Board Support**	
Mr T Lewis, Chief Executive	(TL)	Miss R Fuller	(RF)
Ms E Newell, Chief Nurse	(EN)		
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 had been received from Ms Dutton, Mrs Perry and Ms Barlow Mr Samuda welcomed Prof Thomas to her first formal meeting as a Non-Executive.	
2. Staff Story	**Presentation**
Ms Newell introduced Darren and Sister Kayleigh Jepson from Prior 2 a surgical ward. Sister Jepson informed the board Darren was a long term inpatient who spent 5 months on a number of wards including ITU and his main stay on Priory 2. Darren gave an overview of his care and how he came into Hospital. Darren was admitted to Hospital via Sandwell A&E after suffering adnominal pain (pancreatitis) in February 2016 and spent 7 weeks in Critical Care mostly under sedation as his symptoms were very severe. He was moved to Priory 2 and the nursing care he received was good but his health deteriorated with extreme weight loss, loss of mobility and he became depressed. The doctors treating him were constantly in discussion with the QE over his treatment and of if he would be transferred. He was eventually discharged in October 2016 but was readmitted 6 days later and was an inpatient on Priory 2 for 5 weeks. Darren was discharged and readmitted following a consultant appointment on New Year's Eve 2016. He was an inpatient until his discharge in February 2017, and returned for a gallbladder removal in May 2017. Darren is currently vising his GP for dressing changes but is still experiencing acute pain. Darren informed the board that his time on Critical Care was good even though sedated and the staff kept a diary for him. On Priory 2 the nursing staff were caring but some of the agency staff did not have the same level of care or understanding especially about his pain management which was severe and many analgesics given including morphine, oramorph and codeine where not pain relieving enough. The consultant care was on occasions was frustrating as the consultants would talk over him and they did communicate clearly about his planned care.	

Darren finally informed the board that he went back to work as a paramedic in March 2017 has gained weight and is regaining his strength.

Darren answered the following questions from board members:

Ms Newell stated the Trust were working hard to reduce agency staff, this pleased Darren and he clarified the regular agency staff got to know him and were as good as the sustentative staff; the difficulty was with the agency staff who were not familiar with his care and would not respond proactively when he informed them he was in pain. This also applied to a number doctors who did not know his history and did not listen to him when he wanted to explain his treatment.

Mr Kang thanked Darren for coming to the board and hearing about his experiences and asked if he could identify why some of the clinical staff had no time to listen. Darren commented the staff were busy and exampled a doctor who had to be chased so Darren could discuss his lack of sleep due to the pain he was experiencing. Darren also informed the board that due to the pain he was experiencing he could be difficult and rude to staff.

Darren praised Mr Hanif and his dedication when he came to visit Darren on his day off.

Dr Stedman informed the board Darren's condition was difficult to treat and understand especially around pain management as each patient's tolerance was different.

Mr Samuda thanked Darren for coming to the board to share his experiences as a long term inpatient and reiterated the Trust was working hard to reduce agency nursing with its own bank staff. Mr Samuda wished Darren success in his future treatment and recovery.

3. Questions from the public	**Verbal**

There were no questions from the public.

4. Chair's opening comments	**Verbal**

Mr Samuda drew attention to the following:

Midland Met Hospital - the announced delay to Spring 2019 of the Midland Metropolitan Hospital was due to technical issues on the build programme and the news has been well received by staff and the local community. Investments and programmes supporting MMH has not been delayed and continue to advance.

STP – local chairs have discussed STPs and await the results of the local general election to obtain further clarity of how STPs can be developed. It was stated continued work with the BCA was important including corporation with Wolverhampton Trust where possible.

5. Charitable Funds	**SWBTB (06/17) 002** **SWBTB (06/17) 003**

Cllr Zaffar reported on the following:

Draft Charity Accounts - the draft accounts of the Trust's Charity were agreed and will be formally presented at the Trusts AGM.

Barclays Wealth - There was a meeting prior to the Charitable Funds committee with Barclays Wealth to discuss the investment strategy, Barclays proposed investment in alcohol, arms and tobacco firms. This was rejected by the Trust as it contradicts the Trust's public health plan. Mr Lewis was dismayed at the proposal as the Trust 3 years ago agreed not to pursue investments in these companies, however Mr Waite confirmed it was Barclays obligation to inform the Trust of gains in these companies even though they are aware of our rules on investment and adhere to those.

6. Public Health, Community Development and Equality Committee Update	**SWBTB (06/17) 004** **SWBTB (06 /17) 005**

Mr Samuda reported on the following:

- Volunteering The Committee discussed the volunteer service and future appointments to be made in the next quarter
- Community Development The Committee discussed working more closely with the local authority and using the Midland Met site to engage with the community by holding events whenever possible. There is also a public appeal to raise money which is being supported by the Trust Charity.
- Alcohol Services – the funding of an alcohol nurse has been secured for 2 years with money from the Trust Charity and work is progressing in sourcing its continued retention. The nurse is also leading on preventable work in conjunction with external organisations.

7. Audit and Risk Management Committee	**SWBTB (06/17) 006** **SWBTB (06/17) 007**

Miss Dhami reported to the board the internal audit plan was agreed by the Audit and Risk Committee along with the draft annual report including the AGS. The draft annual accounts have been recommended to the board for agreement. It was noted the board has had prior sight of the draft accounts at its April meeting. It was also confirmed an additional 100 days has been added to the internal audit plan to accommodate the data quality discussions due to the fast moving of the agenda.

The Audit and Risk Management Committee thanked KPMG for their work as their contract with the Trust had ended and welcome the new External Auditors Grant Thornton.

8. Finance and Investment Committee	**Verbal**

Mr. Samuda reported on the meeting that took place on the 31st May and reported good progress on the production plan, the process on negotiations of a cash loan and the financial improvement work by EY. The work of EY in delivering the cost improvement programme and discussions on the run rate would be discussed at the private Trust Board.

9. Quality and Safety Committee	**Verbal**

Miss Dhami reported on the following:

- Safety Plan – this has been discussed in detail including the ward compliance data and its robustness which is being monitored at the Executive PMO. The ward buddies were discussed to ascertain if the roles were working and how could support be received by those who required it.
- DNA CPR – Improvements have been made but it was noted that not all assessments of patients' mental capacity were being documented or discussions with family regarding patients who lacked capacity, Dr. Stedman agreed to follow this up and report back to the Quality and Safety Committee. Mr Lewis requested and the board agreed to review DOLs and DNA CPR as progress with patients and families was progressing but due to the length of time the organisation has had in achieving better results, compliance of individual employees should be considered and a consequence step now be actioned.
- Transition services – Good progress has been made on a trust wide guide for transition services of children who were moving into adult services, the report received highlighted some gaps in the self-assessment and a follow up report would be provided by Dr. Stedman.
- Hip Fractures – this would be discussed as part of the IPR report on the agenda.
- CLE, Quality and Safety Structure – Mr. Lewis reported work was underway in reorganising the function of these committees to achieve a better alignment with the executive leadership as some operational arrangements are being discussed at the Board without prior discussion as a sub committee

ACTION:

- DOLS and DNA CPR consequences be considered for individuals not compliant with the policy

10. Chief Executive's Report	**SWBTB (06/17) 011**

Mr Lewis highlighted the following matters from his report:

- Recruitment of senior leaders and managers. Mr. Lewis advised the board that progress in the recruitment of leaders and managers in the clinical groups has progressed to either in post of out at final advert. This included the recruitment of two Deputy COOs and Group Director in Medicine and Emergency Care. The role of Group Director of Nursing for Medicine is still outstanding but the vacancy is out to advert. Allison Binns the Interim Group Director of Nursing returns to her Governance role from Monday. Mr. Lewis also advised that good progress has been made with the compliance of junior doctors' hours since the change in August 2016.
- Cyber Attack. The recent global attack was not as severe for the Trust due to the work done on strengthening the IT infrastructures during 2016.
- Planned Care. There will be a step up in activity in June but work is continuing over the next few weeks to catch up the position which is currently behind plan.
- Thornbury Switch off. It was reported from today no bookings would be made to the Thornbury agency. This is due to the high cost of the agency which the Trust cannot support. The organisation has been working to overcome reliance on Thornbury by moving to the use of the trust staff bank and reorganising staff on duty. Mr Lewis continued to state no other Trust has done the same but a number of local Trusts are considering the same approach.
- Executive Committee Structure. It was reported work is progressing to engage better with staff groups at senior management level due to senior staff joining the organisation but leaving within months of commencement. Mrs Goodby will be reviewing this area during the Summer and looking at how to get the best of all employees who work for the organisation including staff retention and organising the best way to ensure there are closer links with the executive directors and the leaders at triumvirate level. This work has already stated with Mr Lewis forming a working group with senior management working on 7 day services. The board expressed its desire to support all new joiners at the Trust.
- Redeployment. Mrs Goodby reported currently there are 18 people on the list for redeployment, including 6 medical records staff and a nurse. There are only 4 members of staff proving difficult to redeploy due unusual arrangements they have on working part time hours; however she was confident that these staff would have a positive outcome. Mrs Goodby confirmed to the board that 150 staff have been successfully redeployed.
- Update on Recruitment. Mrs Goodby reported the activity report is in the new format and now reconciles with offers to employment. Highlighted was the band 5/6 nurses offers made of 181 which included offers in acute and community since March 2017 and the report also noted reported on levers which can be matched to the groups savings plans. Ms Newell explained to the board the refusal of offers was usually due a candidate accept 2 or 3 offers from other organisations and in September there are 51 predicted newly qualified nurses commencing in post. Ms Newell informed the board of an external recruitment fayre in July in Liverpool and London which was an opportunity to promote working in Birmingham, these fayres also attract a lot of staff wishing to move out of nursing homes and into a hospital/community setting. Mrs. Goodby also informed the board that the Trusts within the BCA have a similar nurse vacancy of around 5%. It was reported work has been completed on the HCA role including changing the entry level to enable recruits to gain qualifications while employed as the current vacancies are not part of a local or national shortage. it was also stated some vacancies will translate into apprenticeships.

11. Trust Risk Register	**SWBTB (06/17) 012**

Miss Dhami reported no new risks have been escalated to the Board from the Risk Management Committee or Clinical Leadership Committee. The removal of risk number 328 was recommended as senior appointments have been made to the clinical groups which had personnel gaps.

Mr. Lewis informed the board of the Annual Governance Statement, which forms part of the Annual Report. The external auditors made a number of initial comments for concern i.e. IT infrastructure but many of these will be resolved during the build of the Cerner system, however all issues have been fully disclosed and discussed with the CQC.

12. Board Governance Review: update on actions	**Verbal**

Miss Dhami reminded the board of the 4 areas of discussion from the April, they were:

1. Assessment of non chairing board committees. There are 7 board sub committees excluding the remuneration committee.

2. More focus by the sub committees on the 18 points. This is to align some of the sub committees focus. This work is still undergoing which has been included to the sub committees of CLE.
3. Upward reporting from CLE to the Board – this has been reviewed and actioned by the Chief Executive
4. Good board discipline in the context of papers, ensuring items are presented and have a robust action log. Miss Dhami was overseeing this area following the resignation of the Head of Governance but the post was currently being advertised and an update will be tabled at the next meeting.

It was explained CLE was the Clinical Leadership Executive the main governance body to ensure delivery of the business chaired by the Chief Executive.

ACTION:

- Paper on board governance to be on agenda for the next Trust Board

13. Integrated Performance Report	**SWBTB (06/17) 013**

Mr Waite drew the board's attention to the positives for April of 62 day cancer, RTT, VTE, MRSA, Cdiff and readmissions. There has also been excellent progress on sepsis but neutropenic sepsis proved slightly difficult in maintaining the 100% compliance, however this has been achieved in the last two weeks.

The following was highlighted:

- ED 4 hour – will be discussed as part of the agenda
- Persistent Reds – Mr Waite tabled a document highlighting the areas who persistently just missed compliance and actions being taken to overcome their non compliance. Progress will be monitored via the PMC and will be reported routinely as part of the IPR report.
- VTE – Dr Stedman stated the indicator showed 95% to 96% complaint but there was still a gap in achieving the full 100%, (the national average is 95%), the outstanding 5% equated to approximately 150 patients who had received a VTE assessment on admission. The implementation of EPR by Cerner would highlight those doctors choosing not to undertake VTE assessment and the reason why.
- Cancelled Operations – This gave the board concern as non-compliance would result in poor patient experience. Ms Geary stated a new approach was being trailed in Theatres where escalation goes up to the Group Director of Operations who will review included in that was the why a high number of cancelled operations happened during the low utilisation of theatres. Work is underway on smart bookings to reduce cancelling operations during the day. The results of this work have already seen a small decrease and was being monitored daily via the PMO. Dr Stedman commented that with casenote scanning some of the administration failures of missing notes would now be avoided. Mr. Lewis informed the board that there was a high level of cancelled operations and he requested an update to be provided by Ms Barlow for the next meeting.
- Hip Fractures – it was reported that performance fell from 91.3% last month to 41% in April, and the group have been charged to investigate the failure in escalating the issues as having peaks of activity is common in this area.

ACTION:

- Ms Barlow to provide an update on the cancelled operations in ophthalmology

14. Financial performance: Period 1	**SWBTB (06/17) 014**

Mr Waite updated the committee following the Finance Investment Committee that was held yesterday. The Financial plan of the Trust is to return to break even, the 3 objectives to achieving this are:

1. Secure planned care income through the production plan, it was stated there has been some success on this in April
2. Reduce reliance on temporary pay and usage of very expensive agencies, this item is on the agenda for discussion. Mr Waite reported the pay bill was higher than budget due to some of the reduction in agency costs not yet realised.
3. Cost improvement and delivery. There is some confidence on deliverance of the CIP which is being recorded in the TPRS, any additional savings from EY will also be included.

Currently the Trust is approximately £1m off plan and Mr Waite stressed the importance of reducing agency spend in period 1 and finding a remedy to ED 4 hour waits. It was clarified to the board the income figure reported as £39m was a revised profile and there was no income problem, the overall position is compliant to plan but the Trust will not be

able to plug the income gap in this financial year, the income also included closing beds as planned. Work was progressing to restore finances however key to this was securing the proceeds from the land sale.

It was stated the Thornbury switch off would have an impact on the £10m savings bill and, Ms Goodby stated during the Winter months Thornbury cost the trust approximately £200 - £250k per month.

15. Production Plan months 1 and 2	**SWBTB (06/17) 015**

Mr. Waite updated the board on the position of the tests set by the board at previous meetings.

All specialities now have a signed off production plan in place to the value of £112m apart from a residual £700k which is being resolved. There is an issue in orthopaedics around the group providing numerical assurance in productivity step up and alignment to scheduling in theatres notwithstanding the 40% outstanding vacancies, the Chief Executive is planning to meet with the speciality to understand what the issues are. The production plans produced by all specialities align to the groups annual targets and delivery will be monitored via weekly PMOs lead by the COO this includes the on-going work to finalise the granular level of phasing and providing further assurance on governance.

Mr Waite continued to inform the board that during April the results on planned care showed activity and income delivered ahead of plan and currently May was on target to deliver similar successes, however it was stressed the remaining months of the year would be monitored closely as a mix of activity has been recorded in ambulatory and admitted care and the organisation required all elements of the plan to be delivered. Ms Geary commented the timeliness of bookings required monitoring as in June bookings was off plan but the system now was able to report on a daily basis of any specialities below plan. Further improvement was required in booking on a timely and complete basis including better discipline for theatre activity.

The board discussion further and it was noted that there may be a dip in activity during quarter 1 which would need to be phased due to the launch of casenote scanning and staff training on EPR therefore some rephrasing in June would be required for the booking teams to achieve realistic targets. Mr Waite confirmed holidays have been factored into the plan but more work was required to assure colleagues on the control and grip.

16. Never Events Action Plan review	**SWBTB (06/17) 016**

Miss Dhami informed the board of 4 Never Events during 2016/17 which have been investigated and learning steps taken to prevent from happening again. All the Never Events took part in difference areas of the Trust and included 3 retained items and one wrong site surgery. The actions taken to prevent this type of Never Event happening include changes in clinical practices and different ways of working such as the surgical pause which is used when imaging films are used in surgical procedures. All clinicians who perform operations have signed a safety notice confirming their compliance with the changes. There is also community awareness of sharing what went wrong for other areas to learn by and the organisation undertake discussions as part of the QHID. To also strengthen the elimination of Never Events a Never Event Assurance Committee has been formed to look at all nearly Never Events and action any weaknesses found. There is also a clinical audit committee which review changes in practice are working.

Dr Stedman informed the board to move away from the use of standardised trays would have a high cost implication as it would not be feasible for all procedures to have a non standard tray. He exampled a hip operation could have over 100 items that were provided, however work is underway to procure from a single manufacturer and to ensure all theatres are using the same trays for the same procedures. Dr Stedman also responded to a challenge that good progress is underway for the colour coding of items to be retained in a patient to be different colour to those for removal.

Mr Lewis asked if assurance could be given that the 20 actions have been implemented. Miss Dhami confirmed she would check which actions have been implemented for the next Board, but assured the board that monitoring, spot checks, audits and unannounced visits were a standard part of evidencing compliance with any new working practices.

ACTION:

- Miss Dhami to review the 20 Never Event actions for compliance and report back to the next board.

17. A&E performance: delivery in June	**SWBTB (06/17) 017**

Ms Geary informed the board of a deterioration in performance in May to 81% on delivery of the 4 hr target in A&E and the significant challenge to improve performance.

Mr Holland, Deputy COO – Planned Care reported on the Urgent Care challenge week which will focus on internal ED and speciality professional standards practiced consistently. There will be a marked step up in performance in July to 90% which is equivalent to 60 fewer breaches a day to get the department back on track. The signs for June were encouraging with more attendees being seen compared to the previous month. Ms Geary informed the board that the challenge will also be in ensuring staff take responsibility, challenging behaviours and maintaining consistency. There will also be a senior member of staff providing support to clinical staff until 10pm each day.

Mr Holland informed the board there were daily reviews monitoring the movement of patients as the overnight service reported more breaches from assessment units to wards, this will include implementation work on reviewing length of stay and practices by engaging consultants and ward managers to take ownership of patients in a timely manner by using HCA and nurses to transport patients.

The ambulatory care model will be revisited to remodel the hours to reflect demand after 8pm and work on sustainability of changes to maintain long term improvement. The ED at Sandwell will be physically reconfigured to provide more capacity and building works was to be completed by Sunday.

The board queried the recruitment of the 3rd consultant post, this information was not available but would be followed up after today's meeting. Mr Holland continued to inform the board that the decision to admit within the first hour has increased to 55% and was being monitored for consistency.

The situation on how the organisation was affected by the non availability of beds in the community and social care sector was discussed and Mr Lewis informing the board of a meeting with Dale Bywater, Regional Director at NHSI on A&E, however many of the actions are for the Trust which it should focus on to ensure it finishes the month in the high 80% - 90% of performance.

Further discussion continued with the board and it was confirmed Red to Green is still an important aspect of reducing patient length of stay.

Mr Holland was thanked for attending the meeting.

18. 2016/17 Annual complaints and PALS report	**SWBTB (06/17) 018**

Miss Dhami reported during the year 81% of complaints were responded to within the 30 day target. The number of complaints has increased this year from 935 to 1026 and the trends and themes is in line with the quarterly reports provided during the year to the board. The service has been reorganised merging the Complains and PALs service into one team whereby they provide a triaging service.

The 97% target of responses to be completed within 30 days was high and was monitored daily to ensure breaches do not happen. This also included working with clinical groups. Miss Dhami drew the board's attention to the high number of complaints from the Black Caribbean Community and would be reviewing what we do in care and treatment.

A new initiative will be launched from September to have purple phones installed outside wards so patients and relatives can call and get an immediate response to an issue before it escalates into a formal complaint. Miss Dhami stated there was something similar in America not in the UK. It was stated all calls will be logged and an audit trail available.

The board discussed some of the issues of ethnicity of complaints and Miss Dhami confirmed there was an ethnic split but she would need to check if it was by type. It was also confirmed that investigations involving staff, the staff member

would be alerted and offered support if required and any learning from complaints would be included in an individual's PDR and/or taken as a theme for the QHID session.

19. Research and Development Plan	**SWBTB (06/17) 019**

Dr Stedman reported the R&D team would be presenting to members after the private session this afternoon. The plan reflected the objectives and approach to delivering one of the key pillars of the 2020 Vision and was the 2nd plan to be shared with the board which has been built upon the 2014-2017 model. This plan was more ambitious in its approach and growth and was geared to the recruitment of more patients and ensure consultants time is available to undertake more research.

Discussion reflected on the significant increase in the growth figure of 53% or 6000 recruits over 3 years and whether the Trust had partnerships with the big external research trails that exist. Dr Stedman noted the plan was ambitious but the focus would be on researching in areas that were not research active and collaboration with external agencies came with risk but there is some engagement with external agencies but not on research. The Trust did undertake some work with agencies but in many cases they are resource expensive and not always profitable. The board continued to discuss research and development and agreed that there was more opportunity to undertake trails in many specialities as in some areas it was routine for patients to become part of a trail.

20. Diversity Pledges	**SWBTB (06/17) 020**

Mrs Goodby reported on the staff and patient pledges which have been presented to the Public Health, Community Development and Equality Committee and drew the boards attention to the patient pledges for further development. The discussion on the complaints report could be extended in the pledges under patient experience.

The board discussed how best to help our patients and the community by focusing on a limited number of pledges and ensuring their success, attention was also drawn to language services run by the Trust Bank and will be fed into the pledges including sign language and the possibility of having a bank of staff members available to interpret when necessary.

Mrs Goodby will present an action plan to the board but welcomed any comments outside of the meeting.

ACTION:

- An action plan on patient diversity pledges to be presented to the trust board.

21. Reduction in use of agency staff	**SWBTB (06/17) 021**

Mrs Goodby reminded the board of the target to reduce agency spend by £10m by March 2018. There are 4 main areas that will be focused on to achieve the reduction backed up by KPIs. The clinical group PMOs will be monitoring closely to ensure delivery is maintained. The 4 main areas are:

1. Productive Rostering. This involves booking staff 42 days in advance and releasing shifts early to be filled by other staffing groups. A key feature is ensuring improved rostering practices including compliance with completing rotas 6 weeks in advance. This will reduce the reliance on bank/agency staff. Ms Newell reported her concerns with the rotas produced and was speaking with the Barnacles as 6 out of 26 wards missed the reporting deadline. Mr Lewis stated the organisation has had 3 months to get rosters correct and was concerned why more time was required. However, Ms Newell informed the board that significant progress has been made on the quality of the data produced including the switch off of Thornbury and improvements in HCA agency rates which will contribute to a reduction in bank/agency staff.
2. Reduce Open 'Hard to Fill Vacancies. Work is currently underway to reduce the level of these vacancies with clinical groups and reduce need for backfill with bank/agency.
3. Managed and Reduce Owed Hours. Within 2 months all ward managers would have reduced this to less than 10 hours for any staff member who own hours to the Trust. Ms Newell reported that the Barnacles system will be amended to automatically trigger any member of staff booking bank shifts but still own the Trust hours to enable a swifter recovery.
4. Improved Attendance. The sickness hot spots will be focused on to reduce sickness and reduce the use of bank/agency to back fill.

22. Never Event notification	**Verbal**

Mr Tyagi, Group Director of Surgery reported on the care of a patient had received a wrong site femoral neve block prior to spinal anaesthesia for a right hip fracture. Mr Tyagi informed the board the patient was placed 4th on the list but usually a patient with challenging behaviours are placed first on the list to avoid any distress or anxiety. The anaesthetists were assisting another procedure in an adjacent room and the patient was checked into theatre by an unsupervised ODP student who had not completed the correct checks upon admitting the patient into theatre. The experienced ODP assigned to that theatre had also been called away and the doctors carrying out the procedure preceded to give a femoral block which is used as a pain relief prior to the proper anaesthetic procedure being given on the left side which was incorrect. The error was spotted by the experienced ODP when the patient was being given the spinal block on the opposite side (the right). The anaesthetics team carrying out the procedure had failed to complete the WHO sign in and the Stop before your block. No harm came to the patient and the procedure has since been completed. Mr Tygai concluded that key safety actions introduced to eliminate incidents of this kind including all key personnel signing the WHO sign in report and the Stop before you block challenge were not carried out due to members of the team being out of the room when these checks should have been done.

The board questioned and challenged on procedures including why the Stop before your block was not actioned as this was a key action that arose from a similar incident two years ago. The failure of the team not being in the room at the same time when the first block was administered and the marked area on the patient's leg was covered leading to a number of assumptions being made. This included a trainee staff member being unsupervised when the first check should have taken place. Dr Stedman reiterated this failure was unavoidable and the distraction of staff being called away was why on sign in you have the correct members of the team present. Dr Stedman continued to note that following the incident in 2015 a snap shot audit was taken shortly after and compliance was 68% since then 2 recent audits have taken place where 100% compliance was recorded, therefore the issue for the leadership team is to ensure sustainability and vigilance of staff is maintained.

Mr. Tyagi reassured the board that the procedure of sign in and Stop before your block has been reissued to all surgeons including anaesthetists. The Group Directors in Imaging and Medicine have also been informed and in due course a learning meeting will take place with the individual clinicians and a learning piece will be circulated to all clinicians. Mr. Tyagi continued to stated that all members of the team including junior staff are empowered to speak up if they have a query.

The board noted their disappointment of the Never Event which would be discussed further at a number of sub committees.

23. Midland Metropolitan Hospital: delay update	**Verbal**

Mr Lewis reported on the 6 month delay announced to staff and in the media of the opening of the new hospital due to engineering issues on the build. The formal contractual notice of the delay will be provided by the end of the week and the Private board will discuss commercially the delay. Mr Lewis stressed this was a one off delay and following changes in personal at Carillion he was confident other areas of the build will remain on track.

24. Financial Statements for the Year Ended 31st March 2017 – to adopt	**SWBTB (06/17) 022**

M Waite presented the Trusts financial statements and highlighted the following:

- The Trust met 3 of its 4 obligations failing on the annual control total recording a deficit where an unqualified opinion was received.
- The external auditors report no issues of probity or stewardship of public funds or matters of significant public interest.
- The Audit and Risk Committee has challenged the Trust's accounting decisions.

Mr Waite confirmed the draft annual accounts have been presented to the Audit and Risk Committee and recommend for escalation to the board for approval. The draft annual report including the Annual Governance Statement from Mr Lewis, the Letter of Representation to the external auditors and the ISA260 which has been provided separately to board members when considering the financial statements are recommended for approval.

Mr Waite requested delegated authority to authorise the relevant certificates regarding the financial statements to the CEO and Director of Finance.

The board were content with the presented financial statements and agreed for delegated authority on authorising the relevant certificates to the CEO and Director of Finance.

ACTION:

- Delegation of the relevant certificates relating to the financial statements be authorised by the CEO and Director of Finance.

25. Application of the Trust Seal to Lease for the Independent Living Centre	**SWBTB (06/17) 023**

Miss Dhami on behalf of the Director of Estates/New Hospital recommended to the board the affixation of the Trust seal to the document of a lease with Sandwell MBC for the use of accommodation in the Independent Living Centre for iCares and Wheelchair Services

The board approved the application of the Trust seal.

AGREEMENT:

- The use of the Trust seal was agreed for the documentation regarding the lease of the Independent Living Centre from Sandwell MBC.

26. Minutes of the previous meeting and action log: 4th May 2017	**SWBTB (06/17) 024** **SWBTB (06/17) 025**

The minutes of the meeting held on the 4th May 2017 were agreed with the following amendment to the minute that the venue of the meeting was Rowley Regis Hospital.

Action Log. The following actions were recommended for closure:

- BCG vaccines – Assurance has been provided to the Risk Management Committee that all outstanding BCG vaccines have been delivered and availability of future stocks.
- Annual Report – The summary report only will be available in alternative languages.

27. Matters arising	**Verbal**

There were no matters arising.

28. Any other business	**Verbal**

There were no items of any other business.

29. Date and time of next meeting	**Verbal**

The next public Trust Board will be held on 6th July 2017 starting at 09.30am in a venue to be confirmed

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Public Trust Board

Action Log following meeting held on 1st July 2017

Minute number	Action	Assigned to	Due Date	Status
From meeting held on 1st June 2017:				
9	Quality and Safety Committee: DOLS and DNA CPR consequences to be considered for individuals not compliant with the policy	Toby Lewis		Open
12	Board Governance Review: A paper of board discipline to be available at the next meeting	Kam Dhami	July 2017	Closed – on agenda
13	Integrated Performance Review: An update to be provided on cancelled operations within ophthalmology	Rachel Barlow	July 2017	Open
16	Never Events Action Plan review: An update to be provided on the 20 NE actions for compliance	Kam Dhami	July 2017	Closed – on agenda
20	Diversity Pledges: An action to be presented to the board on patient pledges	Raffaela Goodby	August 2017	Open
24	Financial Statements for the Year Ended 31st March 2017: The board agreed the delegation of authority of signing the financial statements and relevant certificates to the CEO and Director of Finance	Tony Waite	July 2017	Closed
From meeting held on 4th May 2017:				
10	CEOReport: Learning Disabilities – update the July meeting on the advisory service with the Black Country Partnership	Toby Lewis	July 2017	Open
16	EDImprovementPlan A&E scorecard to be available at the next meeting	Rachel Barlow	June 2017	?
From meeting held on 6th April 2017:				
11	TrustRiskRegister,Risk1738,Ophthalmologyoutpatients(children): Steps to be taken to close down this risk.	Roger Stedman	June 2017	Open
11	TrustRiskRegister: High/low impact assessment to be completed on all risks on the Trust Risk Register.	Kam Dhami	July 2017	On agenda of meeting

CEO report	Emergencyplanningandbusinesscontinuityplanning: Localised plans to be presented to the Board.	Rachel Barlow	July 2017	On agenda of
From meeting held on 2nd March 2017:				
10(e)	CEO report/Consistency of care: Consistency of care reviews to be presented to the July 2017 Trust Board meeting.	Kam Dhami	July 2017	Closed – on agenda
15	Trust Risk Register: Risk assessment of imaging and pathology results reporting and acknowledging electronically by clinicians to be sent to CLE and presented to Trust Board in April if required.	Roger Stedman	July 2017	Open
14	Localisedsuppliersofmulti-cultural/multi-faithmeals: matter to be resolved and reported to Trust Board.	Toby Lewis	Monthly verbal progress report until resolved	Open – verbal update with the CEO report
From meeting held on 5th November 2015:				
17	Smokingcessation: Matter to be resolved and reported to Trust Board.	Toby Lewis	Monthly verbal progress report until resolved	Open – verbal update with the CEO report