Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION AGENDA

Venue: Rowley Regis Hospital
Moor Lane, Rowley Regis, B65 8DA

Date: Thursday 3rd May 2018, 0930h – 1315h

Members:

Mr R Samuda	(RSM)	Chair
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 D Carruthers	(DC)	Medical Director
Mrs P Gardner	(EN)	Chief Nurse
Ms R Barlow	(RB)	Chief Operating Officer
Mr T Waite	(TW)	Director of Finance
Mrs R Goodby	(RG)	Director of People & OD
Miss K Dhami	(KD)	Director of Governance

In attendance:

Mrs C Rickards	(CR)	Trust Convenor
Mrs R Wilkin	(RW)	Director of Communications
Mr M Reynolds	(MR)	Chief Informatics Officer
Mr D Baker	(DB)	Director of Partnership and Innovation
Miss C Dooley	(CD)	Head of Corporate Governance

Board support

Ms R Fuller	(RF)	Executive Assistant

Time	Item	Title	Reference Number	Lead
0930h	**1.**	**Welcome, apologies and declarations of interest** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting.* **Apologies: Cllr Zaffar**	Verbal	**Chair**
0935h	**2.**	**Patient Story**	Presentation	**PG**
0950h	**3.**	**Questions from members of the public**	Verbal	**Chair**
0955h	**4.**	**Chair's opening comments**	Verbal	**Chair**
		UPDATES FROM THE BOARD COMMITTEES		
1000h	**5a**	To: (a) receive the update from the **Major Projects Authority** meeting held on 20th April 2018 (b) receive the minutes from **Major Projects Authority** meeting held on 23rd March 2018	TB (05/18) 001 TB (05/18) 002	**RS** **RS**
1010h	**5c**	To: (a) receive the update from **the Quality and Safety Committee** held on 27th April 2018 (b) receive the minutes from the **Quality and Safety** Committee held on 23rd March 2018	TB (05/18) 003 TB (05/18) 004	**OD** **OD**
1020h	**5d**	To: a) receive the update from the **Finance and Investment Committee** held on 27th April 2018 b) receive the minutes from the **Finance and Investment Committee** held on 23rd March 2018	TB (05/18) 005 ***to follow*** TB (05/18) 006	**MH** **MH**

Time	Item	Title	Reference Number	Lead
		MATTERS FOR APPROVAL OR DISCUSSION		
1030h	6.	**Chief Executive's Summary on Organisation Wide Issues**	TB (05/18) 007	**TL**
1045h	7.	**Trust Risk Register**	TB (05/18) 008	**KD**
1055h	8.	**Unity Countdown to August and December 2018**	TB (05/18) 009	**TL**
1110h		**BREAK**		
1120h	9.	**CQC Improvement Plan Closeout**	TB (05/18) 010	**KD**
1130h	10.	**Maternity Summit – Improvement Actions Update**	TB (05/18) 011	**PG**
1145h	11.	**Amenable Mortality and Learning from Deaths Trajectory**	TB (05/18) 012	**DC**
	11.1	**Sepsis Report**	TB (05/18) 013	**DC**
1200h	12.	**Responding and Learning from Serious Incidents**	TB (05/18) 014	**KD**
1210h	13.	**Financial Plan 2018-20**	TB (05/18) 015	**TW**
1220h	14.	**Bed Base Risk Mitigations / Closing Unfunded Beds**	TB (05/18) 016	**RB**
1230h	15.	**Reducing Sickness Absence and Improving Well Being**	TB (05/18) 017	**RG**
1240h	16.	**Integrated Quality & Performance Report**	TB (05/18) 018	**TL**
1245h	16.1	**Persistent Reds**	TB (05/18) 019	**TL**
1250h	16.2	**Financial Performance – P12 2017/18**	TB (05/18) 020	**TW**
		UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS		
1255h	17.	**Minutes of the previous meeting and action log** To approve the minutes of the meeting held on 5th April 2018 as a true/accurate record of discussions, and update on actions from previous meetings	TB (05/18) 021 TB (05/18) 022	**Chair** **Chair**
	18.	**Matters Arising**	Verbal	**Chair**
		MATTERS FOR INFORMATION		
1305h	19.	**Q4 Complaints Report**	TB (05/18) 023	**KD**
	20.	**Trust Board Declarations**	TB (05/18) 024	**KD**
	21.	**General Data Protection Regulation (GDPR): Trust Preparedness**	TB (05/18) 025	**KD**
1315h	22.	**Application of Trust Seal**	TB (05/18) 026	**KD**
	23.	**Any other business**	Verbal	**Chair**
	24.	**Details of next meeting: The public Trust Board meeting will be held on** Thursday, 7th June 2018 at 09:30h in the Anne Gibson Boardroom, City Hospital. **Annual General Meeting:** Thursday, 21st June 2018, 18.00-20.00, the Conference Room, Education Centre, Sandwell General Hospital		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MAJOR PROJECTS AUTHORITY UPDATE	
Date	Friday 20th April 2018
Attendees	Mr Hoare (Chair), Mr Lewis, Mr Waite, Ms Barlow, Mr Kenny, Mr Reynolds and Ms Dooley
Apologies	Mrs Goodby and Ms Dutton
Key points of discussion relevant to the Board	***IT Infrastructure*** An update was provided, and discussion took place on the work in progress to reduce the 3 IT infrastructure red rated risks, in relation to WAN, LAN and back-up (storage). The CIO advised these should be resolved throughout April/May with all concluded by end May 2018. A sustainable approach/2 year plan on IT infrastructure would be presented at the next digital committee (which also took place on 20th April). Actions required following the annual cyber security assessment will be provided to the May MPA meeting. ***IT EPR – Initial Feedback from First Dress Rehearsal*** The COO provided a verbal report on the issues and actions that took place during week one of three of the first dress rehearsal for Unity and noted a full report will be provided to the May MPA meeting. It was noted that 50% of wards and 30% of out-patient clinics, involving 130 staff too part in week one, with clear visibility of the training/technical team across the Trust. It was noted 15th June is last official day for sign off of final Unity product and this is discussed weekly at implementation meeting. At the May MPA meeting Unity will be a main focus item, to include: - Implementation plan through to December 2018 - Outputs from dress rehearsal - Risks, issues, hazards report - Readiness checklist (including training competencies) ***Midland Met*** Mr Lewis provided a verbal update to the MPA members on the 3 options (previously provided to MPA and Trust Board) to complete Midland Met, following the liquidation of Carillion in January 2018. The associated timescales, an outline of additional investment for each option and potential delay deadlines are the current focus of the Trust (Chair/CEO/DoF) with Government, government agencies and the Hospital Company to resolve. Mr Lewis advised the Chairman has formally written to DH outlining board concerns and weekly meetings with DH now take place. A preferred contractor is awaiting approval/clearance from Treasury to proceed (short-term) with re-opening the site and agreement is required on the timeframe for this (whether an early works contract can be approved) .

	In essence, Mr Lewis advised that at this point no resolution has been reached on the three options (appraisal) put forward. ***2018/19 Capital Plan Delivery*** The capital plan programme, focussing on the non-Midland Met estate, was reviewed and continuously scrutinised at the monthly estates committee chaired by the Chief Operating Officer. MPA received progress updates on schemes underway and it was noted there are no material concerns in relation to schemes to delivering throughout 2018/19.
Positive highlights	Unity Implementation and Capital Plan commitments
Matters of concern or key risks to escalate to the Board	Midland Met update
Matters presented for information or noting	
Decisions made	

Mike Hoare
VICE CHAIR OF THE MAJOR PROJECTS AUTHORITY MEETING
For the meeting of the Trust Board scheduled for 3rd May 2018

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TB (05/18) 002

Major Projects Authority Committee Minutes

Venue Anne Gibson Committee Room, City Hospital Date 23rd March 2018 1430 - 1530

Members Present:

Mr Richard Samuda	Chair		
Mr Mike Hoare	Non-Executive Director (Chair)		
Mr Toby Lewis	Chief Executive		
Mr Tony Waite	Director of Finance	In attendance:	
Mr Alan Kenny	Director of Estates and New Hospital	Ms Clare Dooley	Head of Corporate Governance
Mr Mark Reynolds	Chief Information Officer	Ms Bethan Downing	Head of Learning & Development

1. Welcome, apologies and declarations of interest	Verbal
Apologies were received from Ms Dutton, Mrs Goodby and Ms Barlow.	
2. Minutes of the previous meeting	SWBMPA (03/18) 001
The minutes of the meeting held on 16th February 2018 were accepted as an accurate record.	
3. Matters arising (action log)	SWBMPA (03/18) 002
• Taper relief action outstanding / to be resolved. • IT actions closed • Capital actions to remain on the log and updated at the next meeting.	
4.0 IT: Infrastructure 4.1 Informatics Infrastructure Scorecard	SWBMPA (03/18) 003

Mr Reynolds provided a paper on RAG rating definitions and detail on tackling red and amber risks over the next 18-24 months. Mr Reynolds advised one of the red risks related to WAN issues which should be reduced to amber by end of April 2018 and he is meeting with a new supplier week commencing 26th March 2018 to progress this.

Mr Lewis queried if any amber risks are likely to impact the running of the business (and in potentially escalated to red) and Mr Reynolds responded that the main business as usual risks, which generate most contact to the helpdesk, are printer fault and failure issues which impact both clinical and administrative staff. This issue remains a constant (and legacy issue) and generates the most calls. It was noted that full implementation of Unity will mitigate this issue in the longer term.

Mr Lewis asked if the WAN and LAN storage issues might escalate into more significant risks and how resolution on these can be assured before that point. Mr Reynolds replied that Unity will improve LAN and wifi will also improve once the LAN is fixed (with funding from NHS Digital to support this). Mr Reynolds advised there is a new Head of Service in place and he is contracted on a results of improvement (performance) basis, by addressing and resolving the "red" issues.

Mr Reynolds commented that the N3 network which connects the site to the wider NHS is old and has "go slow" periods. He further advised 2 storage areas will be closed and external expertise has been secured to complete this. Mr Reynolds will provide an update on this at the next meeting.

Mr Hoare asked about data centre environmentals in place and Mr Reynolds replied that environmentals are monitored regularly via alarms and temperature testing with a robust/complete data-set checklist in place to enable this.

Mr Reynolds agreed that the WAN issues will reduce to amber by end of May 2018, and there were no other individual issues which should escalate to red, but a number of combined issues could result in an escalated (red) rating, and if this occurs will be reported to MPA as a priority issue.

5.0 IT: EPR 5.1 Unity Milestone Criteria	SWBMPA (03/18) 004

Mr Reynolds confirmed this report was provided to the public board and he highlighted the requirement for the 2 dress rehearsal dates. A smaller scale rehearsal in April, which will be led/sequenced for clinical staff by Ms Barlow (to explain the product more widely and in more detail), and then at the end of June the wider full dress rehearsal will take place.

Mr Lewis asked for the final decision point on complete implementation success and Mr Reynolds advised this is ultimately decided by the rosters (working backwards on an 8 week plan), and the decision point would be mid May, but in reality the decision will be made on back of first dress rehearsal.

Mr Lewis asked what we will know at end of May that we don't know now and Mr Reynolds reiterated clarity would be dependent on feedback from the first dress rehearsal.

Mr Lewis asked for an update on staff knowledge/training. Mr Reynolds had issued a survey and results are starting to be returned. Mr Kennedy is working on the report from the responses to provide evidence of the state of readiness. Mr Lewis asked about workflow changes (patterns, style and policy) as he was concerned this should be focussed on prior to the end of August to enable staff to have time to prepare/transition through the change process with support. Mr Reynolds advised the Executive team will need to make sure the implementation plan considers this in real terms and Mr Lewis asked for the readiness checklist to be reported to MPA in May for assurance to the Board in June. Ms Barlow Chairs the implementation group where live issues of change risks are considered and a hot-spots list of issues can be produced from these discussions.

Mr Samuda asked if there is a risk analysis undertaken by Cerner and Mr Reynolds confirmed this is a national standard for risks/hazards to be considered and reported, and this has been provided to the public board.

Estates 6.1 Update on the Hospital Company Progress	Verbal

This item was discussed in the Private Trust Board meeting which took place immediately prior to the Major Projects Authority Meeting, and minutes of that meeting are recorded/provided separately.

7.0 People and Organisational Development 7.1 People Plan 2018/19 Goals Alignment	SWBMPA (03/18) 006

Ms Downing referred to paper provided for the meeting, which the People and OD committee had also received/ discussed. The alignment of goals for MPA oversight is the focus on cross programmes work, shared risks and how these are joined up.

Mr Lewis noted that long-term workforce modelling is aligned to both committees (MPA and People and OD) and felt this oversight should be provided by one. It was agreed this issue would be discussed by the Executive Group and confirmation of this decision will be provided to the next MPA meeting. Mr Waite commented that the Finance and Investment Committee also discussed this issue (the triangulation of plan/money/workforce) and agreed a definitive

view on oversight would be welcomed. Mr Hoare felt recruitment and retention should be added to the list, however clarity of the "ask" of the HR Team for each committee will need to be agreed.	
8.0 Meeting Effectiveness	Verbal
The members were of the view the meeting had facilitated useful discussions.	
9.0 Matters to raise to the Trust Board.	Verbal
• Unity milestones and actions approved • Midland Met update	
10. Any Other Business	Verbal
No other items of business was discussed.	
Date and time of next meeting	
The next meeting will take place on Friday 20th April 2018 at 9.30 am in Room 13, The Education Centre, Sandwell General Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE UPDATE	
Date of meeting	27 April 2018, 10.45am – 12.15pm
Attendees	Ms. O. Dutton (Chair), Ms. M. Perry, Ms. R. Barlow, Mr. D. Baker, Ms. E. Newell, Dr. D. Carruthers, Miss K. Dhami and Ms. C. Dooley
Apologies	Apologies were received from Mr. R. Samuda
Key points of discussion relevant to the Board	• Patient Story for May Board : A patient and his partner will be attending this month's Board meeting to tell the story about the care they have received from the Trusts Alcohol Support team. The alcohol team and the DDD team worked together to ensure he and his partner were both supported on their journey. • CQC Improvement Plan : Progress Report : The CQC Improvement Plan Progress Report was tabled and discussed. 106 ations have been implemented as at the end of March 2018. Of those remaining, 2 continue, with the Board's approval to be ongoing with external assistance and 23 are behind schedule but are in the process of being implemented with some actions already in place. • Integrated Quality and Performance Report : the year-end delivery of performance across the IQPR was summarised in the supplement summary: the Trust completes the year with some very robust and sustained delivery across the year in a number of key areas along with some challenges. Successes include: CDiff target , MRSA; RTT and Cancer which has had a couple of dips but has achieved each quarter. Challenges were briefly outlined. CQUINs 2017-18 Q4 reporting is due at the end of April. Expectation is delivery of 90% which is a strong result. Risks identified were briefly outlined. The IQPR was issued on WD5 to key stakeholders for April. There were some gaps which we will work through to get the best version on WD5 and work is continuing to be carried out. All of the red indicators have now been categorised between Resolve, Improve or Tolerate. This allows us to put more effort into the resolve effort. • Persistent Reds : Plans to address non-compliance A summary of performance up to March 2018 was outlined. Resolve items have moved largely into the right direction through March. Worthy of mention in March are: the Neutropenic Sepsis performance (91.3% with just 6 minutes being the step to success); Emergency Care Unplanned Re-attendance rate that fell from 7.9% to 5.3% (just 0.3% to go); and PDRs that rose from ~73% to 82%. Sickness remains stubborn and is perhaps worthy of trying some new ideas to make an impact along with a staged target. • Neonatal Peer Review Report and Trust Response : The Directorate are working towards the action plan to ensure safe consistent, safe staffing of the neonatal unit. A further update is to be provided in September. • Amenable Mortality : Previous submissions on mortality data have focused on descriptions of the different indices used and the methodology to calculate the comparative data. Factors that influence the data had been explored. In 2014 a Mortality Development Plan was produced which was reviewed at the monthly mortality meeting, with tracking of items from that plan. This plan has been reviewed and items aligned with the National Quality Board Learning From Deaths Guidance from March 2017, prioritising areas to improve mortality rates at SWBHT. This aligns with clinical areas identified for improvement in the Quality Plan which is currently under review. One of the main factors in mortality is sepsis and at the last Q&S an update was requested on data previously presented with a plan to improve outcomes, which was explained and discussed in detail. The plan for improving mortality was tabled at the meeting and discussed. A Sepsis flowchart will be presented to the

QUALITY AND SAFETY COMMITTEE UPDATE	
	Board. • Maternity Summit Action Plan : The Board was asked to note the completion of all actions relevant to the previous Perinatal Mortality Action Plan. Progress on actions arising from the Maternity Summit - most notably related to the successful completion of early reviews. Work has been initiated with support from the Communication team to focus on dissemination of learning, communication and staff engagement. The Perinatal Mortality Review Board (PMRB) is now established (inclusive of patient representative and external expert representative), well ahead of other Trusts who have yet to implement. • Draft 2017/18 Quality Account : The 2017/18 annual Quality account detailed the Trust's performance for 2017/18 was outlined. It included our performance against a range of quality and safety indicators, against the priorities we set ourselves for the year and against our agreed CQUINs for the year. The account also documented the priorities we have set ourselves for the forthcoming year. • Quality Plan : The Quality plan was put on hold 12 months ago to allow focus on the Safety Plan. It is now time to look at the process for implementation of the contents of the quality plan. The original aims of the plan have been reviewed with likely areas identified for initial project work. These will overlap with issues identified from mortality data. The projects will be carried out in association with the relevant clinical teams, by adopting a quality improvement strategy in conjunction with the Improvement team. The aim is to build on the need for trainee doctors to be involved in quality improvement projects as part of their training. By combining the support from corporate teams with the enthusiasm of trainees in their chosen subject areas (hopefully in conjunction with business managers) we hope to develop a process by which the broad reaching aims of the quality plan can be achieved while trainees develop greater understanding of the process for effective quality improvement. • Complaints Report : Q4 : The Complaints Report provided a summary of complaints received during Quarter 4 2017/18, breaking down these complaints by Clinical Groups and Corporate Directorates, themes of complaints and learning as a result. Of particular note a total of 239 formal complaints, and 518 informal complaints were made against the Trust in Q4 2017/18. At year end 92% of complaints had been responded to within the 30 day target, an improvement on last year. The high number of complaints (73%) partially or fully upheld was called out as positive and demonstrated an organisation that was open to patient feedback and learning. A update report was given on the first 2 months of the Purple Point initiative. Detailed were calls received and how they were managed.
Positive highlights of note	The meeting discussions were felt to be useful and constructive.
Matters to escalate to the Board	The Committee wished to bring the following matters to Trust Board's attention; • Update to IQPR and Persistent Reds • Management of Sepsis • Neonatal Plan Review • Mortality Reviews
Matters presented for information or noting	See above.
Decisions made	There were no specific actions beyond those being progressed by management
Actions agreed	No specific additional actions beyond those being progressed by management.

Olwen Dutton
CHAIR OF THE QUALITY AND SAFETY COMMITTEE MEETING
For the meeting of the Trust Board scheduled for 3 May 2018

Sandwell and West Birmingham Hospitals NHS

NHS Trust

QUALITY AND SAFETY COMMITTEE MINUTES

Venue Anne Gibson Committee Room, City Hospital **Date** 23rd March 2018; 1045 - 1215

Members attending:

Ms. O. Dutton	Non-Executive Director & Chair
Ms. M. Perry	Non-Executive Director
Mrs. E. Newell	Chief Nurse
Mr. D. Baker	Director of Partnerships and Innovation
Ms. R. Barlow	Chief Operating Officer
Dr. D. Carruthers	Medical Director

In attendance:

Ms. A. Binns	Deputy Director of Governance
Mrs. S. Cattermole	Executive Assistant

Minutes	**Paper Reference**
1. Welcome, apologies for absence and declarations of interest	***Verbal***
Apologies were received from Mr. R. Samuda, Miss K. Dhami and Ms. C. Parker. The members present did not have any interests to declare.	
2. Minutes of the previous meeting	***SWBQS (03/18) 002***
The minutes of the previous meeting held on the 23rd February 2018 were approved as a correct record.	
3. Matters and actions arising from previous meetings	***SWBQS (03/18) 003***

The following matters and actions from previous meetings were discussed. All other items for discussion were agenda items.

- ***Purple Point : Delivery Plan Update*** – An update was provided on the launch of the 'Purple Point' previously referred to as the purple phone. Since *'go live'* date of 27 February 2018 at Sandwell and Rowley Regis Hospitals and the following day (28th February 2018) at City Hospital, 11 calls have been received, of which 5 were compliments. Flyers and posters in various languages are being distributed to all clinical groups and the executive. An automated activity report will be provided on a monthly basis and increased to weekly once numbers start to increase. Ways of promoting the service were briefly discussed and staff will be encouraged to support the service on their wards.

- ***In-house Inspections Feedback*** – Ms. Binns gave an update on the in-house inspections that have taken place around the Trust over the last couple of weeks. Areas covered so far include ED, Wards at Rowley Regis and the Birmingham Midland Eye Centre. A further three wards in Medicine were being inspected later in the day. Results from the inspections carried out so far have been found to be quite positive. More inspections around the Trust are planned over the coming weeks.

  There was a query raised in the last round of inspections about the cleanliness of wards, Ms. Dutton asked if this is being raised again. Ms. Binns advised that the checklist is based on the actions we have taken to address the 'must do' and 'should dos' which were outlined in our CQC Inspection report of 2017. The primary aim of the inspection is to check that actions have been taken and they are embedded and will be assessed by

observing in practice or asking patients or staff. The issue of cleanliness on the wards (ie wear and tear, painting etc.) will be picked up by the Estates team.

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

Ms. Newell informed members that the Patient Story at the April Board will be a young lady who is visually impaired will be attending the Board for this month's patient story. She will be telling her story about the level of help she gets when she attends her appointments with her assistance dog. The patient has also agreed to assist in making a video for staff to help with advice on rules of engagement with visually impaired patients.

5. CQC Improvement Plan: Progress Report	***SWBQS (03/18) 004***

A report was presented by Ms. Binns updating the Committee on the progress of actions that were targeted for completion at the end of December 2017. 131 actions were detailed in the CQC report from our March 2017 inspection. 57 were identified to be completed by December 2017 with the remaining 74 having a due date of March 2018. 43 of the December deadline actions have been completed. Of the remainder, 11 are currently on track to meet the revised dates. Two are not going to be completed by March 2018 due to requiring external assistance to complete. Both actions have a plan for completion and have Executive oversight.

Validation is in progress with some results from early audits showing encouraging results. Data on ED re-admissions is showing very slight improvement and this will hopefully improve month on month. Some actions have already been completed ahead of their March 2018 due date. Monitoring of actions is ongoing through March 2018.

On-going progress in the delivery of the Improvement Plan will continue to be monitored by the Board Quality and Safety Committee and the Executive Quality Committee.

6. Integrated Quality and Performance Report	***SWBQS* (03/18) *005 & 006***

The IPR and Persistent Reds data were discussed. Concerns were raised as to the incompleteness of the report in certain areas. The Group were informed that work is taking place on action plans and these will be presented to the Board in April.

Due to the commitments on Groups and broader teams it is felt that the concept of prioritisation and pragmatic planning is a strong one. It was agreed that we should re-look at the ones that we feel will really make the difference and the levels to which we can improve them over a reasonable time scale. The recommendation is that this is worked through in OMC/CLE and from which a re-categorisation is made and plans subsequently built to achieve improvement/resolution is the prioritised areas. This approach would also give us the chance to sort out a few anomalies around measures.

The following items were discussed in more detail :

Readmissions have increased to 7.8%. Care needs to be taken that this is not a negative reaction to the focus on LOS reduction drive. Ms. Barlow confirmed that she has no concerns as the increase is due to flu and norovirus. The team are keeping a close eye on the statistics and work is being done to reduce the figures.

CDiff – compliant with target year to date x26 cases vs 28 target; February in month 4x cases; full year target set for 30, hence tolerating 4 breaches in March.

62 day cancer non-compliant at 81.9% in January (reporting in arrears) vs. target of 85%; however, recovered for February to 86% (un-validated) and March is also expected to deliver the standard, hence securing Q4 overall performance. Impact of prospective changes to oncology services on measured performance being assessed & could risk future compliance. All other cancer standards continue to perform to required standards.

WHO Safer checklist - Variation in performance and again improving in February, but needs to be sustainably achieved. Dr. Carruthers confirmed that work is being done with medical and surgical teams.

A new version of the IPR and Persistent Reds will be brought back to the April Quality and Safety Committee

meeting.

7. Learning from Deaths Progress Report	***SWBQS (03/18) 007***

Dr. Carruthers outlined the report circulated which was an update from the last report sent in February and highlighted the progress with medical examiner recruitment, mortality reviews and external data submission.

Dr. Carruthers reported that since the last Quality and Safety meeting, an appointment of 3 more medical examiners has been made, one of whom can offer up to 5 sessions of work in this role. Other avenues of recruitment to post of medical examiner via local GPs or clinical groups providing up to 5 clinical sessions as part of a portfolio career for individuals will continue to be explored as needed. The plan is to implement the medical examiner role at Sandwell initially. A half day meeting for all 10 medical examiners is arranged for later this month by Dr Cobb, lead for LFD process. The plan is for the system to be fully implemented by August/September. A quarterly report will be brought back to the Quality and Safety Committee.

8. Clinic Cancellations : 3-monthly review	***SWBQS (03/18) 008***

Ms. Barlow presented the progress update on the changes made to the clinical cancellations process.

The report discussed was an update from the last report sent in February that highlighted the number of clinic cancellations and the cancellations through ERS. At the August Committee we highlighted the clinic cancellation form that had been amended so that every time a clinic is cancelled the speciality has to clearly identify where they are moving the patient to, ensuring the appointment is re-arranged. This process is now embedded and used on every clinic cancellation.

The report discussed provided an update on the 3 points above illustrating the on-going improvement to a clinic management and scheduling process.

The booking of patients whether they have had an appointment cancelled or not, is to book in chronological order to ensure equitability. This has been the working practice of the elective access team for over a year now and is monitored through our new booking report. This continues to decrease waits for new outpatient appointments, reducing complaint numbers from patients.

To ensure the processes are sustained, we will, by the end of April have centralised all New Outpatient booking into Elective Access team with the Follow up booking to be transferred by the end of July. This will ensure that one standard is used across the trust and all patients are booked in chronological order with more accurate management information to evidence this.

9. Neonatal Peer Report and Trust Response	***SWBQS (03/18) 009***

Ms. Newell gave an update on the recent visit from the NHSE Quality Surveillance Team who visited SWBH neonatal services on the 9/2/18 to complete the scheduled peer review. The visit comprised of observations and a walkthrough of the neonatal services / pathways whilst visiting the neonatal unit, interviews with members of the MDT regarding neonatal service provision and a group discussion with the MDT to explore and answer identified key lines of enquiry. It was reported that comments received back were positive. Staffing issues were picked up as a concern. The department is functioning at level 3 but staffed for level 2. Discussions are taking place to share work with other Trusts. Risks were briefly discussed and Ms. Newell confirmed that no risks to patient safety were identified. The team are monitoring safety measures and work is being done to find a solution and get an action plan in place. Ms. Dutton asked for a follow up report to be brought back to the Quality and Safety Committee in 6-months' time.

ACTION : Neonatal Peer Report Trust Response Update to be given at September 2018 Q&S Meeting.

10. Maternity Summit Action Plan	***SWBQS (03/18) 010***

Ms. Newell informed members that the plan from maternity following the safety summit has been drafted by the Directorate but requires sign off by the Group at their Governance Board. The final report will be presented to the April Quality and Safety meeting once it has been seen and signed off by the CEO.

11. Gynaecology/Oncology Ward : Quality Issues Case	***SWBQS (03/18) 011***

Ms. Newell gave a summary on the staffing shortages and details on how we are currently mitigating the risk of a reduced quality of service delivery to our patients and ensuring that quality and safety remains our primary focus. Work is taking place to look at the patient related quality and safety indicators that we are monitoring and how we can seek assurance.

12. Sepsis : Briefing Note	***Verbal***

Dr. Carruthers provided an update around the current national and local initiatives in management of sepsis at SWBHT and data from sepsis team to show performance at the Trust. Local initiatives around sepsis management have been communicated via Hot topics and focus on a sepsis awareness campaign.

The Deteriorating Patient & Resuscitation Team have developed an adult sepsis screening sticker that may help aid the screening of sepsis on acute ward settings and meet national guidelines. This could reduce paperwork, safeguard staff and promote appropriate escalation of patients. The tables were looked at in more detail and the number of serious incidents associated with Sepsis were briefly discussed.

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

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

- Management of Sepsis
- Neonatal Plan Review
- Mortality Reviews

14. Meeting Effectiveness	***Verbal***

The committee agreed that the meeting discussions were useful and constructive.

15. Any other business	***Verbal***

Ms. Perry requested that the Board Assurance Framework be presented to future Quality and Safety Committee meetings.

ACTION : Board Assurance Framework to be presented to future Q&S Meetings.

16. Date and time of the next meeting

Next meeting: 27 April 2018 at 10.45h in Room 13, Education Centre, Sandwell.

Signed ……
Print ……
Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FINANCE & INVESTMENT COMMITTEE MINUTES

Venue: Anne Gibson Committee Room, City Hospital **Date**: 23 March 2018, 0900h – 1030h

Members present:		**In attendance:**	
Mr Mike Hoare	Chair	Ms Dinah McLannahan	Deputy Director of Finance
Mr Harjinder Kang	Non-Executive Director		
Mrs Marie Perry	Non-Executive Director		
Mr Tony Waite	Director of Finance		
Ms Rachel Barlow	Chief Operating Officer		
Mrs Raffaela Goodby	Director of People & Organisation Development	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 Mr Richard Samuda. The members present did not have any interests to declare.	
2. Minutes of the previous meeting held on 23 February 2018	**SWBFI (03/18) 002**
The minutes were agreed as a true record.	
2.1. Matters arising and update on actions from the previous meetings	SWBFI (03/18) 002(a)
The Committee noted that there were no on-going actions.	
3. Financial Performance – P11 February 2018	**SWBFI (03/18) 003**
The Committee noted that the headline year to date surplus is £3.842m, being £8.029m ahead of plan and is a significant positive variance. This was noted as being driven by the use of non-recurrent technical items; mainly the profit on land sale. The Committee noted the underlying position to date is a deficit of £26.006m, an adverse variance to plan of £9.807m. Underlying pay costs were noted to remain stubborn at £25.928m; with agency spend slightly increased at £1.283m (vs. £1.077m in P10). This was noted as being driven by unfunded beds being open, although the unfunded beds CIP had now been mitigated by the receipt of £0.95m winter money. Mr Waite advised the Committee that the recently announced pay awards go beyond the Trust's financial plan and would therefore expect additional funding to be centrally allocated. Based on the development of the recovery plan, together with the key assumptions, the £8m deficit forecast (pre-STF) was updated to a (pre-STF) deficit of £3.951m compliant with Control Total. The benefit of securing compliance with Control Total would be recovery of £2.6m of STF in respect of Quarter 4. The Committee noted the key assumptions underpinning that forecast; specifically that the Trust and SWBCCG have agreed a full year contract sum at £264.5m; £17.4m CIP delivery - current projection to year end £15.6m; Production	

Plan delivery of £110m - £1.779m off track ytd with challenging projection which has been mitigated by emergency activity to some extent and the year-end deal with SBWCCG; £4m additional CIP+ stretch delivery – identified, mostly non-recurrent. Additional non-recurrent opportunities to be identified through the process of listing risks and upside opportunity.

The Committee challenged and confirmed the prospective delivery of key assumptions and residual scope for mitigation. Specifically, the Committee challenged the financial performance in March that would be compatible with control total compliance and was advised of the potential headroom presented by residual net opportunities.

The Committee considered the merits or otherwise of using any such headroom to over-achieve the Control Total and earn 'bonus' STF. This was noted as likely being of immediate £ for £ benefit and real additional cash. The Committee supported the Finance Director in making such judgement in drawing up the full year results.

Capital spend at £19.3m was noted as being £2.4m behind revised plan to date. The capital Control Total of £26m has now been agreed by NHSI.

Cash balances were noted as being ahead of plan and any borrowing requirement is now expected in 2018/19.

4. Financial Plan 2018-19 Update	**SWBFI (03/18) 004**

Mr Waite reported that there were no significant changes to the construct of the plan previously reported to the Committee.

The Committee received and noted the paper that set out the assumptions, together with the further work required to achieve compliance with its Control Total for 2018/19, prior to final plan submission on 30th April.

The Committee noted the CIP plans and that there was a genuine route to increase activity. Specifically, it noted the assurance piece of work that was being undertaken with the specialities that weren't being fully utilised and the opportunities therein. It was noted that a more detailed CIP update, to include production planning, was to be presented at the Private Board session in April. Ms Barlow committed to providing further information in respect of demand, capacity and productivity underpinning the plan and the reasons for confidence in that generating the margin proposed in the financial plan.

The Committee gave due consideration to the question of whether the Trust accepts or rejects its financial control total for 2018/19. Mr Waite advised that this could appropriately be considered as representing two discrete matters – financial incentives and good governance.

In respect of the former he indicated that there was clear merit to accepting the control total – it provided access to a potential £14m of STF payments and moderation of exposure to contract fines and penalties.

This was not, however, sufficient and good governance required that acceptance be based on a credible financial plan. Mr Waite suggested that that could appropriately be a plan with risk but required at least one plausible route to control total achievement to be determined.

Mr Waite drew attention to the progress on CIP development and the plausible commercialisation opportunities that are work in progress and noted that there was a significant gap remaining to be closed. His contention was that further work may provide for a plausible route to control total compliance.

The Committee challenged and confirmed the basis for consideration of the control total compliance question. The Committee agreed that there was no compelling reason for rejection of the control total, however, the output of further work was necessary and the matter should necessarily be considered by the Board.

5. eCommunications & Centralised Printing	**SWBFI (03/18) 005**

The Committee challenged and confirmed the process of procuring a printing and postage service in relation to the Trust's e-Communications and Centralised Printing Project. It noted that the proposal aligns with the Trust's I.T strategy and financial plan. The Committee gave its recommendation to the Trust Board for approval.

6. Strategic Board Assurance Framework Q3	**SWBFI (03/18) 006**

Mr Waite reported that there were no other material changes to the Quarter 3 Strategic BAF to what had previously been reported and that were pertinent to the Committee. The Committee received the update and noted the risks aligned to it.

7. Matters to highlight to the Trust Board and Audit & Risk Management Committee	**Verbal**

The Committee wished to highlight the following matters: • Forecast outturn for 2017/18 remains positive; • Financial Plan: Control total and STF recovery/undertakings; • Financial Plan: confirm supply and demand plan route to margin; • Capital programme commitments and affordability – review on back of Q1 results.	
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 other items of business.	
Details of the next meeting	**Verbal**
The next Finance and Investment Committee meeting will be held on 27th April 2018 at 0900h – 1030h Room 13, Education Centre, Sandwell General Hospital.	

Signed ……..

Print ……..

Date ……..

Paper ref:	TB (05/18) 007

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Organisation Wide Issues - Summary for April 2018		
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

The Board might usefully discuss, among other matters and questions:

(a) The coherence and risks associated with our plan to maintain financial balance in 2018-19 and 2019-20. This plan excludes any new costs associated with the delay to the Midland Metropolitan Hospital opening which are assumed to be addressed through additional taper relief arrangements via NHS England. At the time of writing no contract variation is agreed with NHS England to support investments in neonatal staffing, gynae cancer surgery or solid tumour oncology, but negotiations to that effect continue.

(b) The resilience of our IT infrastructure and continued issues and pressures created for frontline staff by the instability of the system.

(c) The mobilisation programme associated with the Trust's Quality Plan 2018-2020, which will return to the Board for our June meeting.

(d) The route to concluding negotiations associated with both opening Midland Met and any termination should that be required of the existing provider (THC). The Early Works Contract to restart work, which we expected to commence in March, remains unapproved and unexecuted.

(e) Expectations for the upcoming second Trust-wide Speak Up Day, which takes place on May 16th. The Board received detailed information in January on the historic issues flagged by local teams from our first Speak Up Day, as well as the immediate issues raised by staff.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan		Public Health Plan		People Plan & Education Plan	X
Quality Plan	X	Research and Development		Estates Plan	X
Financial Plan	X	Digital Plan	X	Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

N/A

4. Recommendation(s)

The Trust Board is asked to:

a. Note the contents of this report.

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s): 3020 and 3021					
Board Assurance Framework		Risk Number(s): BAF 5 and BAF 10					
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

Public Trust Board

May 2018

It is immensely pleasing to end 2017-18 reporting a financial surplus at, or indeed above, that expected. That is a distinctive achievement locally and one due to the work of staff across the organisation. It has allowed us to invest in quality, for example through our NIV unit, or through recruiting more midwives, and it provides a good basis for 2018-19 and beyond. The financial challenge becomes harder yet, but until we match or exceed "model hospital" metrics there is an acceptance by our senior clinical leaders that there is scope to do better still. Continuing to stretch services across two acute sites militates against success and that delay and deferment is reflected in our very significant bid for additional "taper relief" resources to reflect the Carillion delay. The suggestion that such funds might come in the form of an interest bearing local loan appears to run counter to the idea that the cost of delay would not be borne by the local NHS.

It is though frustrating to enter 2018-19 with further and renewed IT infrastructure issues. These have bedevilled the Trust, our staff and our patients for two years now. The Board recognised and prioritised investment in 2014 and we are drawing to the end of that investment programme. That said, we are in effect retiring decade old equipment, and are a few months away from replacing the 2010 equipment. By 2020 we have to have replaced our 2015 stock and must test that our 2020-2030 capital expenditure ideas are consistent with an ongoing replacement commitment. Again the Midland Met delay has regrettable relevance, in that our "non-retained estate" will need to have funds spent on it to permit use beyond 2019, outwith our current funded plans. As we discuss in the Unity deployment paper in today's Board we will not be able to proceed to deploy Unity in August unless we have resolved in May the remaining major infrastructure issues, such that we have a ten week period of stability prior to go-live.

1. Our patients

Consistent with our commitment to openness and transparency, we consider as a Board the learning from the 2017-18 Serious Incidents experienced by our patients and indeed staff. It is clear that there is more we must do in a number of areas of clinical care, including the management of head injuries and spinal cord decompression. Whilst that makes us no different to any NHS organisation, what must be true is that we find best practice inside and outside our Trust and make sure it happens consistently in here. Within that we are looking to find ways to remove the risks of human error, and the deployment of our new EPR, Unity, must give us benefit in that regard, perhaps especially around prescribing. We replace paper systems with electronic systems, but in addition the HIE link means that, for the first time locally, our clinicians will be able to see precisely the medications prescribed and dispensed beyond our walls, in particular in general practice. In 2016 when we were building collaboratively our quality and safety plans across the organisation medicines reconciliation was the single most common issues raised by our staff, and was considered the most vital marker of care integration too. Within three months we will have the tools to deliver.

The implementation of the safety summit outcomes in maternity is providing an opportunity to test something of huge relevance of all of our quality endeavours. How best to share knowledge, and

policies, and to create permission to challenge practice deviation. The Clinical Leadership Executive is committed to learning from that deployment example over the next three months. At the same time within our new SWB TeamTalk team brief system we highlight now good practice each month, under the banner of Learning From Excellence. The written material is appended to my report. Tammy Davies' presentation focuses on how we have used a mandatory feedback loop on the quality of discharge between our wards to drive up standards. Two facets of that implementation are generalizable and relevant – the use of feedback on every discharge depersonalises the evaluation, making it less 'challenging' for staff when commenting on a colleague's practice, and the clinician to clinician conversation makes it less likely that individuals will repeat mistakes.

The Consistency of Care LiA benfitted during April from large scale attendance and illustrated again the focus of frontline clinicians and the executive on introducing better care into medicine inpatient care. What was encouraging about the event was the vocal role taken by individuals in challenging peers but also the key leadership role now being played by the Group and Directorate leadership teams. The data flow for consistency of care is now strong and it is possible to see in our community wards, medical wards and ED specific measurable improvements in delivery of key clinical standards. If we are to achieve our Going for Good aim we know that medicine and urgent care is absolutely critical. Given the challenge created by prolonged dual site working it is even more important that we do what we can to drive up standards.

The publication of our annual report will illustrate the continued good practice we have in place around the management of complaints, now augmented by our Purple Point service. As with incidents, we need to see complaints as a key opportunity to learn, not just locally but Trustwide. The governance team is being reorganised to ensure that each Clinical Group now has a local service business partner able to support that process. The Executive Quality Committee has been in place for six months and is now showing promise in driving change across our groups. It will increasingly be the place where all matters of safety and quality are driven, recognising the assurance role provided by the Board's quality and safety committee. Group Directors are to the fore in the EQC, and in particular will take a personal accountability role in each SI action plan. We have not had a Never Event now for some time, but clearly the same approach would apply in those cases.

2. Our workforce

We entered Q1 2018-19 with a number of programmes requiring rapid deployment towards our aim of better line management of our staff.

- Between Apri l and June we intend to have undertaken a PDR on all employees and at time of writing 5,200 of our staff are booked for that purpose, from 6,600. We will implement the escalation protocol for any unbooked individuals by May 13th but should, I would suggest, be very encouraged by take up to date. Of course the challenge is to convert appraisal time into meaningful objectives and two way feedback. We will set out the detail of that to the Board over the summer via the people and OD committee. Notwithstanding the complications of the national pay award process we would expect to enter 2019-20 with fair ratings for performance and potential in place for everyone within our organisation.

- The Accredited Line Manager programme seeks to passport over 700 individuals through a series of competency enhancing peer group learning exercises. This will be augmented later

in the year with a 360-degree feedback programme and the opportunity for many individuals to volunteer to be and to have mentors and engage in coaching qualifications. We will, as part of that, as our work on engagement, undertake again our organisational climate study, which we undertook with Hay/Korn Ferry in 2015-16. That showed limited role scope for multiple leadership styles, despite a moderate blend of capability to deploy different styles across the top leaders of the Trust.

Of course our recruitment – and certainly our retention - and sickness endeavours both rely upon, and reflect our progress in, developing our immediate line managers. We have a follow up paper on sickness in today's Board meeting, seeking to target hot spot areas, and we have adopted that focused approach to recruitment over the last twelve months with some success. We have made much of progress on nurse recruitment, and recognise the risk that Midland Met delay poses to our position. We also need to recognise that material gaps remains, and going forward we will seek to report much more clearly teams within the Trust where vacancy rates exceed 5%.

Recognising the work we discussed in February, the clinical leadership executive continues to develop our engagement platform. We have explored several national best practice examples, and expect to participate in due course in a collaborative of like-minded organisations seeking to put into practice well researched interventions intended to improve advocacy, involvement and engagement across our staff base. We have some very engaged and participatory teams internally from whom we might learn what works here. To achieve our intention to obtain and sustain a good rating with the CQC we know that it is imperative that we do just that, however complex the situational context in which we are asking staff to operate.

Linked to the Board's decision to become a founding partner in the Black Country Pathology venture, we have commenced the relevant TUPE consultation associated with staff transfer. At this stage the broadest possible group of staff are involved in that dialogue, notwithstanding future decisions about specific services. Understandably this is an anxious time for this affected, as the new venture will mean relocation of workplace in a number of cases.

3. Our partners

We continue to work to create and deliver our Integrated Care System partnerships as a place level, and that is rehearsed below. The Sandwell Children's Trust is now live too, and we are working with them to see how we can contribute to a very detailed and specific improvement plan.

Beyond that, joint working is currently dominated by the delay position on Midland Metropolitan and the future or otherwise of THC (The PFI Special Purpose Vehicle). After many weeks of intensive work clarity and certainty continues to elude us all. What is apparent is that the site is deteriorating now and that rework costs will therefore be significant. We continue to press for an early restart and therefore the most rapid route to a single acute hospital, which in our view could be achieved by 2020. Some options being considered make a 2022 opening date more likely, with certainty not achieved until early next year owing to chosen procurement routes in an uncertain supplier market. Every reasonable representation is being made to frame the full facts and permit informed decisions. However, we do recognise that this is unprecedented territory and ultimately the approach taken will be shaped nationally and instructed locally.

We discussed at the prior Board meeting, and elsewhere, work on the clinical safety thresholds for our current configuration, and the likely need to relocate some services should Midland Met be materially delayed. Initial discussions with regulators have helpfully provided points of comparison against other parts of the NHS family, that said it is important that we set high standards for what our patients should expect, not least as that is the basis on which we will retain dedicated and committed staff who want to do a great job. It is recognising that reconfiguration will have an effect on other Trusts, in particular Walsall and Dudley, and we will use forums within our STP to explore timings and mitigations. The upgrade of the Walsall A&E department to accommodate changes associated with Midland Met was agreed in principle in 2016, but is not currently funded or subject to deployment as yet.

Within our private Board we will explore the latest commercial position. But we recognise the obligation to undertake our material business in public and will seek to make key documents and information available through our next public Board meeting, notwithstanding our AGM on June 22nd. I would expect by that point that the procurement route instructed by government will be apparent. It will also be clearer whether the funding required to support that option is being made centrally available. We are working to update our two risk register assessments and will issue those to Board members, prior to May's meeting.

4. **Our regulators**

Our CQC improvement action plan is reported within the Board and is broadly positive. However, progress in resolving paediatric ophthalmology issues across the region remains unacceptably slow. It was agreed at the Quality Summit in 2017 that this would met by a clear response across NHSE and NHSI and we will now seek to have those bodies bring parties together to find a resolution. The issue has featured on our risk register for many years and a need for constructive collaboration is evident.

We have previously discussed the serious concern issues arising from the region wide neonatal review. Although no direct harm can be identified within our service, we do not meet core quality standards on occasion. This reflects the acuity of babies with us, which in turn reflects capacity issue elsewhere. We have had productive funding discussions with NHS England and will not sign a contract for 2018-19 until that matter is settled. We would hope this can be done without having to close cots, which will exacerbate the issue both at the Trust and elsewhere.

5. Our STP and ICSs

Helen Hibbs has agreed to take over the as the Senior Responsible Officer (SRO) for the STP, replacing Andy Williams who has returned to his prior role. At the same time recruitment has now formally commenced for an independent chair of the STP, and a programme director. NHS England and NHS Improvement are holding monthly meetings with us, and the expectation presently is that we accelerate work to create place based vertically coherent partnerships, before identifying those areas for horizontal collaboration across the district. This latter piece will include further conversations about how specialised services for local residents might best be developed.

At the same, within SWB, with a population now of more than 700,000 work progresses to ensure that for both Sandwell and for western Birmingham we are taking the right steps to connect

services. Our Modality linked outpatient project is now live in seven specialties and creates a potentially duplicable model to alter how hospital consultation and primary care delivery connect. At the same time, through the SWB Urgent Care Board we are exploring the right offer to local residents between the expanded primary care capacity in place since autumn 2017 and our Emergency Departments, and in particular how we ensure attendees are clear when we will redirect care to a more appropriate setting.

Attached to this month's report are four annexes. The Freedom to Speak Up Guardians report is not yet ready for issue and will be circulated when it is. Our next Speak Up Day is on May 16th. Going forward I would expect the safe staffing data to form part of the IQPR item. The safe staffing data shows continued cause for concern about our gynae oncology ward staffing, which was reviewed last month at the quality and safety committee. Urgent discussions are taking place to seek further service mitigations to this position, which arises because of the challenge of recruiting to a service (complex surgery) in transition.

Beyond that our routine comms cascade, most senior operational meeting outbrief (CLE), and recruitment position will be standard monthly issue. The format of the recruitment report will be changed in coming weeks in order to give a clearer understanding of our position.

Toby Lewis, Chief Executive

April 26th 2018

Safe Staffing (Rota Fill Rates and CHPPD) Collection

For any techincal queries or additional clarification relating to the collection please contact: NHSI.Returns@nhs.net

For any queries or additional clarification relating to submissions please contact: data.collections@nhs.net

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Please check that the data on this upload template is accurate before being submitted to SDCS. You are reminded that these figures will be published, and it is the responsibility of your organisation that these submitted figures are accurate and in line with national guidance. We will undertake basic validation checks on these figures post submission, and may come back to you with any queries we may have.

RXK Sandwell And West Birmingham Hospitals NHS Trust

Validations
Please correct all issues listed within the tables below. If the issues are not corrected then the pro forma will fail the validation stage in SDCS.

Control Panel

Trust - Frontsheet

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Organisation: RXK Sandwell And West Birmingham Hospitals NHS Trust

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

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

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

Only complete sites your organisation is accountable for

Hospital Site Details			Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
					Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site Name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Critical Care - Sandwell	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	4208	3240	509	336	5704	2970	0	44	77.0%	66.0%	52.1%	-	265	23.4	1.4	24.9
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3565	3277	1426	1730	3565	3438	1426	1690	91.9%	121.3%	96.4%	118.5%	1197	5.6	2.9	8.5
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Older Persons Assessment U	430 - GERIATRIC MEDICINE		1242	1144	931	966	931	966	931	1023	92.1%	103.8%	103.8%	109.9%	593	3.6	3.4	6.9
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPA	930	606	372	384	1364	1287	341	374	65.2%	103.2%	94.4%	109.7%	479	4.0	1.6	5.5
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPA	1702	1633	1426	1489	1069	1069	1276	1445	95.9%	104.4%	100.0%	113.6%	877	3.1	3.4	6.4
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPA	180 - PLASTIC SURGERY	1736	1518	1782	1449	1069	1069	1782	1578	87.4%	81.3%	100.0%	88.4%	946	2.7	3.2	5.9
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1782	1661	1782	1592	1426	1357	1782	1678	93.2%	89.3%	95.2%	94.2%	1005	3.0	3.3	6.3
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 5 - Acute Medicine	100 - GENERAL SURGERY	300 - GENERAL MEDICINE	1782	1598	1782	1351	1426	1403	1782	1610	89.7%	75.8%	98.4%	90.3%	992	3.0	3.0	6.0
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon Ground - PAU/Adole	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPA	1116	1062	682	550	1023	957	341	297	95.2%	80.6%	93.5%	87.1%	417	4.8	2.0	6.9
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 3 - T&O	110 - TRAUMA & ORTHOPA	430 - GERIATRIC MEDICINE	1782	1656	1782	1541	1115	1138	1782	1621	92.9%	86.5%	102.1%	91.0%	911	3.1	3.5	6.5
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 4 - Stepdown/Stroke	314 - REHABILITATION	300 - GENERAL MEDICINE	1426	1345	1069	1058	1426	1380	1069	1048	94.3%	99.0%	96.8%	97.8%	863	3.2	2.4	5.6
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 5 - Haematology	304 - CLINICAL PHYSIOLOG	300 - GENERAL MEDICINE	713	730	356	327	713	713	356	356	102.4%	91.9%	100.0%	100.0%	393	3.7	1.7	5.4
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 2 - Colorectal/General	100 - GENERAL SURGERY		1782	1656	1069	1058	1426	1414	1069	1104	92.9%	99.0%	99.2%	103.3%	776	4.0	2.8	6.7
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2139	1753	1069	1052	1782	1782	1069	1012	82.0%	98.4%	100.0%	94.7%	679	5.2	3.0	8.2
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDI	301 - GASTROENTEROLOG	1426	1305	1069	1075	1069	1288	713	1046	91.5%	100.6%	120.5%	146.7%	942	2.8	2.3	5.0
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPA	1782	1690	713	644	1426	1449	356	358	94.8%	90.3%	101.6%	100.0%	526	6.0	1.9	8.0
RXK02	CITY HOSPITAL - RXK02	CCS - Critical Care Services	300 - GENERAL MEDICINE	301 - GASTROENTEROLOG	2976	3030	372	330	2728	2178	0	0	101.8%	88.7%	79.8%	-	216	24.1	1.5	25.6
RXK02	CITY HOSPITAL - RXK02	D5/D7 - Cardiology (Female)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	3565	3461	713	672	2852	3185	0	0	97.1%	94.2%	111.7%	-	937	7.1	0.7	7.8
RXK02	CITY HOSPITAL - RXK02	D11 - Male Older Adult	430 - GERIATRIC MEDICINE		1069	1052	1069	1006	1069	1035	713	713	98.4%	94.1%	96.8%	100.0%	630	3.3	2.7	6.0
RXK02	CITY HOSPITAL - RXK02	D15 - Gastro/Resp/Haem (Ma	340 - RESPIRATORY MEDI	301 - GASTROENTEROLOG	1069	1127	920	695	1069	1023	563	667	105.4%	75.5%	95.7%	118.5%	639	3.4	2.1	5.5
RXK02	CITY HOSPITAL - RXK02	D16 - (Female)	301 - GASTROENTEROLOG	340 - RESPIRATORY MEDI	1069	1063	1069	879	1069	1081	713	738	99.4%	82.2%	101.1%	103.2%	617	3.5	2.6	6.1
RXK02	CITY HOSPITAL - RXK02	D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	837	804	100	78	682	682	341	286	96.1%	78.0%	100.0%	83.9%	229	6.5	1.6	8.1
RXK02	CITY HOSPITAL - RXK02	D27 - City Surgical Unit (CSU	101 - UROLOGY	120 - ENT	1426	1109	713	615	1000	989	713	632	77.8%	86.3%	98.9%	88.6%	60	35.0	20.8	55.8
RXK02	CITY HOSPITAL - RXK02	D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1069	1063	1265	1029	1069	1058	713	759	99.4%	81.3%	99.0%	106.5%	627	3.4	2.9	6.2
RXK02	CITY HOSPITAL - RXK02	D17 (Gynae Ward)	502 - GYNAECOLOGY		586	528	411	294	744	744	372	360	90.1%	71.5%	100.0%	96.8%	394	3.2	1.7	4.9
RXK02	CITY HOSPITAL - RXK02	D43 - Community RTG	318- INTERMEDIATE CARE	430 - GERIATRIC MEDICINE	1426	1150	1426	1196	1069	1058	1069	1035	80.6%	83.9%	99.0%	96.8%	783	2.8	2.8	5.7
RXK02	CITY HOSPITAL - RXK02	D47 - Geriatric MEDICAL	430 - GERIATRIC MEDICINE		1069	989	1247	1178	713	621	713	701	92.5%	94.5%	87.1%	98.3%	550	2.9	3.4	6.3
RXK02	CITY HOSPITAL - RXK02	D25 - Female Surgery	101 - UROLOGY	120 - ENT	1276	1040	713	667	920	759	644	632	81.5%	93.5%	82.5%	98.1%	482	3.7	2.7	6.4
RXK02	CITY HOSPITAL - RXK02	Labour Ward - City	501 - OBSTETRICS		3921	3250	713	672	3921	3128	713	713	82.9%	94.2%	79.8%	100.0%	294	21.7	4.7	26.4
RXK02	CITY HOSPITAL - RXK02	City Maternity - M1	501 - OBSTETRICS	424- WELL BABIES	1069	1029	713	701	1069	989	356	368	96.3%	98.3%	92.5%	103.4%	411	4.9	2.6	7.5
RXK02	CITY HOSPITAL - RXK02	City Maternity - M2	501 - OBSTETRICS	424- WELL BABIES	1069	960	683	575	1069	989	356	322	89.8%	84.2%	92.5%	90.4%	414	4.7	2.2	6.9
RXK02	CITY HOSPITAL - RXK02	AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	4278	3927	1782	1736	4278	4059	1782	1725	91.8%	97.4%	94.9%	96.8%	1323	6.0	2.6	8.7
RXK02	CITY HOSPITAL - RXK02	Neonatal	422- NEONATOLOGY		2495	2394	713	510	2495	2376	744	516	96.0%	71.5%	95.2%	69.4%	640	7.5	1.6	9.1
RXK02	CITY HOSPITAL - RXK02	Serenity Birth Centre - City	501 - OBSTETRICS		1069	1167	713	460	1069	1081	356	529	109.2%	64.5%	101.1%	148.6%	34	66.1	29.1	95.2
RXK03	INGHAM MIDLAND EYE CENTRE (BMEC) - R	Ophthalmology Main Ward	130 - OPHTHALMOLOGY	180 - ACCIDENT & EMERGE	300	281	232	225	573	527	0	46	93.7%	97.0%	92.0%		149	5.4	1.8	7.2
RXK10	ROWLEY REGIS HOSPITAL - RXK10	Eliza Tinsley Ward - Commu	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	1069	862	1426	1311	713	713	1069	989	80.6%	91.9%	100.0%	92.5%	691	2.3	3.3	5.6
RXK10	ROWLEY REGIS HOSPITAL - RXK10	Henderson	318- INTERMEDIATE CARE		1069	851	1552	1420	713	667	1069	966	79.6%	91.5%	93.5%	90.4%	652	2.3	3.7	6.0
RXK10	ROWLEY REGIS HOSPITAL - RXK10	Leasowes	318- INTERMEDIATE CARE		1008	1014	1392	1230	744	732	744	744	100.6%	94.5%	98.4%	100.0%	565	3.1	3.5	6.6
RXK10	ROWLEY REGIS HOSPITAL - RXK10	MCCarthy	318- INTERMEDIATE CARE		1069	908	1420	1339	713	678	1069	1000	84.9%	94.3%	95.1%	93.5%	695	2.3	3.4	5.6

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Organisation: RXK Sandwell And West Birmingham Hospitals NHS Trust

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

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

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

Only complete sites your organisation is accountable for

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
					Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Critical Care - Sandwell	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	4208	3240	509	336	5704	2970	0	44	77.0%	66.0%	52.1%	-	265	23.4	1.4	24.9
		Total			64966	58933	39086	35420	58875	54032	30887	30721					23887			

Nurse Fill Rate' (Safer Staffing) data for March 2018

Ward name	Main 2 Specialties on each ward	Main 2 Specialties on each ward	Day	Day	Day	Day	Night	Night	Night	Night	Day	Day	Night	Night	Care Hours Per Patient Day (CHPPD)				Note
			Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff										
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	
Critical Care - Sandwell	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	4208	3240	509	336	5704	2970	0	44	77.0%	66.0%	52.1%	#DIV/0!	265	23.4	1.4	24.9	
AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3565	3277	1426	1730	3565	3438	1426	1690	91.9%	121.3%	96.4%	118.5%	1197	5.6	2.9	8.5	
Older Persons Assessment Unit (OPAU) -	430 - GERIATRIC MEDICINE		1242	1144	931	966	931	966	931	1023	92.1%	103.8%	103.8%	109.9%	593	3.6	3.4	6.9	
Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	930	606	372	384	1364	1287	341	374	65.2%	103.2%	94.4%	109.7%	479	4.0	1.6	5.5	
Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1702	1633	1426	1489	1069	1069	1276	1449	95.9%	104.4%	100.0%	113.6%	877	3.1	3.4	6.4	
Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPAEDICS	160 - PLASTIC SURGERY	1736	1518	1782	1449	1069	1069	1782	1575	87.4%	81.3%	100.0%	88.4%	946	2.7	3.2	5.9	
Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1782	1661	1782	1592	1426	1357	1782	1679	93.2%	89.3%	95.2%	94.2%	1005	3.0	3.3	6.3	
Lyndon 5 - Acute Medicine	100 - GENERAL SURGERY	300 - GENERAL MEDICINE	1782	1598	1782	1351	1426	1403	1782	1610	89.7%	75.8%	98.4%	90.3%	992	3.0	3.0	6.0	
Lyndon Ground - PAU/Adolescents	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	1116	1062	682	550	1023	957	341	297	95.2%	80.6%	93.5%	87.1%	417	4.8	2.0	6.9	
Newton 3 - T&O	110 - TRAUMA & ORTHOPAEDICS	430 - GERIATRIC MEDICINE	1782	1656	1782	1541	1115	1138	1782	1621	92.9%	86.5%	102.1%	91.0%	911	3.1	3.5	6.5	
Newton 4 - Stepdown/Stroke/Neurology	314 - REHABILITATION	300 - GENERAL MEDICINE	1426	1345	1069	1058	1426	1380	1069	1046	94.3%	99.0%	96.8%	97.8%	863	3.2	2.4	5.6	
Newton 5 - Haematology	304 - CLINICAL PHYSIOLOGY	300 - GENERAL MEDICINE	713	730	356	327	713	713	356	356	102.4%	91.9%	100.0%	100.0%	393	3.7	1.7	5.4	
Priory 2 - Colorectal/General Surgery	100 - GENERAL SURGERY		1782	1656	1069	1058	1426	1414	1069	1104	92.9%	99.0%	99.2%	103.3%	776	4.0	2.8	6.7	
Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2139	1753	1069	1052	1782	1782	1069	1012	82.0%	98.4%	100.0%	94.7%	679	5.2	3.0	8.2	
Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1426	1305	1069	1075	1069	1288	713	1046	91.5%	100.6%	120.5%	146.7%	942	2.8	2.3	5.0	
SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1782	1690	713	644	1426	1449	356	356	94.8%	90.3%	101.6%	100.0%	520	6.0	1.9	8.0	
CCS - Critical Care Services - City	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2976	3030	372	330	2728	2178	0	0	101.8%	88.7%	79.8%	#DIV/0!	216	24.1	1.5	25.6	
D5/D7 - Cardiology (Female)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	3565	3461	713	672	2852	3185	0	0	97.1%	94.2%	111.7%	#DIV/0!	937	7.1	0.7	7.8	
D11 - Male Older Adult	430 - GERIATRIC MEDICINE		1069	1052	1069	1006	1069	1035	713	713	98.4%	94.1%	96.8%	100.0%	630	3.3	2.7	6.0	
D15 - Gastro/Resp/Haem (Male)	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1069	1127	920	695	1069	1023	563	667	105.4%	75.5%	95.7%	118.5%	639	3.4	2.1	5.5	
D16 - (Female)	301 - GASTROENTEROLOGY	340 - RESPIRATORY MEDICINE	1069	1063	1069	879	1069	1081	713	736	99.4%	82.2%	101.1%	103.2%	617	3.5	2.6	6.1	
D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	837	804	100	78	682	682	341	286	96.1%	78.0%	100.0%	83.9%	229	6.5	1.6	8.1	
											#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	
D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1069	1063	1265	1029	1069	1058	713	759	99.4%	81.3%	99.0%	106.5%	627	3.4	2.9	6.2	
											#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	
D43 - Community RTG	318- INTERMEDIATE CARE	430 - GERIATRIC MEDICINE	1426	1150	1426	1196	1069	1058	1069	1035	80.6%	83.9%	99.0%	96.8%	783	2.8	2.8	5.7	
D47 - Geriatric MEDICAL	430 - GERIATRIC MEDICINE		1069	989	1247	1178	713	621	713	701	92.5%	94.5%	87.1%	98.3%	550	2.9	3.4	6.3	
											#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	
Labour Ward - City	501 - OBSTETRICS		3921	3250	713	672	3921	3128	713	713	82.9%	94.2%	79.8%	100.0%	294	21.7	4.7	26.4	
City Maternity - M1	501 - OBSTETRICS	424- WELL BABIES	1069	1029	713	701	1069	989	356	368	96.3%	98.3%	92.5%	103.4%	411	4.9	2.6	7.5	
City Maternity - M2	501 - OBSTETRICS	424- WELL BABIES	1069	960	683	575	1069	989	356	322	89.8%	84.2%	92.5%	90.4%	414	4.7	2.2	6.9	
AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	4278	3927	1782	1736	4278	4059	1782	1725	91.8%	97.4%	94.9%	96.8%	1323	6.0	2.6	8.7	
Neonatal	422- NEONATOLOGY		2495	2394	713	510	2495	2376	744	516	96.0%	71.5%	95.2%	69.4%	640	7.5	1.6	9.1	
Serenity Birth Centre - City	501 - OBSTETRICS		1069	1167	713	460	1069	1081	356	529	109.2%	64.5%	101.1%	148.6%	34	66.1	29.1	95.2	
Ophthalmology Main Ward - City	130 - OPHTHALMOLOGY	180 - ACCIDENT & EMERGENCY	300	281	232	225	573	527	0	46	93.7%	97.0%	92.0%	#DIV/0!	149	5.4	1.8	7.2	
Eliza Tinsley Ward - Community RTG	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	1069	862	1426	1311	713	713	1069	989	80.6%	91.9%	100.0%	92.5%	691	2.3	3.3	5.6	
Henderson	318- INTERMEDIATE CARE		1069	851	1552	1420	713	667	1069	966	79.6%	91.5%	93.5%	90.4%	652	2.3	3.7	6.0	
Leasowes	318- INTERMEDIATE CARE		1008	1014	1302	1230	744	732	744	744	100.6%	94.5%	98.4%	100.0%	565	3.1	3.5	6.6	
MCCarthy	318- INTERMEDIATE CARE		1069	908	1420	1339	713	678	1069	1000	84.9%	94.3%	95.1%	93.5%	695	2.3	3.4	5.6	
D17 (Gynae Ward)	502 - GYNAECOLOGY		586	528	411	294	744	744	372	360	90.1%	71.5%	100.0%	96.8%	394	3.2	1.7	4.9	
D25 - Female Surgery	101 - UROLOGY	120 - ENT	1276	1040	713	667	920	759	644	632	81.5%	93.5%	82.5%	98.1%	482	3.7	2.7	6.4	
D27 - City Surgical Unit (CSU)	101 - UROLOGY	120 - ENT	1426	1109	713	615	1000	989	713	632	77.8%	86.3%	98.9%	88.6%	60	35.0	20.8	55.8	
	Trust Totals		**64966**	**58933**	**39086**	**35420**	**58875**	**54032**	**30887**	**30721**	90.7%	90.6%	91.8%	99.5%	**23887**	**4.7**	**2.8**	**7.5**	

Sandwell and West Birmingham Hospitals NHS
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CLINICAL LEADERSHIP EXECUTIVE: SUMMARY NOTE	
Date	24th April 2017
Attendees	Executive Group, Group Triumvirates and Staff Convenor
Key points of discussion relevant to the Board	• Detailed discussion on results acknowledgement, head injuries and other safety matters • Inclusive conversation took place around Unity, strongly suggesting improvements in operational insight and oversight of the implementation issues
Positive highlights of note	• Alignment on the financial changes we are planning to make between the Groups and corporate functions was stronger than in prior years • There is largely good grip and control on PDR bookings but a need to ensure that sessions proceed and that we can demonstrate in Q2 a connection to the training spend we prioritise.
Matters presented for information or noting	• The full meeting agenda is available on request, but as always the meeting covered all aspects of the 2020 vision and support plans
Decisions made	• Timelines confirmed for resolution of PDR booking backlog and Incident reporting backlog
Matters of concern or key risks to escalate to the Board	• None beyond the extant risk register, with a particular focus on emergency medicine staffing and the sustainability of dual EDs

Toby Lewis, Chief Executive
Chair of the Clinical Leadership Executive
For the meeting of the Trust Board scheduled for 3rd May 2018

SWB TeamTalk

April 2018

NHS
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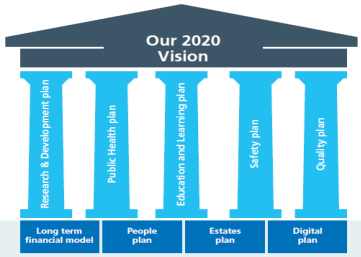
Welcome to our new SWB Team Talk

Becoming renowned as the best integrated care system in the NHS…



Ruth Wilkin
Director of Communications

SWB TeamTalk

April 2018

NHS
Sandwell and West Birmingham Hospitals
NHS Trust

Team Talk Agenda

1pm: Tune In: local and national news
1.10pm: Learning from Excellence: using feedback
1.20pm: What's on your mind? worries and issues
1.35pm: Things you need to know – with Toby
1.50pm: This month's topic: Unity preparedness

The Chief Executive's video monthly post will be issued tomorrow, and will reflect TeamTalk feedback.

swbh.nhs.uk where everyone matters

SWB TeamTalk

April 2018

NHS
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NHS Trust

Tune in - our news

End PJ Paralysis – national 70 day initiative to try and mobilise patients and support independence. All of our ward managers are working with an app to record the impact of our actions on patient mobilisation and wellbeing, and showcase our excellence.

myConnect - is our new free communications app. Download from the Apple store and Google play – search SWBH myConnect. This will become a key tool to share news and information.

Star Awards – nominations for our Star Awards open on 30 April. Details will be in April's Heartbeat and on Connect. We want to get more than 500 nominations.

GDPR – we have a single steering group overseeing our implementation to revised data protection regulations. Please make sure if you plan to alter your approach to data management that you have cross checked your interpretation of that regulations with that group led by Refeth.Mirza2@nhs.net

Speak Up Day – look out for details of May 16th, our Trust-wide event on raising concerns

SWB Leadership Conference – takes place on May 22nd. If you have been asked to attend please reply!

SWB TeamTalk

April 2018

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Learning from excellence:

Safe transfer of care – acute to community wards

Tammy Davies

Group Director of Nursing, PCC&T

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SWB TeamTalk

April 2018

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NHS Trust

Why the discharge process matters

- Patient experience:

  "The staff didn't know me and nobody told me why I was moved – they even forgot my tablets and left my glasses behind."

- Patient safety
- Increased complaints/incidents
- Readmissions

SWB TeamTalk

April 2018

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Evaluating Transfers

Potentially Unsafe / High Risk of Readmission	Poor Quality	Safe & Effective
No handover / communication	Incomplete handover	Detailed & complete handover
Medication / prescription missing	Discharge plan not commenced	Prescription & medication
Safety checks incomplete	Patient / carers not aware of transfer	Safety checks complete
Missing documentation	Unrealistic / inappropriate EDD	Equipment in place
Not medically fit		Discharge planning commenced
		Patient / carers informed

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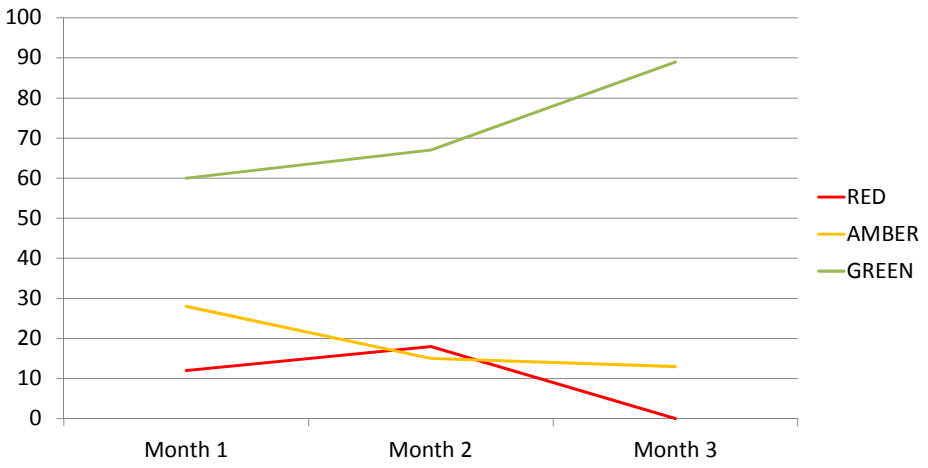
SWB TeamTalk

April 2018

Sandwell and West Birmingham Hospitals NHS Trust

Progress so far



Using data to improve care: continuous feedback loop

Sandwell and West Birmingham Hospitals NHS Trust

Weekly results → PCC&T / Medicine & EC working together → Results shared locally

SWB TeamTalk
April 2018

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Next Steps

- Utilise tool with community teams (DNs / iCares)
- Work with partners – nursing homes / GPs
- Patient feedback

SWB TeamTalk
April 2018

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What's on your mind?

Your opportunity to raise any issues or ask a question.

Kam Dhami, Director of Governance

SWB TeamTalk

April 2018

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Feedback from the Q&A sessions

Star awards
Suggestion to have 20 Golden Tickets that anyone in the organisation could receive.

End PJ Paralysis
Concern about provision of night clothes on wards and agreement to look at opportunities for colleagues to donate clothes for use on wards for people who don't bring in their own, similar to the clothes available in ED for homeless patients. Also request for promotion of stories from the end PJ paralysis campaign.

Car parking
The board is looking at different car parking options including developing new car parks at City and Sandwell. That may take time to get approved and developed so we may need to look at interim solutions.

IT issues
Recent issues of slowness should now be largely resolved and a set of activities have been put in place to stop this happening. The IT team were commended for their hard work in supporting people who call up with problems and working to resolve the issues. Broadly we are getting to the end of the improvements to infrastructure and systems upgrades. There remain local systems that will need review if they are at end of life. Please remember to sign up to reset your own password. That will cut down drastically on calls to the helpdesk.

SWB TeamTalk

April 2018

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Things you need to know – from our Clinical Leadership Executive

Safety first: We continue to work to deliver our Safety Plan metrics each day, including resolving any missed checks. In the coming two months we will be working to improve our Head Injury pathway and to ensure we have robust arrangements for results acknowledgement now and when Unity goes live.

Stable finances: We ended March with enough cash to invest in our IT and estate in 2018. Our cost reduction plans for 2018-19 are above £25m, with new ward establishments in place for May and the ending of most, if not all, non-clinical agency spend. Our contract with commissioners are ready to sign and we aim to treat more patients than ever before, with our new 23 hour surgical unit opening later in May.

Stable IT: By the end of May we expect to have addressed all our "red rated" infrastructure risks and removed by the end of June our technology which dates from 2003. Please continue to report issues and use the helpdesk. You will get a faster service if we all opt in to password self service.

Right patient/right bed: The Trust's Board has mandated a bed base by July which is 58 beds less than today. The first step in that journey is to ensure that we have the right specialty patient in the right bed. Which is why last week at City we have started to move patients between wards, largely to ensure frail older people are staying in our specialist geriatric wards (L4, L5, D11 and D26). That shift happens at Sandwell next week. Cutting overnight bed moves relies on daytime discharges and changes to nursing and medical models in medicine are intended to help us to achieve that. It is possible and should not wait for winter!

swbh.nhs.uk where everyone matters

SWB TeamTalk

Sandwell and West Birmingham Hospitals NHS Trust

Team Talk Topic - April 2018

Get set for Unity – do you need to change how you work?

When Unity is launched in August over 5,500 colleagues will be using the electronic patient record on a daily basis. In order to prepare it is essential that you consider whether you will have to change the way you work when Unity is in place. The Unity Readiness Checklist is a guide for you and your department to get yourselves ready for the new electronic patient record. Departments will have now received hard copies of the checklist and should be working through each section.

You must also consider your usual work practices and whether they will be impacted by Unity.

In your teams please discuss:

1) Have you identified and documented any ways of current working that will need to change when Unity is live?
2) If you have not already changed these, or there is more to do, how will you make sure this happens?
3) Have you created time to work through the readiness checklist as a team?
4) What further support (apart from training) do you require to be ready for Unity being live?

For advice and support please contact,

- Digital Champions (details on Connect)
- Directorate and group leadership team
- Dean Harris Programme Manager

Recruitment Activity Report

Report Date: 20/04/2018

Criteria		Measure/Month		Actual						Forecast						Target	
				Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18		
Band 5 Nurses (excluding Theatre Practitioners)	SIP	FTE	Establishment						768.26	768.26	768.26	768.26	768.26	768.26	768.26		
		FTE	FTE In Post						642.76	642.76	642.76	642.76	642.76	642.76	642.76		
		FTE	New Starters						5.00	5.00	5.00	5.00	5.00	10.00	43.00		
		FTE	Leavers						11.01	11.01	11.01	11.01	11.01	11.01	11.01		
		FTE	Vacancies in month						125.50	125.50	125.50	125.50	125.50	120.50	77.50	88.33	----- Target Missed
	Offers External Applicants	FTE	Conditional offers (in month)						31.26	31.26	31.26	31.26	31.26	31.26	31.26		
		FTE	Offers Confirmed (in month)						7.67	7.67	7.67	7.67	7.67	7.67	7.67		
Band 5 Community Nurses	SIP	FTE	Establishment	164.35	165.47	165.47	165.47	165.47	156.47	156.47	156.47	156.47	156.47	156.47	156.47		
		FTE	FTE In Post	132.62	139.82	139.43	142.26	143.26	140.35	140.35	140.35	140.35	140.35	140.35	140.35		
		FTE	New Starters	2.20	2.46	0.00	2.20	0.00	0.00	1.10	1.10	1.10	1.10	1.10	9.10		
		FTE	Leavers	0.40	0.00	0.00	5.64	0.61	0.00	0.20	0.20	0.20	0.20	0.20	0.20		
		FTE	Vacancies in month	33.08	25.65	26.04	23.21	22.21	16.12	16.12	16.12	16.12	16.12	16.12	7.02	31.73	----- Target Met
	Offers External Applicants	FTE	Conditional offers (in month)	1.00	0.00	0.00	0.00	0.00	0.60	0.00	0.00	0.00	0.00	0.00	0.00		
		FTE	Offers Confirmed (in month)	1.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Band 5 Nursing (Total)	SIP	FTE	Establishment						924.73	924.73	924.73	924.73	924.73	924.73	924.73		
		FTE	FTE In Post						783.11	783.11	783.11	783.11	783.11	783.11	783.11		
		FTE	New Starters						5.00	6.10	6.10	6.10	6.10	11.10	52.10		
		FTE	Leavers						11.01	11.21	11.21	11.21	11.21	11.21	11.21		
		FTE	Vacancies in month						141.62	141.62	141.62	141.62	141.62	136.62	84.52	120.06	----- Target Missed
	Offers External Applicants	FTE	Conditional offers (in month)						31.86	31.26	31.26	31.26	31.26	31.26	31.26		
		FTE	Offers Confirmed (in month)						7.67	7.67	7.67	7.67	7.67	7.67	7.67		
Band 6 Nurses (excluding Theatre Practitioners)	SIP	FTE	Establishment						388.74	388.74	388.74	388.74	388.74	388.74	388.74		
		FTE	FTE In Post						366.38	366.38	366.38	366.38	366.38	366.38	366.38		
		FTE	New Starters						2.82	2.82	2.82	2.82	2.82	2.82	2.82		
		FTE	Leavers						3.25	3.25	3.25	3.25	3.25	3.25	3.25		
		FTE	Vacancies in month						22.36	22.36	22.36	22.36	22.36	22.36	22.36	34.05	----- Target Met
	Offers External/Internal Applicants	FTE	Conditional offers (in month)						5.00	5.00	5.00	5.00	5.00	5.00	5.00		
		FTE	Offers Confirmed (in month)						9.82	9.82	9.82	9.82	9.82	9.82	9.82		
Band 6 Community Nurses	SIP	FTE	Establishment	143.55	150.15	150.15	150.15	150.15	145.95	145.95	145.95	145.95	145.95	145.95	145.95		
		FTE	FTE In Post	136.02	140.32	139.41	140.41	139.91	137.15	137.15	137.15	137.15	137.15	137.15	137.15		
		FTE	New Starters	1.36	2.60	0.00	1.36	0.00	1.00	1.18	1.18	1.18	1.18	1.18	1.18		
		FTE	Leavers	1.00	1.00	0.00	1.00	0.70	0.00	0.85	0.85	0.85	0.85	0.85	0.85		
		FTE	Vacancies in month	9.61	9.61	10.74	10.74	10.74	8.80	8.80	8.80	8.80	8.80	8.80	8.80	9.61	----- Target Met
	Offers External Applicants	FTE	Conditional offers (in month)	2.36	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
		FTE	Offers Confirmed (in month)	1.96	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Band 6 Nursing (Total)	SIP	FTE	Establishment						534.69	534.69	534.69	534.69	534.69	534.69	534.69		
		FTE	FTE In Post						503.53	503.53	503.53	503.53	503.53	503.53	503.53		
		FTE	New Starters						3.82	4.00	4.00	4.00	4.00	4.00	4.00		
		FTE	Leavers						3.25	4.10	4.10	4.10	4.10	4.10	4.10		
		FTE	Vacancies in month						31.16	31.16	31.16	31.16	31.16	31.16	31.16	43.66	----- Target Met
	Offers External Applicants	FTE	Conditional offers (in month)						5.00	5.00	5.00	5.00	5.00	5.00	5.00		
		FTE	Offers Confirmed (in month)						9.82	9.82	9.82	9.82	9.82	9.82	9.82		
Band 5 & 6 Midwives	SIP	FTE	Establishment	192.55	192.39	192.39	192.39	192.39	192.39	192.39	192.39	192.39	192.39	192.39	192.39		
		FTE	FTE In Post	164.59	167.09	164.77	162.27	162.67	158.47	158.47	158.47	158.47	158.47	158.47	158.47		
		FTE	New Starters	7.00	3.00	0.00	3.15	0.00	0.00	1.50	1.50	1.50	1.50	1.50	1.50		
		FTE	Leavers	4.32	1.26	3.44	3.00	1.20	2.92	2.96	2.96	2.96	2.96	2.96	2.96		
		FTE	Vacancies in month	27.96	25.30	27.62	30.12	29.72	33.92	33.92	33.92	33.92	33.92	33.92	33.92	26.64	----- Target Missed
	Offers External/Internal Applicants	FTE	Conditional offers (in month)	0.60	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
		FTE	Offers Confirmed (in month)	4.00	2.60	0.00	0.00	0.00	0.92	0.46	0.46	0.46	0.46	0.46	0.46		
Consultants	SIP	FTE	Establishment	320.10	320.10	320.10	320.10	320.10	321.10	321.10	321.10	321.10	321.10	321.10	321.10		
		FTE	FTE In Post	291.12	292.25	287.39	286.70	287.65	283.80	283.80	283.80	283.80	283.80	283.80	283.80		
		FTE	New Starters	3.00	1.00	0.00	2.39	0.00	3.00	1.70	1.70	1.70	1.70	1.70	1.70		
		FTE	Leavers	2.05	0.55	4.00	3.80	2.90	3.90	3.35	3.35	3.35	3.35	3.35	3.35		
		FTE	Vacancies in month	28.98	27.85	32.71	33.40	32.45	37.30	37.30	37.30	37.30	37.30	37.30	37.30	33.36	----- Target Missed
	Offers External Applicants	FTE	Conditional offers (in month)	3.00	1.00	0.00	0.00	0.00	4.00	0.50	0.50	0.50	0.50	0.50	0.50		
		FTE	Offers Confirmed (in month)	0.00	1.00	0.00	0.00	0.00	3.00	0.00	0.00	0.00	0.00	0.00	0.00		
Specialty Registrars (including Junior Specialist Doctors)	SIP	FTE	Establishment						311.00	311.00	311.00	311.00	311.00	311.00	311.00		
		FTE	FTE In Post						257.00	257.00	257.00	257.00	257.00	257.00	257.00		
		FTE	New Starters						0.00	0.00	0.00	0.00	0.00	0.00	0.00		
		FTE	Leavers						10.71	10.71	10.71	10.71	10.71	10.71	10.71		
		FTE	Vacancies in month						54.00	54.00	54.00	54.00	54.00	54.00	54.00	36.00	----- Target Missed
	Offers External Applicants	FTE	Conditional offers (in month)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
		FTE	Offers Confirmed (in month)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		

Notes:

Staff in post this includes staff in post as at the first of the month

New starters Actual - : This includes all agreed start dates from the first of the month

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

Leavers -: 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.

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

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

Specialty Registrars (including Junior Specialist Doctors): Includes all approved doctors in training posts except foundation Y1 and Y2 doctors. It also includes GPSTs that are being trained at SWBH but employed by lead employer (St Helens)

Data source: ESR, Recruitment data base and Medical Staffing Database

Forecast for band 5 Staff Nurses

Final Year Students 46/54 students are engaging with the process and are forecast to start including 8 commmunity staff nurse posts. 6 FYS still need placing as we were unable to accomodate their preferences. **RCN fair Birmingham March** 10/ 11 offers made being proccesed with the Groups to confirm offers for 2 candidates. (4 of the candidates at the RCN fair are qualifed with 1 student due to qualify in April and the rremaining students due to qualify in August. 13 candidates were students who wanted A+E which we could not accomodate. PH to invite these invite these students to a meeting to explore other options including rotation.
Health Sector Jobs Fair Dublin: 5 offers made(1 x student with preference for A+E, 1 x Elderly Care, 1 x Coronary Care but would require Tier 2 visa, 1 X not registered with NMC and requiures IELTS, 1 x Not registered and requires Return to practice.

Paper ref:	TB (05/18) 007 Annex

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	The Midland Metropolitan Hospital: Risk Assessments		
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

The Board agreed in April to incorporate two specific high rated risks into our Risk Register reflecting, principally:

- The organisational and clinical risks arising from Midland Met opening date delay options
- The commercial and financial risks arising from THC partner failure or termination

The attached material confirms good progress with the actions envisaged but no material change in the risk ratings. I would suggest that it is June's Board meeting where we take a more final and formal view on treat or tolerate. No decisions are requested of the Board beyond acknowledging the work required to complete the next steps on the process.

No funding model for the 'work up' of options nor for any interim reconfiguration has yet been agreed but it is acknowledged that such costs exist, are outside the Trust's 2018-19 financial plan and control total, and will necessitate discussions directly between the Trust, NHSI, NHSE and DHSC. Those discussions are shortly to commence.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	**X**	Public Health Plan		People Plan & Education Plan	**X**
Quality Plan	**X**	Research and Development		Estates Plan	**X**
Financial Plan	**X**	Digital Plan	**X**	Other *[specify in the paper]*	**X**

3. Previous consideration *[where has this paper been previously discussed?]*

April Trust Board.

4. Recommendation(s)

The Trust Board is asked to:

a.	Note work done to date by all parties on this difficult situation.
b.	Support the Chairman and others in pressing for resolution of both the termination advice considerations (if applicable) and other outstanding information requested.
c.	Request a formal assessment be completed (and published) by July 1st on site deterioration to assess the cost rework now required after three and a half months of a fallow site.

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register	X	Risks 3020 and 3021					
Board Assurance Framework	X	BAF 5 and BAF 10					
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Risk Assessment

Risk Number	Risk Version	Owner	Assessor	Control Potential	Status
3020	1	Toby Lewis	Kamaljeet Dhami	Treat	Live (With Actions)

Level of RR where risk features Clinical Group/Corporate Direc

Where is this risk monitored? Trust Board

Risk Details

Department	Midland Metropolitan Project	**Directorate**	Midland Metropolitan Project
Specialty	Management	**Clinical Group / Corporate Directorate**	Estates & New Hospital Project
Site	Midland Metropolitan Hospital		
Type	Clinical Care/Treatment	**Sub-Type**	Delay

Risk There is a risk that Mid Met opens after April 2020 caused by the collapse of Carillion Construction which will result in delays to our wider vision, clinical risks leading to potential reconfiguration, new and unexpected expenditure, significant bandwidth issues for senior leaders, and recruitment and retention workforce difficulties.

Scope Future of organization, stability of finances, and sustainability of acute clinical services

Hazard Patients, staff, physical environment, service delivery, contract security and retention

Initial Risk Scoring

Severity	Likelihood	Initial Risk Score	Initial Risk Rating
4 Major	4 Likely	16	Red

Controls in Place

Control	Details
Policy/Procedure/System	weekly senior management core group, supported by weekly meetings with THC and with lenders. clinical oversight of seven Board level hazards will be confirmed by 11/4/2018 board level governance now delegated to revised weekly MPA

Current Risk Scoring (based on how the controls in place have affected the severity and/or likelihood)

Severity	Likelihood	Current Risk Score	Current Risk Rating
4 Major	4 Likely	16	Red

Actions

Type Develop/update Plan **Person Responsible** Toby Lewis

Target Date 23/04/2018 **Completed Date** 23/04/2018

Details:

Revisit prior alternate options for acute adult services to achieve minimal safe moves, against externally assured staffing thresholds

Undertake initial regulatory engagement of options

Develop costed site options

Progress:

Risk Assessment

Risk Number	Risk Version	Owner	Assessor	Control Potential	Status
3020	1	Toby Lewis	Kamaljeet Dhami	Treat	Live (With Actions)

Level of RR where risk features Clinical Group/Corporate Direc

Where is this risk monitored? Trust Board

Actions

Type Develop/update Plan **Person Responsible** Toby Lewis

Target Date 16/04/2018 **Completed Date** 16/04/2018

Details: **Progress:**

Actions

Type Develop/update Plan **Person Responsible** Toby Lewis

Target Date 16/04/2018 **Completed Date** 16/04/2018

Details: **Progress:**

non retained estate investment has been grounded in 2018-2019 move

Review dates

Last review date / / **Next review date** / / **Review frequency** Weekly

Risk Assessment

Risk Number	Risk Version	Owner	Assessor	Control Potential	Status
3021	2	Antony Waite	Toby Lewis	Treat	Live (With Actions)

Level of RR where risk features Clinical Group/Corporate Direc

Where is this risk monitored? Trust Board

Risk Details

Department	Midland Metropolitan Project	**Directorate**	Midland Metropolitan Project
Specialty	Management	**Clinical Group / Corporate Directorate**	Estates & New Hospital Project
Site	Midland Metropolitan Hospital		
Type	Legal/Regulation Breach	**Sub-Type**	Regulation Breach

Risk There is a risk that the potential insolvency of THC caused by the collapse of Carillion construction leads to contractual changes in the provider of funds, construction and FM to the Midland Metropolitan project resulting in delay and increased cost, after a prolonged period of uncertainty and stasis

Scope financial impact on this project, and all other projects which may compete with this for funds

Hazard money, workforce, leadership bandwidth

Initial Risk Scoring

Severity	Likelihood	Initial Risk Score	Initial Risk Rating
4 Major	5 Almost Certain	20	Red

Controls in Place

Control	Details
Policy/Procedure/System	weekly liaison with DHSC and THC
	engagement of industry experts in appraising option A, B or C
	use of formal contractual processes

Current Risk Scoring (based on how the controls in place have affected the severity and/or likelihood)

Severity	Likelihood	Current Risk Score	Current Risk Rating
4 Major	4 Likely	16	Red

Actions

Type Develop/update Plan **Person Responsible** Toby Lewis

Target Date 13/04/2018 **Completed Date** 17/04/2018

Details:

assists Board and DHSC and HMG in choosing between options A, B and C

Progress:

Risk Assessment

Risk Number	Risk Version	Owner	Assessor	Control Potential	Status
3021	2	Antony Waite	Toby Lewis	Treat	Live (With Actions)

Level of RR where risk features Clinical Group/Corporate Direc

Where is this risk monitored? Trust Board

Actions

Type Develop/update Plan **Person Responsible** Toby Lewis

Target Date 13/04/2018 **Completed Date** 17/04/2018

Details:

finish analysis of contract remedies available under standard PF2 contract

Progress:

Review dates

Last review date / / **Next review date** / / **Review frequency** Weekly

Paper ref:	TB (05/18) 008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Trust Risk Register		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author	Refeth Mirza, Head of Risk Management		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Committee should focus on]*

The Trust Risk Register (TRR) provides the Board with details on all identified operational risk exposures across Sandwell and West Birmingham Hospitals NHS Trust.

The Board is invited to consider, challenge and confirm the correct strategy has been adopted to keep potential significant risks under prudent control;

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	✓	Public Health Plan		People Plan & Education Plan	
Quality Plan	✓	Research and Development		Estates Plan	
Financial Plan	✓	Digital Plan		Other *[specify in the paper]*	X

3. Previous consideration *[where has this paper been previously discussed?]*

RMC & CLE (April 2018)

4. Recommendation(s)

The Committee is asked to:

a.	**NOTE** the revision to **Risk 114**
b.	**DISCUSS** and **AGREE** the proposal to include **Risk 2955** onto the TRR
c.	**NOTE** the planned revision to risks **566 &1738**
d.	**DISCUSS** and **AGREE** the proposal to remove **Risk 533**

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s): 114, 566, 1738 & 533					
Board Assurance Framework		Risk Number(s):					
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 3 May 2018

Trust Risk Register

1. Introduction

1.1 The Trust Risk Register (TRR) provides the Board with details on all identified operational risk exposures across Sandwell and West Birmingham Hospitals NHS Trust. Significant risks which feature in the TRR are those with a risk score of 15 or above, or those with a lower rating but which the Board has decided to keep under surveillance. These risks are currently subject to monthly review at the Risk Management Committee (RMC) and Clinical Leadership Executive (CLE). This report has been updated to capture any decisions made by those Committees.

1.2 The Executives have identified a range of significant risks, which are currently being mitigated, whose impact could have a direct bearing on the achievement of Trust Plans and priorities and requirements within the NHSI Accountability Framework or CQC registration should the mitigation plans be ineffective.

1.3 A summary of the main controls and mitigating actions for the significant risks currently identified in each Clinical Group and Corporate Directorate is available in **Appendix A.**

2. Discussion points

2.1 Since the TRR was reported to the Board at its April 2018 meeting the Head of Risk Management has supported risk owners in further reviewing their risks and updated each risk assessment to provide an accurate position against the progress of mitigating actions.

2.2 All risks on the TRR have been reviewed in a timely way ensuring that actions are carried out so that none are overdue and if any are overdue, these are highlighted and escalated. The TRR is being actively monitored and updated with progress to maintain its current position.

2.3 Following discussions at April Trust Board, four areas below have been discussed at April RMC and subsequently CLE;

2.3.1 **Risk 114 (Workforce Plan)** - The Executive Director of People & Organisation has reviewed this risk and updated the risk statement and mitigating actions.

2.3.2 **Risk 2955 (unfilled Middle Grade shifts in Emergency Department) –** This is a new risk being escalated to Trust Board for discussion and agreement to be included onto the Trust Risk Register. **Appendix B**

2.3.3 **Risk 566 (Senior ED Medical staffing**) This risk is currently undergoing revision in light of changes that have occurred since the risk was first placed on the risk register and will be discussed at May RMC.

2.3.4 **Risk 1738 (Ophthalmology)** – This risk was discussed at length at March RMC, and it was agreed that there are 3 separate issues associated with this risk. The Group Director of Operations for Surgery has agreed to review this risk, which is ongoing.

Risk No. 114	Risk No. 2955	Risk No. 566	Risk No. 1738
The Trust may experience pay costs beyond that which is affordable as set out within the 18/19 financial plan if the delivery of the pay cost improvement programme is delayed or not delivered to the required timescale or financial value.	*ED is unable to fill the ED Middle Grade rota (mainly out of hours shift, 22:00 to 08:00) due to the 9 ED Middle Grade vacancies the department is carrying. This will directly impact on patient care and operational delivery, i.e. time to be seen.*	*There is a risk that further reduction or failure to recruit senior medical staff in ED will lead to an inability to provide a viable rota at consultant level. This will impact on delays in assessment, treatment and will compromise patient safety.*	*There is a risk that children under 3 years of age, who attend the ED at BMEC, 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. This could potentially result in severe harm to the patient.*

2.3.5 **Risk 533 (Oncology)** As the Trust no longer has visiting Oncologists, RMC and CLE felt that this should also be removed from the TRR and overseen at directorate level.

3. Recommendations

Trust Board is recommended to:

a) **NOTE** the revision to **Risk 114**
b) **DISCUSS** and **AGREE** the proposal to include **Risk 2955** onto the TRR
c) **NOTE** the planned revision to three risks (**566 &1738)**
d) **DISCUSS** and **AGREE** the proposal to remove **Risk 533**

Refeth Mirza
Head of Risk Management

26 April 2018

TRUST RISK REGISTER - April 2018

Risk No.	Clinical Group	Department	Risk	Initial Risk Rating (LxS)	Existing controls	Owner *Executive Lead*	Review Date	Current Risk Rating (LxS)	Gaps in control and planned actions	Target Risk Rating Score (LxS)	Completion date for actions	Status
121 24/01/2017	Women And Child Health	Maternity 1	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 is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service.	4x4=16	1- Maximisation of tariff income through robust electronic data capture and validation of cross charges from secondary providers.	Amanda Geary ***Rachel Barlow***	25/04/2018	3x4=12	**Cross charging tariff affecting financial position.** **1**-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. **(30/06/2018)** **2**-Options appraisal from finance in progress which will be discussed between the Clinical Group Director of Operations and Director of Finance. **(30/06/2018)**	2x4=8	**30/06/2018**	Live (With Actions)
221 22/09/2015	Medical Director Office	Informatics(C)	There is a risk of failure of a trust wide implementation of a new EPR. Failure of the EPR to go-live in the timescale specified will impact on cost and lost benefits resulting in an inability to meet strategic objectives.	4x4=16	1-Recruitment of suitably skilled specialist resources for EPR Programme and Infrastructure Stabilisation 2-Funding allocated to LTFM 3-Delivery risk shared with supplier through contract 4-Project prioritised by Board and management. 5-Project governance including development, approval and tracking to plan. 6-Focus on resources to deliver the implementation including business change, training and champions.	Kulvinder Kalsi ***Rachel Barlow***	31/05/2018	3x4=12	**Insufficient skilled resources within the Trust to deliver the EPR system.** **1**-Develop and publish implementation checklists and timescales for EPR. Report progress at Digital PMO and Committee **COMPLETED** **2**-Agree a plan for Unity to go live meeting the needs of clinicians, Informatics and operational staff.. **(28/04/2018)** **3**-Embed Informatics implementation and change activities in Group PMOs and production planning **(31/03/2018)** **4**-Agree and implement super user and business change approaches and review and re-establish project governance **COMPLETED**	1x2=2	31/05/2018	Live (With Actions)
1643 11/02/2016	Corporate Operation	__	Unfunded beds with inconsistent nursing and medical rotas are reliant on temporary staff to support rotas and carry an unfilled rate against establishment. This could result in underperformance of the safety plan, poor documentation and inconsistency of care standards.	4x4=16	1-Use of bank staff including block bookings 2-Close working with partners in relation to DTOCs 3-Close monitoring and response as required. 4-Partial control - Bed programme did initially ease the situation but different ways of working not fully implemented as planned. **Additional controls** - Funded bed model approved in Q3 and recruitment on track with substantive staffing improving. Medicine forecast 35 band 5 vacancies at end of Q4 2017. Safety plan and Early warning trigger tools in place on all wards and tracked through Consistency of Care and Executive Performance Committee. Associated risks are managed at group level and tracked through Risk Management Committee.	Rachel Barlow ***Rachel Barlow***	15/03/2018	4x4=16	**Unfunded beds - insufficient staff capacity.** 1. Patient flow programme to be delivered to reduce LOS and close beds. This includes: consultant of the week model for admitting specialties / new push/ ull AMU led MDT/ADAPT pathway / no delay for TTA project/criteria led discharge / OPAU to directly admit from ED -**31/03/2018** Contingency bed plan is agreed in October for winter - L5 to be opened in November.**(31/12/2017) - COMPLETED**	1x4=4	31/03/2018	Live (With Actions)
228 22/09/2015	Medical Director Office	Informatics(C)	There is a risk that a not fit for purpose IT infrastructure as current systems are not flexible to support clinical activity redesign. This will result in a failure to achieve strategic objectives and significantly diminishes the ability to realise benefits from related capital investments.	3x4=12	1-Approved Business Case in place for Infrastructure Stabilisation programme (approved by Trust Board June 2015) 2-Specialist technical resources engaged (both direct and via supplier model) to deliver key activities 3-Informatics has undergone organisational review and restructure to support delivery of key transformational activities 4-Informatics governance structures and delivery mechanisms have been initiated to support of transformational activities	Dean Harris ***Mark Reynolds***	30/04/2018	3x3=9	**IT infrastructure not fit for purpose.** **1**-Establish infrastructure plan and track progress. **(31/12/2017) - COMPLETED** **2**-Migrate SAN storage and close P4500 and 3PAR **(30/04/2018)** **3**-Migrate VMs from VMware to Hyper-V **- (31/03/2018) - COMPLETED** **4**-Standardise network config to resolve performance issues **(30/04/2018)**	1x1=1	30/04/2018	Live (With Actions)
325 12/05/2015	Medical Director Office	Informatics(C)	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.	4x4=16	1-Prioritised and protected investment for security infrastructure via Infrastructure Stabilisation approved Business Case 2-Information security assessment completed and actions underway.	Mark Reynolds ***Mark Reynolds***	13/06/2018	2x4=8	**Sytems in place to prevent cyber attack.** **1**- Upgrade servers from version 2003. **(31/05/2018)** **2**-Implement security controls (VLAN, IPSEC) to stop access to and from restricted devices. Over time this should harden the Trust infrastructure against attack, recognising that securing the physical network is a challenge on the estate. **(30/09/2018)** **3**-Achieve Cyber Security Essentials **(31/03/2018) - COMPLETED** **4**-The Trust must achieve cyber-security essentials as part of the minimum commitment to security. This will likely form part of our CQC inspections. **(31/03/2018) - COMPLETED** **5**-Complete rollout of Windows 7. **(31/05/2018)** **6**-Restricted Devices Security Controls **(31/12/2017) - COMPLETED**	2x4=8	30/09/2018	Live (With Actions)
2642 20/06/2017	Medical Director Office	Medical Director's Office	There is a risk that results not being seen and acknowledged due to I.T. systems having no mechanism for acknowledgment will lead to patients having treatment delayed or omitted.	3x5=15	1-There is results acknowledgment available in CDA only for certain types of investigation. 2-Results acknowledgement is routinely monitored and shows a range of compliance from very poor, in emergency areas, to good in outpatient areas. 3-Policy: Validation Of Imaging Results That Require Skilled Interpretation Policy SWBH/Pt Care/025 4-Clinical staff are require to keep HCR up to date - Actions related to results are updated in HCR 5-SOP - Results from Pathology by Telephone (attached)	***David Carruthers***	15/02/2018	2x5=10	**Multiple IT systems some of which have no mechanism for acknowledgment or audit trail.** **1**-Implementation of EPR in order to allow single point of access for results and audit **(30/03/2018)** **2**-All staff to comply with the updated Management of Clinical Diagnostic Tests policy **(28/02/2018)** **3**-To review and update Management of Clinical Diagnostic Tests **(28/02/2018)**	1x5=5	31/03/2018	Live (With Actions)

TRUST RISK REGISTER - April 2018

Risk No.	Clinical Group	Department	Risk	Initial Risk Rating (LxS)	Existing controls	Owner *Executive Lead*	Review Date	Current Risk Rating (LxS)	Gaps in control and planned actions	Target Risk Rating Score (LxS)	Completion date for actions	Status
1738 15/04/2016	Surgery	BMEC Outpatients - Eye Centre	There is a risk that children under 3 years of age, who attend the ED at BMEC, 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. This could potentially result in severe harm to the patient.	3x4=12	1-Contingency arrangement is for a general ophthalmologist to deal with OOH emergency cases. 2-Agreement with BCH to access paediatric specialists advice. 3-There is a cohort of anaesthetists who are capable of anaesthetising children under 3 who can provide back-up anaesthetic services when required. 4-Where required patients can be transferred to alternative paediatric ophthalmology services beyond the local area - potentially Great Ormond Street Hospital 5-The expectation of the department is that a general ophthalmologist should be able to treat to the level of a general ophthalmologist and will be able to deal competently with the	Bushra Mushtaq ***David Carruthers***	15/12/2017	2x4=8	**Limited access to OOH service.** **1**-Engage with ophthalmology clinical lead at BCH and agree a plan for delivering an on call service. **(30/11/2017)** 2-Liaise with commissioners over the funding model for the Paediatric OOH service. **(31/03/2018)** 3-Paediatric ophthalmologists from around the region to participate in OOH service (for discussion and agreement at a paediatric ophthalmology summit meeting)**(31/03/2018) - Awaiting update** 4-Clarify with Surgery Group leads what the paediatric anaesthetic resourcing capacity is. **(22/12/2017) - Awaiting update**	1x4=4	31/03/2018	Live (With Actions)
215 16/09/2016	Corporate Operations	Waiting List Management (S)	There is high Delayed Transfers of Care (DTOC) patients remaining in acute beds, due to a lack of EAB beds in nursing and residential care placements and social services. This results in an increased demand on acute beds.	4x5=20	New joint team with Sandwell is in implementation phase. **Additional Controls - Birmingham city council: bed base confirmed and expanded for 2017-18. Package of care service responsive. Sandwell Social Care continue to purchase beds at Rowley Regis to mitigate bed capacity issues. 7 day social workers on site and DTOC patients in acute beds <10 generally.**	Rachel Barlow ***Rachel Barlow***	30/04/2018	2x4=8	**Lack of EAB beds in nursing and residential care placements and social services.** **1**- The System Resilience plan awaits clarification from Birmingham City Council. The system resilience partners are considering risk and mitigation as part of A&E delivery group. **(31/12/2017) - COMPLETED** **2**- To review and update the ADAPT pathway, with a management data set and KPI standards. The new process to be implemented in September to provide more focused assessments and care planning. **(31/12/2017) - COMPLETED**	2x4=8	**COMPLETED**	Live (Monitor)
2849 28/11/2017	Corporate Operations	Medical Surgical Team	Continued spend on unfunded beds will impact on the financial delivery of CIP and the overall Trust forecast for year end. Deviation from the financial plan will impact on STF which is assumed in the financial outturn forecast. This could result in a significant financial deficit year end.	5x4=20	Design and implementation of improvement initiatives to reduce LOS and EDD variation through establishing consistency in medical presence and leadership at ward level - consultant of the week	Rachel Barlow ***Rachel Barlow***	30/04/2018	5x4=20	**1**- implement at pace the improvement programme to reduce LOS and improve EDD compliance **(30/06/2018)** **2** - design local improvement work with clinical teams to reduce bed days in LO sup to 8 days. **(31/05/2018)** **3** - review ADaPT and integrated health and social care approach to reduce bed days in LOS category > 8 days. **(31/03/2018)** **4** - revise weekly LOS and bed closure trajectory exceptional weather condition impact on bed base **(31/03/2018)**	4x3=12	31/03/2018	Live (Monitor)
214 18/03/2016	Corporate Operations	Waiting List Management (S)	The lack of assurance of the 18 week data quality process, has an impact on patient treatment plans which results in poor patient outcomes/experience and financial implications for the Trust as it results in 52 weeks breaches. There is a risk delay in treatment for individual patients due to the lack of assurance of the 18 week data quality process which will result in poor patient outcome and financial implications for the trust as a result of 52 week breaches	4x3=12	1- SOP in place 2-Improvement plan in place for elective access with training being progressed. 3-following a bout of 52 week breach patients in Dermatology a process has been implemented where by all clock stops following theatre are automatically removed and a clock stop has to be added following close validation 4-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. **Additional controls** review of 6 months of 52 week breaches to review themes. consider clinician competency training.	Liam Kennedy ***Rachel Barlow***	30/04/2018	3x3=9	**Lack of assurance on 18 week process.** **1**-Data quality process to be audited - Monthly audits **(31/03/2018)** **2**- E-learning module for RTT with a competency sign off for all staff in delivery chain - to b e rolled out to all staff from October. **(31/03/2018)** **3**-Bespoke training platform for 18 weeks and pathway management for all staff groups developed in line with accredited managers programme. **(31/10/2017) - COMPLETED**	2x2=4	31/03/2018	Live (With Actions)
533 29/12/2015	Primary Care And Community Therapies	Oncology Medical	There is a risk of negative impact to cancer waiting times, caused the withdrawal of oncology consultants and transfer of patients to other providers, which may lead to longer waits for oncology treatment.	3x5=15	1- Use of locums to fill staffing gaps. 2- NHS Improvement-seconded UHB manager on site at SWBH to try and facilitate communication with UHB clinical team and improve perception of performance.	David Carruthers ***David Carruthers***	30/04/2018	3x5=15	**Staffing gaps due to non replacement UHB roles.** **1**- Recruitment halted by UHB. Notification of withdrawal not rescinded. Service due to cease **28/02/2018**	1x5=3	30/04/2018/ 2018	Live (With Actions)
1603 22/012016	Finance	Financial Management (S)	The Trust's recent financial performance has significantly eroded cash balances and which were underpinning future investment plans. There is a risk that our future necessary level of cost reduction and cash remediation is not achieved in full or on time and which compromises our ability to invest in essential revenue developments and inter-dependent capital projects	5x5=25	1-Routine & timely financial planning, reporting and forecasting including fit for purpose cash flow forecasting. 2-Routine five year capital programme review & forecast 3-Routine medium term financial plan update 4-PMO infrastructure and service innovation & improvement infrastructure in place & effective Independent controls / assurance 1- Internal audit review of core financial controls 2-External audit review of trust Use of Resources including financial sustainability 3-Regulator scrutiny of financial plans 4-Routine scrutiny of delivery by FIC	Timothy Reardon ***Tony Waite***	28/02/2002	4x5=20	**Lack of assurance on the sufficiency of our plans to achieve cost reduction and cash remediation** **1**- Deliver operational performance consistent with delivery of financial plan to mitigate further cash erosion - **(31/03/2018)** -Use relevant benchmarks to underpin multi-year & specific CIP plans -Align trust CIP to commissioner QIPP to secure collective system cost reduction -Secure market opportunities to drive financial margin gain- **(31/03/2018)** **2**- Ensure necessary & sufficient capacity & capability to deliver scale of improvement required **3**- Develop and secure alternative funding and contracting mechanisms with commissioners to secure income recovery and to drive the right long term system behaviours- **(31/03/2018)** **4**- Refresh LTFM to confirm scale of cash remediation required consistent with level 2 SOF financial sustainability rating -**((31/03/2018)** **5**- Secure borrowing necessary to bridge any financial gap- **(31/03/2018)**	2x5=10	31/03/2018	Live (With Actions)

TRUST RISK REGISTER - April 2018

Risk No.	Clinical Group	Department	Risk	Initial Risk Rating (LxS)	Existing controls	Owner *Executive Lead*	Review Date	Current Risk Rating (LxS)	Gaps in control and planned actions	Target Risk Rating Score (LxS)	Completion date for actions	Status
534 29/12/2015	Primary Care & Community Therapies	Oncology Medical	There is a risk of Trust non-compliance with some peer review standards and impact on effectiveness of tumour site MDTs due to withdrawal of UHB consultant oncologists, which may lead to lack of oncologist attendance at MDTs	3x4=12	Oncology recruitment ongoing. Withdrawal of UHB oncologists confirmed, however assurance given around attendance at MDT meetings. Gaps remain due to simultaneous MDT meetings.	Jennifer Donovan ***David Carruthers***	11/02/2018	3x4=12	**Lack of Oncologist attendance at MDTs.** **1**- Review of MDT attendance underway as part of NHS Improvement/ NHS England oversight arrangements for oncology transfer. **31/03/2018**	1x4=4	31/03/2018	Live (With Actions)
666 20/07/2017	Women and Child Health	Lyndon 1	Children-Young people with mental health conditions are being admitted to the paediatric ward due to lack of Tier 4 bed facilities. Therefore therapeutic care is compromised and there can be an impact on other children and parents.	4x4=16	1- Mental health agency nursing staff utilised to provide care 1:1 2- All admissions are monitored for internal and external monitoring purposes. 3-Awareness training for Trust staff to support management of these patients. 4-Children are managed in a paediatric environment.	Heather Bennett ***Rachel Barlow***	16/03/2018	4x4=16	**There is no specialist medical or nursing MH team to care for their needs with limited access to in/OOH CAMHS support.** **1**- 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. **(31/03/2018)**	3x4=12	31/03/2018	Monitor (Tolerate)
566 17/10/2017	Medicine And Emergency Care	Accident & Emergency (S)	There is a risk that further reduction or failure to recruit senior medical staff in ED will lead to an inability to provide a viable rota at consultant level. This will impact on delays in assessment, treatment and will compromise patient safety.	4x5=20	1- Recruitment campaign in place through local networks, national adverts, head-hunters and international recruitment expertise. 2- Leadership development and mentorship programme in place to support staff development. 3-Robust forward look on rotas are being monitored through leadership team reliance on locums and shifts are filled with locums.	Michelle Harris ***Rachel Barlow***	13/03/2018	3x4=12	**Vacancies in senior medical staff in ED.** **1**- Recruitment ongoing with marketing of new hospital. **(31/03/2018)** **2**- CESR middle grade training programme to be implemented as a "grow your own" workforce strategy. **(31/03/2018)** **3**- Development of recruitment strategy **(31/03/2018)**	4x3=12	31/03/2018	Live (With Actions)
114 04/04/2016	Workforce And Organisational D	Human Resources	The Trust may experience pay costs beyond that which is affordable as set out within the 18/19 financial plan if the delivery of the pay cost improvement programme is delayed or not delivered to the required timescale or financial value.	4x5=20	1-The Executive led delivery plan is progressing the reduction of WTEs alongside a change management programme and formal consultation, including TUPE or other statutory requirements. 2 - Executive led pay cost reduction programme for 18/19 inclusive of 12 work streams tackling temporary and permanent spend. 3 -Scrutiny at Finance and Investment Committee 4 - Scrutiny at People and OD Board Committee 5 - Trust Board oversight of whole pay and non pay programme for 18/19	Raffaela Goodby ***Raffaela Goodby***	07/06/2018	3x5=15	**Delivery of Workforce Plan.** **1.** Groups required to develop and implement additional CIP plans to address identified CIP shortfall if schemes are not successful in year. Must replace schemes with others of same amount - **31/03/2019** **2.** Weekly CIP Board developed and in effect, chaired by Chief Executive, with oversight of pay and non pay plans for 18/19 that are aligned and visible **- 01/09/2018** **3.** Implement Spring 2018 consultation and evaluate impact and plan for further consultation if temporary spend reductions are not made in line with the financial plan **- 30/06/2018** **3.** Identification of sufficient pay schemes to delivery 18/19 pay position, phased via quarter **- 30/04/2018** **4.** Identification of £25m of pay and non pay improvements for 18/19 that are detailed via group with a risk log, effective programme management and executive led oversight**- 01/04/2018** **5. Implementation of 2nd year of the 16-18 CIP's monitored via TPRS - 31/03/2019** **6.** Plans to be developed with a view to commencing an open and transparent consultation process in the spring of 2018 **- 31/03/2018 - COMPLETED** **7.** Implementation of pay improvement plans that are detailed on TPRS with a clear delivery plan via group **- 31/03/2018 - COMPLETED**	3x3=9	31/03/2019	Live (With Actions)
410 04/10/2016	Surgery	Outpatients - EYE (S)	Risk of Breach of Privacy and Dignity Standard, Information Governance Risk and Infection Control Risk at SGH Opthalmology Outpatient Department as a consequence of poor building design which can result in financial penalties and poor patient outcomes	5x4=20	Staff trained in Information Governance and mindful of conversations being overheard by nearby patients / staff / visitors	Laura Young ***Rachel Barlow***	30/01/2018	3x4=12	**Poor building design of SGH Ophthamology OPD** **1**-Review of moving the community dental rooms. Plans being drawn up - should be available for consultation mid Sept 2017 - potential for renovation around mid 2018.**(31/07/2018)** **2**-Review plans in line with STC retained estate **(31/07/2018)**	2x2=4	29/09/2018	Live (With Actions)
3020 05/04/2018	Estates & New Hospitals Project	Midland Metropolitan Hospital	There is a risk that Mid Met opens after April 2020 caused by the collapse of Carillion Construction which will result in delays to our wider vision, clinical risks leading to potential reconfiguration, new and unexpected expenditure, significant bandwidth issues for senior leaders, and recruitment and retention workforce difficulties.	4x4=16	1. Weekly senior management core group, supported by weekly meetings with THC and with lenders. 2. Clinical oversight of seven Board level hazards will be confirmed by 11/4/2018	Toby Lewis ***Toby Lewis***	30/04/2018	4x4=16	1. Revisit prior alternate options for acute adult services to achieve minimal safe moves, against externally assured staffing thresholds - **23/04/2018** 2. Undertake initial regulatory engagement of options - **23/04/2018** 3. Develop costed site options - **23/04/2018** 4. establish agreed approach to land release with Homes England - **16/04/2018** 5. Price new estate and IT investments required for interim reconfiguration - **16/04/2018**	4x3=12	**30/04/2018**	Live (With Actions)
3021 05/04/2018	Estates & New Hospitals Project	Midland Metropolitan Hospital	There is a risk that the potential insolvency of THC caused by the collapse of Carillion construction leads to contractual changes in the provider of funds, construction and FM to the Midland Metropolitan project resulting in delay and increased cost, after a prolonged period of uncertainty and stasis	4x5=20	1. weekly liaison with DHSC and THC 2. engagement of industry experts in appraising option A, B or C 3. use of formal contractual processes	Toby Lewis ***Toby Lewis***	30/04/2018	4x4=16	1. Complete option appraisal & assist Board and DHSC and HMG in choosing between options A, B and C - **13/04/2018** 2. Finish analysis of contract remedies available under standard PF2 contract - **13/04/2018**	4x3=12	**16/04/2018**	Live (With Actions)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Assessment

Risk Number: 2955		**Status:**	*Live (Monitor)*
Site:	Sandwell General Hospital	**Department:**	Accident & Emergency (S)
Clin. Grp / Corp Dir:	Medicine & Emergency Care	**Owner:**	Prem John
Directorate:	Emergency And Acute Medicine	**Assessor:**	Elizabeth Miller
Specialty:	Emergency Medicine	**RR Level:**	Ward/Department/Service
Risk monitored by:	Directorate		

Initial Risk	Current Risk	Target Risk
Severity (5) x Likehood (4) = 20 Red	Severity (5) x Likehood (4) = 20 Red	Severity (4) x Likehood (3) = 12 Amber

Risk Type: Workforce **Risk Sub-Type:** Staffing

Risk Statement	Scope	Hazard
ED is unable to fill the ED Middle Grade rota (mainly out of hours shift, 22:00 to 08:00) due to the 9 ED Middle Grade vacancies the department is carrying. This will directly impact on patient care and operational delivery, i.e. time to be seen.	Middle grade workforce With impact on: SHO workforce Nursing workforce Consultant workforce	Time to treatment delays Patient experience Patient care Trust achievement of operational standards

Existing Controls:

1	Fill vacant Middle grade shifts with locums- overnight shifts filled with one substantive and regular locum where possible. Where no Middle grade doctors available, experienced SHO's used to fill shifts.	Staff

Actions:

1	Develop CESR training programme and compile business case for approval through Trust Board. Agree 3 month rotations with Acute Medicine, ITU, Paediatrics and Anaesthetics. Design criteria for acceptance to programme, training material and supervisory support. PROGRESS: Business case written and funding approved through Trust Board. Criteria for acceptance to programme agreed. Material for programme written. Meeting with Anaesthetics and ITU scheduled for 17.04.18. Acute medicine and Paediatrics rotations agreed. Further recruitment required before Middle Grades can be released for the programme. Date Entered : 17/04/2018 12:43 Entered By : Tajinder Virk-Dhugga	29/06/2018	Open	Liz Miller
2	JSD and Specialist doctor adverts to be published on NHS jobs with scheduled interviews PROGRESS: JDs and adverts reviewed. Adverts currently out on NHS jobs with interview dates arranged Date Entered : 11/04/2018 13:02 Entered By : Tajinder Virk-Dhugga	31/05/2018	Open	Elizabeth Miller
3	Make contact with recruitment agency and agree terms. Interviews to be set up weekly as CVs are sent through for review. PROGRESS: 6 Middle Grade doctors recruited. Expected to start before the end of June 18. Date Entered : 11/04/2018 13:38 Entered By : Tajinder Virk-Dhugga ---------- Interviews set up weekly-ongoing action	29/06/2018	Open	Liz Miller

Risk Assessment

Date Entered : 11/04/2018 13:06
Entered By : Tajinder Virk-Dhugga

4	Increase internal locum rate PROGRESS: Locum rate increased until April 18	29/06/2018	Open	Liz Miller

Date Entered : 11/04/2018 13:10
Entered By : Tajinder Virk-Dhugga

Review Dates:

Last Review Date: 17/04/2018 **Next Review Date:** 17/05/2018

Paper ref:	TB (05/18) 009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Unity Countdown to August and December 2018		
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Rachel Barlow, Chief Operating Officer		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

As we work towards preparedness for a "go live" date of UNITY (our electronic patient record) in August, a readiness assessment is in train. This paper provides the Trust Board with an update on:

1. A project plan for go live plan in August summarised by the key milestones. An integrated technical and operational delivery plan is in development and 80% complete at the time of writing. The aim is to have this completed by the end of April. A delivery plan to optimise usage of UNITY to a specified level by December will be considered by the May Digital Committee .

2. Project governance and risk management including the outcome of due diligence review of risk, issues, clinical hazards and change request

3. Infrastructure and IT performance to enable a safe go live. The user confidence of a UNITY go live in the near term with current user experience being one of unplanned interruption is a significant issue and must be resolved before go live. The Major Projects Authority received an update on the IT infrastructure project which details completion of the critical infrastructure work by July.

The Trust Board are asked to discuss the current status of the above 3 points and the next steps necessary to provide the Major Projects Authority meeting in May with assurance of an end to end programme for implementation and critical decision points to a 'go live ' in August.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan		Public Health Plan		People Plan & Education Plan	
Quality Plan		Research and Development		Estates Plan	
Financial Plan		Digital Plan	X	Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Private Trust Board and Major Projects Authority

4. Recommendation(s)

The Trust Board is asked to:

a.	Discuss the risk status and mitigation exceptions.
b.	Note the milestones and intention to take a December count down plan to the Major Projects Authority in May 2018.
c.	Seek assurance via the Major Projects Authority of infrastructure readiness to support go live.

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s):					
Board Assurance Framework		Risk Number(s):					
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

UNITY Countdown to August and December 2018

1. Introduction

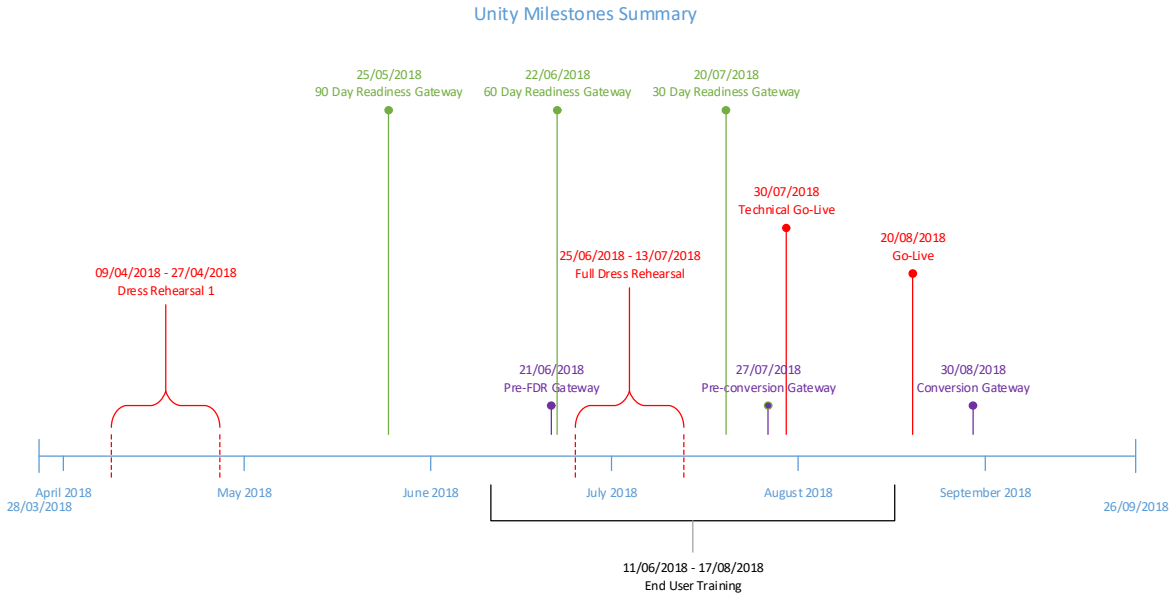
As we work towards preparedness for a go live date of UNITY (our electronic patient record) in August, a readiness assessment is in train. This paper provides the Trust Board with an update on:

- Key milestones to a 'go live' in August, noting a full delivery plan to optimise usage of UNITY to a specified level by December will be considered by the May Digital Committee.
- Project governance and risk management including the outcome of due diligence review of project risks, issues, clinical hazards and change requests (to the purchased product) and assurance on mitigation opportunities before 'go live'.
- Infrastructure and IT performance to enable a safe 'go live'.

2. Project plan to August go live and December optimisation

Due to the delay in the UNITY programme, a detailed end to end integrated technical and operational delivery programme has been a deficit. The key milestones towards an August go live are set out below:

Unity milestones



The Readiness Gateways are advisory and give assurance that the preparedness of the organisation is being managed and measure. All other gateways (e.g. Pre-FDR) are hard stops and must be successful passed through. The context of the mandatory gateway criteria changes focus on the approach to go-live; the full criteria will be reported to Digital Committee and the Major Projects Authority. Examples of gateway criteria include

assurance that the Clinical Safety Case has been approved; Standard Operating Procedures are published and available; that organisational policies have been reviewed and user training KPIs have been met.

A detailed integrated technical and operational delivery plan for a 'go live' in August is in development and 80% complete at the time of writing. The aim is to have this completed by the end of April. A delivery plan to optimise usage of UNITY to a specified level by December will be considered by the May Digital Committee.

The programme now has a full time Programme Manager Dean Harris, Deputy Director of Informatics and executive leadership from Mark Reynolds, Chief Informatics Officer responsible for the technical preparedness and resilient infrastructure and Rachel Barlow, Chief Operating Officer who is leading on readiness and implementation. There is a revised governance structure in place though a UNITY implementation committee, readiness delivery group and integrated governance process that better integrates the technical and operational delivery of this change programme. This programme reports to the Digital Committee chaired by the Chief Executive Officer. The Major Projects Authority is the Board level oversight committee.

3. Governance and risk management

In advance of a decision to 'go live', the Digital Committee and Major Projects Authority will require assurance on a comprehensive risk assessment of the programme and for all high and very high project risks, issues and clinical hazards to be mitigated. A recent due diligence review led by the Chief Operating Officer has been undertaken which reviewed the robustness of the governance arrangements and the current risk, issue and clinical hazard status. A review of the change request process (changes requested to the standard procured IT product) and deferred or declined change requests, was also completed.

The key findings of the due diligence governance review included:

Project risks and issues

- High and very high risks appear to being managed effectively in the main. The review did upgrade 2 high risks to very high.
- Medium risks are not being managed in a timely way and need a comprehensive review.

Clinical Hazards

- Membership and attendance of this session was judged to be inadequate, with non-quorate meetings and a lack of senior operational decision makers to support this governance aspect. The absence of the Clinical Safety Officer was of concern and impacting on effectiveness in this domain. This will be rectified in early May.
- The hazards list on initial review did not appear to cover the breadth and depth of the clinical service aspects that would be expected. Cerner advised the size of the hazards log was smaller than expected for this scale of programme.

Change requests

- The change control process lacked evidence of an end to end process whereby the initiator of a change request signed off the outcome of the request and in the case the product is changed approves that the change is effective. There was variation in feedback to the initiator of the request of the decisions previously made by the change request panel.
- The change control process has not been followed for the lifetime of the project. Changes therefore could have potentially been made to the product that are not recorded within the Trust nor signed off. The Trust has requested change documentation from Cerner to enable full transparency of changes made to date. The Trust is working with Cerner to ensure all design decisions have been fully documented. A large volume of walkthroughs in clinical areas are also taking place to test and provide assurance on the design of Unity.

The management of project risks, issues, clinical hazards and change requests has not been aligned. All aspects are potentially light in content. The first dress rehearsal and completion of clinical pathway walkthroughs of the product and associated clinical and non-clinical processes will be completed in early May. It is anticipated that the output from these events will populate a full list of risks, issues and clinical hazards. These will be rapidly assessed to ensure high and very high risks, issues and clinical hazards are mitigated pre 'go live' and that medium and low risk are effectively mitigated or can be safely tolerated pre and into a 'go live' situation.

There has been a lot of effort and contribution to the governance of the overall project. The due diligence review has however identified some areas of improvement in the effective governance of this project and gaps in completeness of sign off and identification of risks, issues and hazards. New chairs with senior clinical and operational experience have been appointed to manage risks, issues and clinical hazards. A fortnightly integrated governance meeting chaired by the Chief Operating Officer and attended by the governance chairs, programme manager and the medical and nursing professional UNITY leads ensures validation of the risks, issues and clinical hazards, makes certain the integration between those governance domains is effective and oversees the change request decision making.

Current risks, issues and clinical hazards summary

The current risks, issues and clinical hazards status is summarised below and exceptions where mitigation of those high and very high scores is not yet sufficient are summarised.

Risks

There are currently 2 very high risks and 6 high risks to the project including 2 new risks which will be added to the risk log.

EPR Project	Very High	High	Medium	Low
Open	2	6	47	21
Closed	13	29	110	26
Total	**15**	**35**	**157**	**47**

Risks		*Trust Score*	*Residual Score*
New risk	Unity Reporting workstream position is unclear	25	6
370	Endorsement of Results	22	TBC
New risk	Programme Resources	20	6
316	Clinical use of Snomed CT.	16	9
349	Single Document Capture Workflow is not defined	16	6
416	Inconsistencies with content for EPMA-pharmacy	16	8
352	Floor walker cutover support not adequate to ensure patient safety	15	6
405	Business Continuity Plans	15	6

All high and high risks have been reviewed and have mitigation plans to adequately manage the risk before go live, with the exception of 3 where mitigation was assessed as currently inadequate:

Risk new risk: Reporting workstream - despite some progress in this workstream there is no end to end delivery plan to provide assurance of effective and full reporting capability at go live. It is anticipated this risk can be mitigated by early May with the formation of a project team and executive oversight from Dave Baker Director of Innovation and Partnerships.

Risk 370: Results endorsement - There is no agreement on the workflow and clinical application of UNITY to endorse results. This risk links to the equivalent current state risk on the Trust risk register. A design proposal has been drafted and is being discussed with relevant stakeholders. David Carruthers, Medical Director is overseeing design and solution to mitigate this risk pre go-live.

Risk 316: Clinical Terming – the terming process changes with the Cerner product; clinical terming is the description that clinicians select to define the activity they are carrying out. This is not clinical coding, which remains unaffected by the Unity implementation. There is a risk that the clinical users will not be able to fully use the problem, diagnosis and procedure functions in UNITY correctly due to lack familiarisation with Snomed CT as a tool for clinical terming. A project team will be set up to ensure appropriate training to mitigate the risk pre go live.

Issues

There are 6 very high and high risks including 1 new issue.

EPR Project	Very High	High	Medium	Low
Open	2	4	20	8
Closed	7	26	68	13
Total	**9**	**30**	**88**	**21**

ISSUES		TRUST SCORE	RESIDUAL SCORE
371	No Clinical Safety Officer	25	5
383	Citrix Receiver Version 4.9 Upgrade	25	6
362	Inability to print labels at bedside poses risk of incorrect sample labelling	20	10
381	Lack of clearly defined process for ECG capture	16	6
New issue	Insufficient Programme resources	20	4
409	Medcon interface for Cardiology Orders	16	6

There are 2 issues that do not have a robust agreed mitigation plan:

Issue 383: Citrix Receiver version upgrade – Citrix is the software that is able to access iPM and Unity – both systems need a different product version to work correctly. There is an issue that there will be reduced functionality in UNITY unless the Citrix Receiver Version is upgraded to v4.9, for example Single Document Capture will not work. iPM (our Patient Administration System – PAS) will not function on any version above v4.5. The impact is that iPM and UNITY are not able to be installed on the same computer with access to all the functionality of Unity. This will affect critical clinical and administration work flow for staff needing to access both PAS and UNITY. The Trust is working with external partner providers to identify a reasonable mitigation which would enable both systems to be viewed on the same computer can be achieved before go live.

Issue 362: The inability to print bed side labels poses a risk to incorrect test sample labelling which could result in an adverse clinical incident. A new technological solution is in development. The time line for the solution is yet unknown but it is anticipated this could lead to reasonable mitigation plans and milestones by mid-May.

Clinical hazards

There are current 47 identified clinical hazards, which are assessed against 4 domains of design, training, business change and testing. 22 are classified as high or very high. Only 12 of these have been raised within the clinical business which is a current concern, the remainder have been raised by Cerner. It is anticipated as clinical and operational teams familiarise themselves with the UNITY product and clinical workflows through the first dress rehearsal and walkthroughs, that this list increases in size. The clinical hazards group is in the process of benchmarking against other Cerner Trusts clinical hazards logs.

The clinical hazards and mitigations are in the process of comprehensive validation to ensure mitigation is robust and where this involves service redesign that is mapped into the readiness timelines and project plans. This will be achieved by a series of review meetings additional to the standard governance processes in place and quality assure the Hazard Log. This will be reported to Digital Committee and the Major Projects Authority in May.

4. Infrastructure and IT performance to enable a safe go live

Major progress has been made on infrastructure improvements over the past year, led by Mark Reynolds, Chief Informatics Officer. The Major Projects Authority has received updates and assurance to mitigate the 'red' infrastructure risks and Informatics will undertake the following activities to resolve the red areas by end May:

- Local area network (LAN) – resolve specific issues identified with the LAN.
- Wide area network (WAN) – upgrade the Internet links to remove a performance bottleneck
- Backup – upgrade and expand the new backup system

These activities are scrutinised by the Major Projects Authority and Digital Committee.

Infrastructure Scorecard

Area	Planned	Healthy	Resilient	Secure	Managed
Devices	G	G	A	A	A
Mobile Devices	A	A	G	A	A
Compute	G	G	G	A	A
Databases	A	G	G	A	G
Storage	A	G	A	G	A
LAN	G	R	G	G	A
Wi-Fi	G	A	G	G	A
WAN	R	A	G	G	A
Print	A	A	G	G	A
Backup	A	R	A	G	A
Data Centre	G	G	A	A	G
Telecoms	G	A	G	G	G

5. Summary and Conclusion

The Trust Board are asked to receive this update as work in progress. The Major Projects Authority in May will be an extended meeting in order to focus on seeking assurance on:

- Evidence of an end to end delivery programme to December optimisation standards
- Assurance on gateway decision points and success criteria to ensure safe decision making for a 'go live' in August
- Assurance on infrastructure readiness and stabilisation
- Outcome of full risk, issues and clinical hazards review and mitigation of high and very high scores
- Outcome of first dress rehearsal and walkthroughs
- Readiness assessment including training update

Paper ref:	TB (05/18) 010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	CQC Improvement Plan: Progress Report		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author	Allison Binns, Deputy Director of Governance		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Committee should focus on]*

At the Quality Summit in November 2017 the need for assistance to achieve an out of hours paediatric service suitable for the population it serves was accepted by the external regulators and stakeholders present. Despite concerted effort by the Trust, particularly in discussions with NHSE and Birmingham Children's Hospital, this remains an outstanding concern.

The Trust's plan is to achieve an overall 'Good' rating at the next Inspection, likely to be at the end of this year. To achieve this we must sustain improved emergency care performance and provide consistent care on our medical wards. Are the plans we currently have in place sufficient to meet our stated aim.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	x	Public Health Plan		People Plan & Education Plan	x
Quality Plan	x	Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	x

3. Previous consideration *[where has this paper been previously discussed?]*

Quality & Safety Committee 27 April 2018

4. Recommendation(s)

The Trust Board is asked to:

a.	**ACCEPT** the assessment of the actions taken to date as defined by the ratings (Appendix 2)
b.	**RECEIVE** updates on the validation to test successful delivery of the actions in August 2018
c.	**APPROVE** that progress against validation and any areas of concern are highlighted to the Quality & Safety Committee monthly.

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s):					
Board Assurance Framework		Risk Number(s):					
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 3rd May 2018

CQC Improvement Plan: Progress Report

1. Introduction

1.1 The Trust was inspected by the CQC in March 2017. Their report on the services inspected was published in October 2017 awarding us an overall rating of 'Requires Improvement'.

1.2 Although the overall Trust rating, 'requires improvement' has not changed, there were significant improvements in our service and domain ratings, in fact 70 per cent of our services are now rated as 'good' or 'outstanding'. The CQC rated our End of Life Care as 'outstanding' which is a distinctive achievement; very few such services UK-wide have that accolade. Our Surgery and Imaging services moved into a 'good' rating. Recognising the compassion of our workforce, the CQC rated us as 'outstanding' in the caring domain. The safety domain is now rated as 'requires improvement', better than the previous 'inadequate' rating. Disappointingly, the CQC rated our community inpatient wards as 'inadequate' following their visits to Rowley Regis Hospital. The teams have taken the criticism, as well as the positive comments, on board and already addressed most of the areas called out for attention.

1.3 The CQC inspection report contained recommendations designated as 'must dos' and 'should dos,' totalling 131 (**Appendix 1**). Actions to meet these recommendations were assigned a target date of either December 2017 or March 2018 and monitored through various Committees and Boards.

1.4 106 actions have been implemented as at the end of March 2018. Of those remaining, 2 continue, with the Board's approval, to be ongoing with external assistance and 23 are behind schedule but are in the process of being implemented with some actions already in place. (**Appendix 2)**

1.5 This report provide the Board with an update on the work that has been achieved and is on-going to progress our 'Requires Improvement' rating to 'Good'.

2. Progress

2.1 <u>Urgent & Emergency Services</u>

As both part of the CQC improvement plan and the Consistency in Care programme for Medicine & Emergency Care and our community wards , significant improvements have been seen in the documentation used to support patient care. Escalation processes, with use of action cards have been both deployed to staff and, recently, tested given the challenges faced within the Emergency Departments (EDs) from patient attendances. To support staff, the Human Resources Business Partner now attends weekly meetings, which in turn supports the resource needs to care for patients.

2.2 One of the recommendations continues to pose a challenge and the Board had previously agreed this was an ongoing issue requiring external resources (employment of middle

grade doctors). Appointments have been made, but their remains a gap. Five of the recommendations have been partially actioned with further work ongoing; for example MD8, – work is complete at City but work commences at Sandwell on 4 May 2018, MD13 – a push/pull model has been introduced and is embryonic in its implementation whilst not all patients are getting escalated at the right time so patients are staying longer than intended in the ED

2.3 Birmingham and Midland Eye Centre ED (BMEC)

BMEC ED was assessed as part of this service and has successfully implemented patients being advised of waiting times both through verbal communication on registration and on a white board in the department. Water is now available for patients in the waiting area of the ED. Issues proving challenging are those which require possible structural solutions to provide privacy or a paediatric waiting area, but work is ongoing to look at options. The Board also agreed that the provision of a more regional approach to out of hours paediatric medical cover was to be pursued with the assistance of NHSE and BCH.

2.4 Medical Care

Our Medical wards at the time of our inspection were about to embark on a Consistency in Care programme and many of the recommendations made by the CQC were featured as part of this programme. The number of vacancies for nursing staff has significantly reduced requiring less temporary staff to care for patients. Documentation to prescribe and support care has improved and is evidenced through the success of the Safety Plan and through an increase in patients who are assessed for Mental Capacity and considered for a Deprivation of Liberty (DOLS) order, ensuring their safety whilst in our care.

2.5 Some of the actions are not yet completed (8 recommendations). Those relating to mandatory training are improving, with more work to do. Board and ward rounds have seen more robust attendance with a designated Consultant of the Week but this requires consistency across all teams to be achieved. This has also helped in reducing delays in the patient pathway with the Medicine Group being close to agreeing the definition of the setting of correct Expected Dates of Discharge (EDD).

2.6 Surgery

Surgery have implemented all of the actions required, ensuring that infection control practice is maintained by repairing worktops in theatres, consent processes are initiated and completed before the day of the procedure and competency assessments have been revisited for nursing staff ensuring they have the specialist skills required to care for their patient groups. Safety Plan data provides evidence of achievement against the safety standards and of particular note is the improvement in applications for DOLS.

2.7 Outpatient & Diagnostic Imaging

All phlebotomists are trained in taking blood from children and the team have taken steps to ensure that all children have numbing cream on beforehand and for the right length of time to improve the experience for children and their parents. Due to space constraints weighing scales could not be moved but staff have positioned themselves to shield patients and do not read out the weight, thus providing a measure of privacy which is practical. By appointing an infection control champion within the outpatients, hand hygiene training

and awareness has improved significantly as evidenced in monthly audits. Posters relating to the availability of chaperones are displayed in all outpatient areas to ensure patients know to ask if they want one present during consultation. Actions still requiring some work relate to mandatory training levels and environmental issues of privacy which are ongoing.

2.8 Children & Young People (BMEC)

The recommendations for this part of BMECs service are to try and help define the different needs that children and young people have in an environment largely geared towards adults and staff who care for all. The creation of a working group between surgery and paediatrics has enabled the actions to be carried out. Challenges, as with other services are around mandatory training and environmental requirements.

2.9 Community Inpatients

The community wards have achieved all of their actions and have embraced the Consistency in Care programme. Staff have delivered the changes required and evidence shows that there is sustained high quality assessment and documentation across all of the wards. A box was introduced very swiftly onto ward areas to ensure that specimens containing patient details were stored securely whilst waiting for collection.

2.10 End of Life care

The actions required were responded to quickly following receipt of the CQC's report as all had been put in place or rectified around the inspection or shortly after last year.

3. Validation

3.1 In house inspections have so far taken place in the two Emergency Departments, one outpatient department, BMEC and selected medical, surgical and community wards.

3.2 Early indications are that the wards reviewed at Rowley Regis Hospital had extremely positive inspections, with staff showing good knowledge on a range of subjects. Other wards showed mixed results which, with further embedding of actions, may show a more positive response which has been seen through the Consistency in Care programme.

3.3 As the Board is aware audits are taking place and data held centrally is being collected to track that the actions have had the intended improvements.

3.4 Over the next few months, further inspection checklists will be produced to assess areas against the full recommendations and 6 months' worth of audit data will be collated to assess that the improvements have been embedded and sustained.

4. Conclusion

4.1 The Trusts aim is to achieve a 'Good' rating at the next CQC inspection, likely to be later this year, with particular emphasis on addressing the areas which were identified as inadequate in 2017 which were: safe for medical care, responsiveness in services for

children and young people and safe, effective and well-led for community inpatient services.

4.2 While early validation evidence shows some promising information, the pressures facing the urgent care services remains a significant challenge despite the improvements made so far. Sustainability of these improvements will become apparent over the next few months and certainly if admission numbers peak again with blockages in patient flow.

4.3 The community inpatient areas have worked closely with other groups to provide patients with the best transition from the acute bed base. The immediate ownership of the issues highlighted by the CQC during their inspection saw them make swift changes in reaction, but more importantly they have proactively reviewed the way they care for patients within certain pathways to get a consistent approach across all their wards.

4.4 Many of the actions undertaken within medical care wards was a reflection of the work commenced within the consistency in care programme. This programme provides a stronger platform for our attainment of a 'Good' rating as assurances from data are strong and with the much improved staffing position.

4.5 Much of what needs to be consolidated hinges on our ability to ensure we close our unplanned open beds, releasing staff to their base wards, ensuring we define and meet our EDDs enabling patients to move smoothly through the services and on to their discharge destination in a timely way. Together with the pressures on the urgent care services, this will continue to be a challenging time requiring careful and constant monitoring if we are to ensure the good work already undertaken doesn't decline.

4.6 Validation of the actions already implemented is in progress, the results of which will be reported to the Board in August 2018.

5. Recommendations

The Trust Board is asked to:

5.1 **ACCEPT** the assessment of the actions taken to date as defined by the ratings (Appendix 2)

5.2 **RECEIVE** updates on the validation to test successful delivery of the actions in August 2018 and;

5.3 **APPROVE** that progress against validation and any areas of concern are highlighted to the Quality & Safety Committee monthly.

Allison Binns
Deputy Director of Governance

25 April 2018

Sandwell and West Birmingham Hospitals NHS Trust

Our Improvement Plan:

responding to the Care Quality Commission inspection findings in March 2017

Services inspected:

- Urgent and Emergency Services (A&E)
- Medical Care
- Surgery, including BMEC and Children & Young People
- Outpatients and Diagnostic Imaging
- End of Life Care
- Community Inpatients

[NB: CQC reports published on 31 October 2017]

Where EVERYONE Matters

Going for Good:
Our approach in the next 12 months

Purpose
70% of Trust services are now rated good or outstanding. Three of the five current domains improved in 2017 compared to 2015. Our intention by 2019 is to achieve a good rating, notwithstanding that acute services come onto a single site from summer 2019. We recognise that that demands that we retain and enhance our grip on resources, whilst delivering the actions required by the CQC in their latest report.

That report details specific issues, for example in BMEC and in two of our five intermediate care wards, but also reinforces our own view that Medicine and Urgent Care need to achieve the Consistency of Care that we have been targeting since February 2017, after the Board decision in December 2016 to put medicine into 'special measures'.

Governance
The Trust has almost completed implementation of our Safety Plan. During 2018 we will begin phased implementation of the accompanying Quality Plan. These key aims will be managed alongside the CQC Improvement Plan. Clinical Groups and the Executive leadership will oversee and steer that through the new monthly Executive Quality Committee (EQC). This EQC reports to the most senior decision making body of the Trust, the Clinical Leadership Executive, and on to the Trust's Board. The EQC is shadowed by the Board's own Quality and Safety Committee which will own the Improvement Plan on behalf of the Board.

Impact assessment
In common with our approach to Room For Improvement (our 2015 action plan) we must ensure that we deliver outcome changes not simply actions completed. And we wish to generate and sustain local improvement momentum consistent with our Quality Improvement Half Days, and using the single Improvement Methodology in which hundreds of staff have been trained. During Q1 2018-19 100% of Trust employees will have objectives set for the future under our Aspiring to Excellence PDR system. Each of these changes and opportunities contribute to cultural and behavioural effort to reach and sustain good quality care. We will use data, staff voices, board and other visits and our local inspection regime to test delivery.

EMERGENCY AND URGENT CARE

Ref: MD= must do SD= should do	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How has successful completion been evidenced?
URGENT AND EMERGENCY SERVICES (A&E): SANDWELL GENERAL HOSPITAL					
MD1 (S)	The trust must take action to ensure storage and availability arrangements of emergency medicines required for resuscitation follow Resus Council Guidance and robust arrangements are put in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.	• All our trolleys must meet RC (UK) requirements and medications brought to 2222 calls by resus nurse in secure bags. Medications kept on trolleys are supplied in sealed bags (x2 adrenaline 1:10,000)	Elaine Newell	December 2017	Checking audits show 100% compliance for content and frequency.
MD2 (S)	The trust must take action to improve the standard of records completed by doctors when patients are admitted to wards from the ED compromised the clerking process and increased risk to patients.	• We will instigate a Consistency of Care documentation programme within ED designed to support the record keeping standards demanded by our EPR.	Cliona Magee	March 2018	Shift by shift audit checks undertaken during March and April
MD3 (S)	The trust must take action to ensure patients in the ED receive treatment within one hour of arriving in line with the Royal College of Emergency Medicine (RCEM) recommendation.	• The Trust has extremely good 'first 15 minute' triage implementation • Putting RATs consistently into our departments will make sure that we commence treatment in most cases inside one hour	Liz Miller	December 2017	Scorecard data must show 95% consistent delivery
MD4 (S)	The trust must take action to ensure there is a clearly agreed and resourced system in place for safely managing the condition of patients queuing on trolleys when the ED is very busy.	• An escalation process was deployed prior to, and reinforced since, the CQC inspection – following Board level discussions on risk • Staff awareness of the escalation arrangements will be tested by anonymised survey, and line management 1:1s	Nuhu Usman	December 2017	The results of the survey showing that all staff are aware of the escalation arrangements and feel confident to use them.
MD5 (S)	The trust must take action to ensure staff identify patients at risk of sepsis and follow the sepsis pathway in place.	• The Sepsis pathway at the Trust is being reviewed and amended, with a simplification of approach which can be initiated at first hour treatment point outlined above	Roger Stedman	March 2018	Achievement of 80% compliance in Q4, rising to 90% in Q1

Ref: MD= must do SD= should do	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How has successful completion been evidenced?
MD6 (S)	The trust must take action to ensure doctors use the appropriate proforma in place for effective clinical pathways.	• A list of Unity cross checked proformas will be provided to every ED doctor, and will be made available to all locum attendees as well	Prem John	December 2017	Q1 audit of 'missing opportunity' patients to identify whether medical staff proforma awareness was the root cause.
MD7 (S)	The trust must take action to ensure sufficient substantive registrar cover overnight for the safety of patients.	• The process for booking and administering locums in ED has been fundamentally changed, with all bookings now undertaken through the bank office.	Liz Miller	December 2017	Rota compliance achieved, with combined vacancy and sickness position not exceeding 3% of shifts
MD8 (S)	The trust must take action to ensure there is a designated appropriately safe room available within which to care for patients with mental ill health.	• Identify a designated room for the use of patients with Mental Health issues • Communicate to all staff through safety briefings, the intended room.	Liz Miller	December 2017	All staff able to articulate which room has been designated.
MD9 (S)	The trust must take action to ensure the security and safety of staff working in the ED at all times.	• A standard cross site approach will be adopted, with monitored response times in place	Steve Clarke	March 2018	Response compliance rates will be above 90%
MD10 (S)	The trust must take action to ensure unplanned re-attendance rate to the ED within seven days is reduced.	• A specific audit of re-attendance will be undertaken to understand for November patients what lay behind re-attendance rates • Commence GP direct booking work on both sites during November 2017	Liz Miller	December 2017	Reducing trend evidenced through the urgent care score card.
MD11 (S)	The trust must take action to ensure information about patients' assessment and condition recorded by consultants and doctors is sufficiently detailed, precise and legible.	• This will be addressed by the replacement of paper records with the implementation of Unity in Spring 2018 • We will instigate a Consistency of Care documentation programme within ED designed to support the record keeping standards demanded by our EPR.	Prem John	March 2018	Evidence that 100% of medical staff in ED have been advised of expected standards and agree to adhere to them.
MD12 (S)	The trust must take action to ensure patients are treated within one hour of arriving.	• Review RATS process and modify as required to improve arrival to treatment times. • Review current waiting times through arrival to treatment pathway to identify areas to reduce waiting time.	Liz Miller	December 2017	Performance dashboard shows 95% of patients seen within 1 hour consistently.

Ref: MD= must do SD= should do	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How has successful completion been evidenced?
MD13 (S)	The trust must take action to ensure patients are admitted, transferred or discharged within four hours of arrival in the ED.	• All 3 hour wait patients are now escalated to the Capacity Team • Introduction of push / pull model from December will improve bed flow	Rachel Barlow	March 2018	Consistent delivery of emergency care wait time standards
MD14 (S)	The trust must take effective action to mitigate the increasing risks to patients from overcrowding in the ED.	• An escalation process was deployed prior to, and reinforced since, the CQC inspection – following Board level discussions on risk	Nuhu Usman	December 2017	Staff awareness of the escalation arrangements will be tested by anonymised survey, and line management 1:1s
SD1 (S)	Consider reviewing arrangements in place to support the number of newly qualified nurses allocated to the ED.	• Review the preceptorship programme to ensure it adequately supports newly qualified staff. • Review and redefine the PDN role within the Department with respect to newly qualified staff • Meet with Corporate Education team to review level of assistance they can give to support newly qualified staff • Ensure supernumerary status adhered to and working with mentor	Liz Miller	March 2018	Discussion with all newly qualified nurses to assess level of support.
SD2 (S)	Reviewing arrangements in place in order to successfully rotate staff between Sandwell Hospital and City Hospital ED sites.	• Reintroduce a revised and well communicated rotation programme	Liz Miller	December 2017	Staff opinion on the new rotational regime shows broad support
SD3 (S)	Consider reviewing arrangements in place for Human Resources support to the ED staff team and leaders.	• All ED team leaders to achieve accredited line manager status • ED scorecard to record timeliness of all investigative and other conduct investigations	Raffaela Goodby	March 2018	ED investigations and conduct issues meet Trust standards
URGENT AND EMERGENCY SERVICES (A&E): CITY HOSPITAL, INCL. BMEC					
SD4 (C)	The trust should review cleaning schedules and include the windows above the minors' area, which were not part of the housekeeping schedule and	• The cleaning schedule will be amended	Steve Clarke	December 2017	Cleaning schedule in place to include windows above minors.

Ref: MD= must do SD= should do	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How has successful completion been evidenced?
	had not been cleaned for several months.				
SD5 (C)	The trust should review action plans from national and local audits, in particular record keeping audits to improve the quality of patient records.	• Patient record completeness will be addressed under other actions and primarily improved by the introduction of EPR • The audit programme for ED will be specifically reviewed by the Board's quality and safety committee	Medical Director	March 2018	Audit outcome implementation in 2018-19 shows trajectory of marked improvement
SD6 (C)7	The trust should improve the communication of waiting times to patients, especially if electronic displays are not in use.	• We will use electronic systems to display time to be seen	Liz Miller	December 2017	Reduction in 'left without seen' rates
SD7 (C)	Look for ways to improve patient privacy in the department.	• We will explore whether there are any cost effective design changes we can make in advance of the move to Midland Met	Alan Kenny	December 2017	Reduction in formal and informal complaints
SD8 (C)	Improve the waiting area and provision of age appropriate toys and games for children and young people in the department.	• We will create specific paediatric wait space in BMEC ED • We will increase toys in the department	Laura Young and Liz Miller	March 2018	Visual identification of areas for children within the departments.
SD9 (C)	Consider introducing an electronic flagging system for vulnerable patients, such as those living with dementia or a learning disability.	• The flag system is already in use in the Trust and is also incorporated into Unity – and will be deployed in PatientFirst. Patient passport practice is also in place. Improved compliance forms part of our diversity pledges within the disability network	Cliona Magee	March 2018	Documented process available for flagging appropriate patients. Evidence of all staff knowing and agreeing to carry out the process.
SD10 (C)	Consider participating in wider range local and national audits in order to assess, evaluate and improve care of patients in a systematic way.	• The audit programme for ED will be specifically reviewed by the Board's Quality and Safety Committee	Medical Director	March 2018	Audit outcome implementation in 2018-19 shows trajectory of marked improvement

Ref: MD= must do SD= should do	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How has successful completion been evidenced?
SD11 (C)	Staff should routinely assess patients' pain on arrival to the department.	• This is already a Safety Plan standard for our wards and during Q4 we will implement this as part of the triage process	Liz Miller	March 2018	Spot check audits and data showing 100% compliance
SD12 (C)	Introduce a water dispenser in the BMEC ED waiting room to ensure vulnerable patients have quick access to water at all times.	• Install water dispenser	Steve Clarke	December 2017	Water available in BMEC ED.
SD13 (C)	Implement SLAs with other trusts so that paediatric patients are kept safe at all times.	• The Trust has put a formal proposal to BCH and NHS England to address this risk, which has been on the corporate risk register in public for some time. We anticipate resolution over the next eight weeks	Medical director	December 2017	Compliance from Q1 with the regional standards we are seeking to co-opt others into adopting
SD14 (C)	Improve communication from executive colleagues regarding changes being proposed to the department.	• We will continue the current model of involvement in handover and huddles, augmented by further inclusion in our Board visits programme	Rachel Barlow	March 2018	Repeat anonymised staff survey for ED during 2018
EMERGENCY DEPARTMENT: BMEC					
MD15 (C)	Increase availability of specialist medical staff and anaesthetists to minimise the risk that children, particularly those younger than three years of age, who attended department receive timely and appropriate treatment.	• The Trust has put a formal proposal to BCH and NHS England to address this risk, which has been on the corporate risk register in public for some time. We anticipate resolution over the next eight weeks	Medical director	December 2017	Compliance from Q1 with the regional standards we are seeking to co-opt others into adopting
MD16 (C)	Robust policies and procedures are in place to manage the effective security of prescription forms at a local level.	• Secure place for storing prescription forms identified • Nurse in charge of ED to distribute forms each day and document. • Medical staff to document for each prescription provided (name, RXK) • Medical staff to hand back at the end of their shift to NIC with	Bushra Mushtaq	December 2017	Evidence that 100% of relevant staff understand and will adhere to process. Documentation log shows adherence to process in all cases.

Ref: MD= must do SD= should do	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How has successful completion been evidenced?
		list of patients in receipt • All medical staff and nurses taking charge to be advised of procedure and agree to implement. •			
MD17 (C)	The storage of fluids are tamper proof, in line with Resuscitation Council guidelines.	• Assess the existing resuscitation trolleys against the resus policy approved checklist. • Communicate to all ED clinical staff regarding the expected stock on resus trolleys (nothing additional) • Identify who checks trolleys and when and communicate to relevant nursing staff. (removing anything additional) • Nurse checker to document on log anything additional being added to trolleys, remove and advise staff of error in safety briefings.	Laura Young	December 2017	Evidence that all those checking the trolleys have been advised of what should and should not be on the trolley and will implement. Checking audits show 100% compliance for content and frequency. Log shows any trolley equipment discrepancies and safety briefings show comms.
MD18 (C)	Patient records must meet standards for general medical record keeping by physicians in hospital practice**.**	• All our EDs, including BMEC, will be subject to a Consistency of Care documentation programme during Q4	Elaine Newell	March 2018	Evidence that 100% of medical staff in ED have been advised of expected standards and agree to adhere to them. Adherence or ahead of improvement trajectory through audits.

MEDICAL CARE

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
MEDICAL CARE: SANDWELL GENERAL HOSPITAL					
MD19 (S)	All staff across medical services are up-to-date with basic life supporting training.	• BLS training is being pushed Trustwide, and we are on trajectory to re-achieve compliance	Raffaela Goodby	March 2018	90% compliance by March 2018
MD20 (S)	Temporary staff being used are competent to fulfil the role.	• Bank competencies already assessed but local induction to shift process to be established • Agency competencies to be examined together with end of shift assessment by supervising clinician for every agency worker	Elaine Newell	March 2018	Clear documented evidence of local inductions. 100% of staff – evidence of competency assessment.
MD21 (S)	Resuscitation medicines and equipment are stored in a way to protect from tampering and that storage and availability is consistent across all areas within the medical service.	• Assess the existing resuscitation trolleys against the resus policy approved checklist. • Communicate to all clinical staff regarding the expected stock on resus trolleys (nothing additional) • Identify who checks trolleys and when and communicate to relevant nursing staff. (removing anything additional) • Nurse checker to document on log anything additional being added to trolleys, remove and advise staff of error in safety briefings. •	Elaine Newell	March 2018	Checking audits show 100% compliance for content and frequency. Log shows any trolley equipment discrepancies and safety briefings show comms.
MD22 (S)	Guidance from the Resuscitation Council (November 2016) is being followed.	• Trust policy and practice already meets the Resuscitation Council guidelines	Helen Cope	Complete	Resus team audit trollies for compliance monthly in Q4
MD23 (S)	Sufficient storage for equipment on medical wards to avoid delay in relevant equipment being received by ward staff, and to avoid out of service and in service	• Ensure all medical equipment kept at ward level is stored safely and easily accessible • All equipment kept in the medical equipment store must be readily accessible to the wards	Group Director of Nursing, Medicine	March 2018	No IR1 generated in regard to this issue. Equipment store daily checks in place

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
	equipment being stored together.	• PAT testing must be up to date. • Meet with Medical Equipment Manager to discuss solutions.			
MD24 (S)	Sufficient staffing and skill mix to meet safe staffing requirements on medical wards.	• Staff recruitment since the inspection and has gone well and we no longer use expensive Thornbury agency staff • The next acuity audit will take place in November 2017, then June 2018 and November 2018.	Elaine Newell	March 2018	Unify safe staffing report demonstrates compliance within 8% threshold tolerance
SD15 (S)	Using a consistent approach for documentation across the medical service. We saw variations in fridge temperature documentation and patient records.	• Develop standards for documentation and publicise these as part of the Consistency of Care programme	April Hawkins	December 2017	Weekly Audit shows compliance against core standards at >90%
SD16 (S)	Staff are knowledgeable and understand the policies in place to prevent and control infection.	• Check that all infection control policies are in date and available on the Intranet • Identify IC mandatory training levels for each medicine ward nursing staff, AHPs and Medical staff attending medicine wards • Bank Lead Nurse to develop process to ensure bank staff are aware of relevant policies to their role	Elaine Newell	March 2018	Documented assurance that each staff member working within the medical wards are aware of their responsibilities in relation to IC and will follow them Number of infection control breaches within wards and investigation reports. Documented assurance that each bank member is aware of their responsibilities in relation to IC and will follow them.
SD17 (S)	Updating the disinfectant solution log to ensure it reflects clearly how long a solution has been premade for.	• Develop posters for display in key areas directing staff on the correct process	April Hawkins	December 2017	Contemporaneous entries in the log to demonstrate compliance

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
SD18 (S)	Staff are consistently completing relevant risk assessment documentation.	• Shift by shift documentation handover regime implemented in October 2017	Elaine Newell	December 2017	Achievement of Consistency of Care programme goals
SD19 (S)	All staff are confident with procedures and up to date with relevant training for emergency events, such as fires.	• Ward managers to identify named staff requiring relevant training • Schedule individual staff onto e roster for training / update • Revised PDR process to include documented compliance against relevant training	Group Director of Nursing, Medicine	March 2018	Ward based training compliance >90%
SD20 (S)	All staff are clear about Deprivation of Liberty Safeguards (2007) and when it is appropriate to make an application to authorise a deprivation of liberty.	• Check that DOLS policy / process is up to date and easily accessible on the Trust intranet. • Non complaint staff to undertake training through roster allocation. • Work with Safeguarding and Comms teams to raise awareness with medical staff regarding when it is appropriate to make a DOLS application. • Track the number of DOLS applications via IPR. • Safeguarding team to undertake spot audits to assess compliance	Elaine Newell	March 2018	Increased numbers of DOLS application made – monitored via IPR.
SD21 (S)	Continue with improvements made to reduce waiting times and average length of stay for some specialities.	• Ensure EDD set correctly and adhered to • Core LOS dataset to be reviewed and published • Weekly monitoring of mean length of stay by ward and speciality • Establish a Consultant of the Week approach to care management and delivery	Chetan Varma	March 2018	Changes to EDDs below 10%
SD22 (S)	Continue with improvements to gain JAG accreditation for the endoscopy unit.	• JAG accreditation was achieved in July 2017	Mark Anderson	December 2017	JAG accreditation retained

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
MEDICAL CARE: CITY HOSPITAL					
MD25 (C)	Ensure compliance with the Mental Capacity Act (2005) is documented.	• Check that MCA policy / process is up to date and easily accessible on the Trust intranet. • Staff non complaint with Adult safeguarding training to undertake training through roster allocation. • Work with Safeguarding and Comms teams to raise awareness with assurance that every staff member acknowledges messages. • Safeguarding team to undertake spot audits to assess compliance	Elaine Newell	March 2018	Safeguarding audits demonstrate compliance with required documentation.
MD26 (C)	Ensure attendance at mandatory training is improved.	• Review of approach to mandatory training completed and performance management system demonstrably effective via Group Reviews	Raffaela Goodby	March 2018	MT compliance improves >95%
MD27 (C)	Take steps to reduce delays in the patient journey and ensure people are able to access care and treatment in a timely way.	• Ensure EDD set correctly and adhered to • Core LOS dataset to be reviewed and published • Weekly monitoring of mean length of stay by ward and speciality • Establish a Consultant of the Week approach to care management and delivery	Chetan Varma	March 2018	Changes to EDD below 10%
MD28 (C)	Improve the consistency of multi-disciplinary processes and ensure the implementation of consultant led board and ward rounds.	• Establish a Consultant of the Week approach to care management and delivery • Establish SoP for Board / Ward rounds and raise awareness as part of CoC process	Chetan Varma	March 2018	Deliver Consistency of Care outcomes
MD29 (C)	Ensure patients have access to translation services when required.	• Re -publicise in Heartbeat and daily comms how to access translation services. • Undertake assessment to ensure all clinical areas have access to language line. • Advertise access to translation service in key languages throughout ward and clinical areas.	Elaine Newell	March 2018	Utilisation data produced from April 2018 for all clinical areas, showing proportionate and acceptable use

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
MD30 (C)	Ensure governance structures are embedded and a structured approach is taken to the identification and management of organisational risk.	• The Executive Quality Committee will sign off governance structures in each clinical group by the end of Q4	Kam Dhami	March 2018	Risk register penetration and awareness demonstrated in staff surveys
SD23 (C)	Review the content of the emergency resuscitation trolleys and ensure security of the contents.	• Assess the existing resuscitation trolleys against the resus policy approved checklist. • Communicate to all clinical staff regarding the expected stock on resus trolleys (nothing additional) • Identify who checks trolleys and when and communicate to relevant nursing staff. (removing anything additional) • Nurse checker to document on log anything additional being added to trolleys, remove and advise staff of error in safety briefings.	Helen Cope	March 2018	Evidence that all those checking the trolleys have been advised of what should and should not be on the trolley and will implement. Checking audits show 100% compliance for content and frequency. Log shows any trolley equipment discrepancies and safety briefings show comms.

SURGERY

Ref	Issue identified by the CQC Inspectors	Improvement actions to be taken to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
SURGERY: SANDWELL GENERAL HOSPITAL					
MD31 (S)	Measures are in place to prevent further Never Events to protect patient's safety.	• Our comprehensive approach to this issue is detailed in the revised Board approved approach agreed in Q1 2017-18 • Learning from SUIs and Never Events will form the basis for our 2017-18 annual report distributed to all employees in electronic form	Kam Dhami	March 2018	• Minutes of QIHDs will evidence review of SUIs • Trust wide intranet portal / learning hub for SI case studies with actions and learning • Induction plans/agendas
MD32 (S)	Records of care and treatment provided to patients are accurate and complete.	• Audit of notes for completeness with rectification plans as needed monitored through Directorate Reviews and QIHD	Ajai Tyagi	March 2018	• Audit of notes will evidence compliance with good practice for recording of information in patient records
SD24 (S)	Review the system of pooling surgical patients to ensure that patients are not put at risk.	• All Directorates required to confirm adherence with national guidance; reinforced through Directorate Reviews • Booking teams provided with clear rules regarding pooling • Review of pooled patients in accordance with national guidance	Tina Robinson	December 2017	• Patients will be pooled in accordance with national guidance • Booking teams are able to articulate national guidance and how they book patients in accordance with this
SD25 (S)	Identify a non-executive board member to champion theatres issues at board level and support the service.	• The whole Board champions theatre issues and visits theatres. The Theatre Management Board provides reports through the Quality and Safety Committee and the chair of that committee will take a particular interest	Richard Samuda	December 2017	• Minutes of Board meetings
SD26 (S)	Repair work surfaces in theatres to comply with infection prevention and control guidance.	• Risk assess work surfaces in theatres • Cost repair works • Continue cleanliness regime to minimise risk	Donna James	March 2018	• Risk register updated • Repair works carried out as needed • Compliance with cleanliness audits

Ref	Issue identified by the CQC Inspectors	Improvement actions to be taken to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
SD27 (S)	All junior doctors are familiar with escalation process should patients treatment or discharge be delayed by imaging department issues.	• The Red to Green programme will address this issue and give Trust-wide visibility for any delays • Trainee doctors will be inducted into the process for escalating patients delays but the introduction of ward based consultants should mitigate any risk	Rachel Barlow	December 2017	• Junior doctors are able to articulate escalation process • Reduced delays evidenced through R2G
SD28 (S)	Safety thermometer information is displayed on the wards. Staff members should be aware of their ward scores.	• The safety thermometer is NOT a priority measure of safety at the Trust. Our focus is on the daily-real time Safety Plan. • Safety thermometer data will be made available on ward TV screens	Dave Baker	March 2018	• Consistent achievement of Safety Plan metrics ward by ward • Unannounced inspection shows good safety thermometer awareness
SD29 (S)	Competencies for nursing staff working in surgical specialisms should be revisited after their initial competency 'sign off' stage.	• The Trust has in place an educational assessment process for all Band 5s, which took place in summer 2017 • A further surgery specific audit will be undertaken in each ward by the end of Q4 to check that all relevant material has been evaluated	Elaine Newell	March 2018	• Full compliance by end of June 2018
SD30 (S)	Wider learning is promoted through complaint trends being shared across all areas of the trust.	• This is to be included in the new Governance Scorecard which will be reviewed at Group Management Board and assessed monthly at EQC	Kam Dhami	December 2017	• Agendas and Minutes of GMB evidence review of complaints and trends
SURGERY: CITY HOSPITAL, INCL. BMEC					
MD33 (C)	Ensure measures are in place to prevent further Never Events to protect patient's safety.	• Our comprehensive approach to this issue is detailed in the revised Board approved approach agreed in Q1 2017-18 • Learning from SUIs and Never Events will form the basis for our 2017-18 annual report distributed to all employees in electronic form	Kam Dhami	March 2018	• Minutes of QIHDs will evidence review of SUIs • Trust wide intranet portal / learning hub for SI case studies with actions and learning • Induction plans/agendas
SD31 (C)	Safety thermometer information should be displayed on the wards. Staff members should be aware of their ward	• The safety thermometer is NOT a priority measure of safety at the Trust. Our focus is on the daily-real time Safety Plan. • Safety thermometer data will be made available on ward TV	Dave Baker	March 2018	• Consistent achievement of Safety Plan metrics ward by ward • Unannounced inspection shows

Ref	Issue identified by the CQC Inspectors	Improvement actions to be taken to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
	scores.	screens			good safety thermometer awareness
SD32 (C)	Competencies for nursing staff working in surgical specialisms should be revisited after their initial competency 'sign off' stage.	• The Trust has in place an educational assessment process for all Band 5s, which took place in summer 2017 • A further surgery specific audit will be undertaken in each ward by the end of Q4 to check that all relevant material has been evaluated	Elaine Newell	March 2018	• Full compliance by end of June 2018
SD33 (C)	Patients should be consented for surgery prior to arrival on the ward.	• This is the Trust standard and has been for three years. A compliance audit will be undertaken in Q4	Kam Dhami	March 2018	• No patient will be listed without consent
SD34 (C)	Wider learning should be promoted through complaint trends being shared amongst all areas of the Trust.	• This is to be included in the new Governance Scorecard which will be reviewed at Group Management Board and assessed monthly at EQC	Kam Dhami	December 2017	• Agendas and Minutes of GMB evidence review of complaints and trends
SD35 (C)	Ensure all BMEC staff are aware of the duty of candour and when this would be applied following a notifiable safety incident.	• Duty of candour information to be presented at QIHD – January 2018 • Where incident form indicates requirement for DOC - DLN to ensure that appropriate personnel have undertaken this and support as needed	Kam Dhami	March 2018	• Agenda and minutes of QIHD
SD36 (C)	Ensure all BMEC staff can identify a deteriorating patient; and that this is recorded in a structured way in order to monitor the effectiveness of this.	• Audits undertaken as part of the Safety Plan show this is being routinely undertaken. • Competency sign off process to be undertaken under oversight of Chief Nurse	Laura Young	December 2017	• Competency assessment for all current BMEC staff to be reviewed at Critical Care Board
SD37 (C)	BMEC service work towards minimising cancelled procedures due to lack of patient records.	• The Board's cancellation improvement programme will be implemented and tracked in public • The introduction of electronic casenotes has largely eliminated this cause of deviation • A specific BMEC no cancellation programme is being implemented during Q4	Rachel Barlow	March 2018	• Fewer than 20 monthly cancellations Trust-wide

Ref	Issue identified by the CQC Inspectors	Improvement actions to be taken to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
SD38 (C)	BMEC staff to be fully aware of when patients may require a deprivation of liberty safeguard (DOLS) application in order to ensure patients that lack capacity to consent to treatment is provided with appropriate care.	• Information board to be created on the ward to provide visual reinforcement of information and requirements. • All staff to have awareness and training (as required) in DOLs	Laura Young	March 2018	• DOLS applications are completed as appropriate • Notes of team meetings confirm discussion regarding DOLS • Staff are appropriately trained in the completion of DOLS applications

OUTPATIENTS AND DIAGNOSTIC IMAGING

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
OUTPATIENTS AND DIAGNOSITC IMAGING: SANDWELL GENERAL HOSPITAL					
MD34 (S)	Resuscitation trolleys are checked daily, medications and fluid bags are stored appropriately and trolleys are secure and tamperproof.	• Assess the existing resuscitation trolleys against the resus policy approved checklist. • Communicate to all clinical staff regarding the expected stock on resus trolleys (nothing additional) • Identify who checks trolleys and when and communicate to relevant nursing staff. (removing anything additional) • Nurse checker to document on log anything additional being added to trolleys, remove and advise staff of error in safety briefings.	Elaine Newell	March 2018	Checking audits show 100% compliance for content and frequency. Log shows any trolley equipment discrepancies and safety briefings show comms.
MD35 (S)	All staff are up to date with their safeguarding mandatory training.	• This is tracked as a priority and since the inspection we meet the CQuin for compliance. We have a revised and robust system to maintain this position.	Raffaela Goodby	December 2017	Sustained performance above 90%
MD36 (S)	All staff undergo regular assessments to ensure they are competent and confident to carry out their roles.	• A nurse education competency assessment has been carried out Trustwide. This will be repeated as part of the annual appraisal cycle.	Elaine Newell	March 2018	Competency assessment for outpatient nursing shows improvement over 2018-19
SD39 (S)	System and environment for taking children's bloods is child friendly including a children's phlebotomist.	• The Trust will not introduce a single child phlebotomist. Instead all staff will undertake additional awareness training to sharpen their skills to undertake their role	Jonathan Walters	March 2018	We will specifically audit child and parent satisfaction during Q1
SD40 (S)	Staff in the phlebotomy department confirm the time when numbing cream has been applied by the children's outpatients department prior to taking any blood samples.	• The blood request form will have the time of when the numbing cream is applied and time when the patient is ready for blood test	Jonathan Walters	December 2017	

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
SD41 (S)	Patients are given the opportunity to be weighed in private.	• Scales moved to areas not in view of waiting room.	Trish Kehoe	December 2017	• Unannounced inspection
SD42 (S)	Prescriptions for controlled drugs (FP10's) are stored securely at all times in accordance with trust policy.	• Spot checks in areas using FP10s will be introduced to test compliance with our longstanding and restated policy	Pun Sharma	March 2018	• This will form part of our unannounced inspection process
SD43 (S)	Hand hygiene compliance is regularly monitored and recorded in the outpatients department.	• This is already the case and will be reiterated through a specific action in the QIHD programme for outpatients	Bev Jackson	December 2017	• This will form part of our unannounced inspection process
SD44 (S)	Staff have an understanding of their responsibilities in relation to the Mental Capacity Act, 2005.	• We will reissue with payslips and reinforce using a video the responsibility matrix for MCA	Elaine Newell	March 2018	• Awareness testing will be undertaken through survey and unannounced inspection approaches
SD45 (S)	Patients' notes are kept securely at all times in the outpatients department.	• This issue of largely resolved by the introduction of digital casenotes	Trish Kehoe	December 2017	• Re-audit to check no paper stores remain in sight
SD46 (S)	Staff know who the safeguarding leads are at the trust.	• A renewed publicity drive will set out the balance of responsibility between each employee and local service leads, and the expert help they can obtain from specialist service leads	Ruth Wilkin	December 2017	• Sample audit question will be included in Your Voice staff survey
SD47 (S)	Staff appraisals are up-to-date.	• 100% appraisal compliance expected in 2017-18 and 2018-19	Line manager	March 2018	• Staff records/ESR – reviewed at Group Board Level
SD48 (S)	Equipment and furniture in the outpatients department is moved regularly to enable a thorough clean.	• Written SOP to define roles and responsibilities, including frequency of 'whole space' cleaning to be agreed with Chief Nurse	Steve Clarke	December 2017	• Q4 audit of area to show compliance with revised SOP

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
MD37 (C)	The trust must ensure resuscitation trolleys are locked and secured with tamperproof tags.	• Assess the existing resuscitation trolleys against the resus policy approved checklist. • Communicate to all clinical staff regarding the expected stock on resus trolleys (nothing additional) • Identify who checks trolleys and when and communicate to relevant nursing staff. (removing anything additional) • Nurse checker to document on log anything additional being added to trolleys, remove and advise staff of error in safety briefings.	Elaine Newell	March 2018	Checking audits show 100% compliance for content and frequency. Log shows any trolley equipment discrepancies and safety briefings show comms.
MD38 (C)	The trust must ensure patient notes are kept securely and confidentially.	• All stores of notes moved behind locked doors • Lockable trolleys in use to Q1 2018-19 then replaced by EPR	Laura Young	December 2017	Unannounced inspection
MD39 (C)	The trust must ensure sharps bins and clinical waste are stored securely and safely.	• Reiteration of Trust process within BMEC • Sharps bins and clinical waste stored securely within Imaging.	OPD Manager	December 2017	OPD Manager to present audit of compliance to Directorate Quarterly Governance Meeting in January 2018
MD40 (C)	The trust must ensure consulting rooms in BMEC protect patients' dignity and privacy, and prevent people from overhearing conversations between staff and patients.	• Re-audit of compliance with Trust expectations throughout BMEC and options to be considered as part of 18-19 capital programme	Alan Kenny	March 2018	Audit after implementation of plan, including patient feedback
MD41 (C)	The trust must ensure there are improvements with staff completion of mandatory training.	• Mandatory training corporate review reporting to Executive in December 2017 • Full implementation plan during 2018 to consistently achieve full year compliance	Raffaela Goodby	December 2017	Quarterly compliance reviewed via Group Review
MD42 (C)	The trust must ensure all staff who carry out root cause analyses are trained to do so.	• We will undertake RCA training in situ within BMEC during January	Kam Dhami	March 2018	Confidence levels satisfactory among managers undertaking RCAs

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
MD43 (C)	The consulting rooms in the BMEC orthoptics department were large, and two or three patients underwent consultations at the same time, only separated by screens. Patients were able to overhear conversations between staff and other patients in the room. Staff told us they were not able to protect patients' dignity and privacy due to the way the rooms were set up, but they had one single room they were able to use if patients expressed concern. We asked staff if they told patients about this facility and if staff offered it to patients for their consultation; Staff told us that the patients only used the room if they raised the issue.	• Poster to be displayed explaining option to ask for a private consultation area	Laura Young	March 2018	Patient satisfaction survey to be undertaken in March 2018
SD49 (C)	The trust should ensure staff working in the outpatients department have their competencies checked regularly and that this is evidenced.	• All BMEC nursing HODS to initiate a review of competencies to be undertaken annually during appraisals. For this to be evidenced in PDR documentation • Band 2 CARE cert to be updated	Laura Young	December 2017	Inclusion of BMEC OPD in next Chief Nurse educational competency audit process
SD50 (C)	The trust should ensure that staff receive training to improve awareness of who the trust safeguarding leads are.	• A renewed publicity drive will set out the balance of responsibility between each employee and local service leads, and the expert help they can obtain from specialist service leads	Ruth Wilkin	December 2017	Sample audit question will be included in Your Voice staff survey
SD51 (C)	The layout of the consulting rooms in the BMEC orthoptics department did not always ensure patient's privacy and dignity were protected.	• Revisit again how this might best be addressed	Alan Kenny	March 2018	Service passed privacy and dignity audit undertaken via corporate nursing function

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
SD52 (C)	The trust should ensure all incidents are reported including those involving patient falls on the escalator in the Birmingham Treatment Centre.	• Notices have been placed on escalators reiterating the arrangements for reporting and escalating concerns	Alan Kenny	December 2017	Trust incident reporting BTC Building log Minutes
SD53 (C)	The trust should ensure patients in the BMEC outpatients waiting area are kept informed of waiting times and late-running clinics.	• Whiteboards will display wait times	HODs in OPD	December 2017	Unannounced visits
SD54 (C)	The trust should reassess the layout of the BMEC coffee shop seating area to ensure people can move about safely, and sufficient space is provided for people using wheelchairs.	• Achieve cost effective redesign sufficient to support mobility impaired visitors and staff	Steve Clarke	March 2018	Observational visits by patient group
SD55 (C)	The trust should ensure that all staff have an appraisal.	• 100% PDR compliance in 2017-18 and 2018-19	Line managers	March 2018	Meet Trust's commitment and implement consequences regime as required
SD56 (C)	The trust should ensure there are chaperone notices in the outpatient's department.	• BMEC OPD Manager to source and display appropriate signage.	Laura Young	December 2017	Notices visible
SD57 (C)	The trust should ensure there is clear signage in the outpatient department.	• BMEC OPD Manager to arrange a working group including patient and public to look at what signage would help to improve the environment. • Main OPD: Implementation of Intouch Calling Screens that identify clinic name/department	Laura Young	December 2017	Screens working in all areas
SD58 (C)	The trust should ensure staff complete training to raise awareness and improve	• Learning disabilities awareness campaign to be undertaken within BMEC, commencing with November QIHD	Laura Young	March 2018	Audit of patient experience of sample of flagged patients who use the service

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
	skills for working with people with learning disabilities.	• Grounded in the Trust's Board promises for LD and our diversity pledges, specific literature to be promoted inside BMEC setting out rights and systems for reasonable adjustment			in Q4 and Q1

CHILDREN AND YOUNG PEOPLE

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
CHILDREN AND YOUNG PEOPLE: BMEC					
MD44 (C)	Improve local governance and ensure risks to the service are escalated, recorded, acted upon and reviewed in a timely manner	• Governance model to be presented to and approved by Trust Director of Governance • Individually signed for briefing note on the governance system to be provided to all employees in BMEC	Ajai Tyagi	March 2018	Signed returns from all employees working in BMEC adult and paediatric services confirming understanding of reporting model
MD45 (C)	Medical staffing meets needs of patients and the service.	• Demand and capacity exercise for paediatric ophthalmology to clearly identify productivity and capacity changes required • Inclusion of any resultant costs in Trust level investment plan for 2018-19 •	Dave Baker	December 2017	Demand and capacity to be in balance by summer 2018
MD46 (C)	Review the storage of emergency drugs and equipment for children and young people	• Sign off revised approach with Chief Pharmacist and Chief Nurse and implement changes during Q4	Bushra Mushtaq	March 2018	Spot audits demonstrate compliance with revised approach
MD47 (C)	Age appropriate facilities are provided with separation of adult and children waiting areas and treatment areas	• BMEC facilities to be reviewed to create scaled paediatric wait and play spaces during Q1 2018-19 • All points of care to be reviewed at Group level to establish route to child only sessions or 'hours'	Ajai Tyagi	March 2018	Report to CYP Board detailed current state in April 2018
MD48 (C)	Mandatory training targets are met and recorded including paediatric life support.	• Trust wide approach to BLS tracked and targeting 90% compliance by March 2018	Alex Moynhan	March 2018	Data on BLS training
MD49 (C)	A framework for staff to develop and demonstrate competencies to care for children is in place.	• BMEC will assess staff against paediatric competency framework used by another major Eye Centre and will include any outcomes in its 2018-19 TNA	Ajai Tyagi	March 2018	Competency assessment included within local objectives setting in Q1
MD50 (C)	The trust must measure and monitor outcomes in relation to children and	• Outcome monitoring framework for BMEC as a whole will be revised and be made subject to approval of EQC	Medical Director	March 2018	Data collection is in place for 2018-19 and the Board's Quality and Safety

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
	young people.				committee will approve or otherwise Q1 performance
SD59 (C)	That a strategy for services for children and young people is developed and embedded, and there is improved reporting about service plans and priorities.	• A single service plan will be developed for consideration by the Group and Executive	Bushra Mushtaq	December 2017	A plan is agreed and signed off by the COO and Medical Director, and delivery is tracked via directorate performance review
SD60 (C)	Review the arrangements for data collection that is specific to children and young people such as the audit plan and reporting, training and development records.	• Audit plans are comprehensive for children within BMEC – plan to be signed off or amended by Board Quality and Safety committee as part of Trust level Clinical Audit Plan • Training package to be developed for non-trainees (paediatric rotation already part of trainees timetable) in line with RCOph recommendations • Review compliance against National Paediatric Surgical Standards	Bushra Mushtaq	March 2018	Data collection in place for 2018-19
SD61 (C)	Greater visibility and support of the children and young people service from the executive leadership team.	• Trust Board visiting programme to explicitly include in 2018 paediatric services in BMEC • CLE Children and Young People's Board to review the service quality and maintain oversight of compliance	Toby Lewis	March 2018	CYP service in BMEC to have all risks rated above 12 resolved by October 2018

END OF LIFE CARE

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
END OF LIFE CARE: SANDWELL GENERAL HOSPITAL					
SD62 (S)	Updated 'Anticipatory Medication Guidelines'. We could not be assured staff were following the most up-to-date guidelines.	• Guideline reviewed and updated in Feb 2017 • Ensure latest version is available on Connect • Communicate to all clinical staff that guidelines has been updated via QIHD sessions and staff bulletin system • Review of data from Supportive Care Plan audit to ensure correct prescribing adhering to the guidelines	Tammy Davies	December 2017	Monitoring evidences guideline compliance by individual staff members. Results of SCP audit to be reviewed by Lead palliative care nurse to ensure adherence to guidelines. Audit repeated 6 monthly and any prescribing discrepancies to be communicated to relevant staff. 100% compliance with prescribing in line with guideline to be demonstrated by audit
SD63 (S)	Mandatory training for mortuary staff includes infection control training.	• All staff are up to date with mandatory training for infection control	Jonathan Walters	December 2017	Completed mandatory training available on ESR
SD64 (S)	Medical staff document reviews of patients care on their specialist care plans when these are being used.	• Palliative Care team to attend board rounds and identify patients with an SCP or who require and SCP • End of life care facilitators to complete audit of SCP which includes appropriate documentation by all staff • Areas of non-compliance to be discussed with individual clinicians and lead consultant • Palliative care team to provide induction training to incoming medical staff	Tammy Davies	March 2018	End of Life Care Facilitators to record on local database all board rounds attended Audit of SCP to include appropriate documentation by medical staff in >95% of cases
SD65 (C)	The service must ensure they are preventing, detecting and controlling the spread of infections, including those that	• Policies and SOPs in place and regularly updated, SOPs include: • PROC-MORT-C-C5, E3-2 Body Fluid (Biohazard) Spillages	Jonathan Walters	December 2017	Incident review of non-compliance to be undertaken and acted upon

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
	are health care associated in the mortuary department.	• PROC-MORT-C-E3-9 Infected Cases • PROC-MORT-C-C5, E3-3 Leaking Bodies • PROC-MORT-C-C5.6-1 General Cleaning • PROC-MORT-C-E6,C5-1 Releasing Cadavers to Undertakers Infected Cases • All SoPs available on i-passport • All relevant PPE available in department			
SD66 (C)	The trust should ensure they have updated 'Anticipatory Medication Guidelines'. We could not be assured staff were following the most up-to-date guidelines.	• Guideline reviewed and updated in February 2017 • Ensure latest version is available on Connect • Communicate to all clinical staff that guidelines has been updated via QIHD sessions and staff bulletin system • Review of data from Supportive Care Plan audit to ensure correct prescribing adhering to the guidelines	Tammy Davies	December 2017	Results of SCP audit to be reviewed by Lead palliative care nurse to ensure adherence to guidelines. Audit to be repeated 6 monthly and any prescribing discrepancies to be communicated to relevant staff.
SD67 (C)	The trust should review the safeguarding vulnerable adults policy.	• The policy will be reconsidered by the Executive Quality Committee	Elaine Newell	December 2017	Minute of committee confirms re-examination
SD68 (C)	The trust should review the anticipatory medicines policy.	• Communicate to all clinical staff that guidelines have been updated (Feb 2017) via QIHD sessions and staff bulletin system • Review of data from Supportive Care Plan audit to ensure correct prescribing adhering to the guidelines	Tammy Davies	December 2017	Policy monitoring evidences policy compliance by individual staff members. 100% compliance with prescribing in line with guideline to be demonstrated by audit

.COMMUNITY INPATIENTS

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
COMMUNITY INPATIENTS					
MD51 (CO)	Review the process for assessing and documenting assessments in accordance with the *Mental Capacity Act 2005*.	• Undertake a full process review of our MCA process and present it to the EQC for re-affirmation to confirm the process by which we collate and act on this information. • Continue to track DOLs assessment and external referral at Board level • Establish how Unity system will support and record DOL assessment so that data can be easily collated and reviewed by audit	Elaine Newell	March 2018	In House inspection team rolling audits during 2018
MD52 (CO)	Ensure patients are not deprived of their liberty for the purpose of receiving care or treatment without lawful authority, in line with *Deprivation of Liberty Safeguards 2010*.				
MD53 (CO)	Ensure that all staff have regard for the protected characteristics under the *Equality Act 2010*, and support patients in a way that is respectful and promotes their dignity.	• Matron for community beds to lead ward QIHD session to focus on the Equality Act, 2010 – to take place in January 2018 • Trust Head of Diversity and Inclusion to review knowledge of protected characteristics and all staff to complete questionnaire by 31/01/18 • Ward managers to provide support for staff by working alongside them when completing patient assessments to ensure assessments are carried out with respect for protected characteristics. This will begin in November 2017	Raffaela Goodby	March 2018	100% of patient records reviewed during monthly ward reviews will show assessment of protected characteristics 100% completion of questionnaire assessing staff knowledge of equality and diversity Evidence of written feedback from ward managers to staff members regarding approach to assessing and responding to protected characteristics Review of all PEQ and complaints with 0% relating to dignity

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
MD54 (CO)	The service must comply with the requirements of the *Data Protection Act 1998*, and ensure staff keep service user's personal data safe and secure at all times.	• Install a box to store blood samples waiting for collection to ensure sensitive information is not left in sight • Staff to undertake their mandatory IG training	Tammy Davies	December 2017	0% of data protection breaches observed during matron monthly ward reviews Team meeting minutes, agenda and attendance to demonstrate communication to all staff regarding responsibilities with IG and data protection >95% compliant with IG mandatory training
MD55 (CO)	Ensure risk assessments and safety reviews are considered and undertaken where changes to service provision is made.	• Group Head of Nursing and Matron to develop in house training for all staff undertaking the role of bleep holder • Specific training regarding business continuity planning to be provided for all staff • Full risk assessment regarding OOH working for RRH to be undertaken by group head of nursing and managed via directorate with updates to group management board • Each ward manager to undertake a skills analysis of all staff undertaking the role of bleep holder • Devise a schedule of appropriate meetings from ward level through to directorate and management board. Ensure attendance is monitored and documented, with each meetings including standard agenda items and accurate minutes held on a shared drive, accessible to all members of the team	Tammy Davies	March 2018	List of all service changes made in year retained at Group Management Board and cross referenced to risk assessments

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
MD56 (CO)	Ensure risk registers are accurate, contemporaneous, and reviewed and update routinely, as required.	• Each ward manger to review local risk register with Matron, Group Head of Nursing and lead therapist as appropriate to ensure risks are accurate and to develop appropriate mitigation. • Risks to be discussed as a standard agenda item at monthly ward meetings with all staff • Local risk registers to be presented to the iBeds directorate Matron / Group Head of Nursing during monthly governance meetings to ensure risks are escalated appropriately and mitigation is supported	Tammy Davies	March 2018	Risk register for each ward available on safeguard and updated within the set timeframes
MD57 (CO)	Ensure that all professionals document contemporaneous and acute information within patient's medical records.	• Ward QIHD in January 2018 to include record keeping • Ward Managers to undertake documentation audit each week by randomly selecting 10 sets of notes and assessing against set criteria. Any areas of non-compliance will be flagged with the individual clinician. Episodes of repeat non-compliance will result in the line manager of the member of staff being informed so that specific training / performance management can be undertaken • Group Head of Nursing to meet with GP lead to discuss the role of GPs in ensuring medical records are contemporaneous and accurate • Any episodes of noncompliance by GPs to be monitored via weekly notes audit. • Ward Manager or Matron to liaise directly with GP and GDN to apply contract sanctions for any repeated poor performance by GPs	Tammy Davies	March 2018	Record keeping audits show >95% adherence to criteria

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
MD58 (CO)	The service must ensure that staff work in accordance with medicine management policies, procedures and national best practice and legislation.	• Medicines management policy to be discussed in ward meetings and in individual coaching sessions to ensure all staff are aware of policies, procedures and individual responsibilities • Named Pharmacist for Rowley Regis hospital to attend wards twice weekly to review medication storage, prescriptions and administration. Areas of concern to be discussed with Ward Managers and matron • Monthly medicines management audits to be undertaken for each ward with results outlined in the EWTT and reviewed by the GDON	Tammy Davies	December 2017	Agendas, minutes and attendance demonstrated discussion of medicines management policy with 100% of staff Monthly report produced by pharmacist indicating 0% areas of concern with regards to medicines management 0% medicines managements errors shown on EWTT
SD69 (CO)	Staff should review the use of magnetic information boards above patient bed spaces and ensure these accurately reflect the needs of the patients.	• Full review of the use of magnetic boards and their relevance for community wards to be undertaken by ward mangers and matron. This will include a survey of staff / patients and relatives. • If the use of magnetic boards are continued, each shift leader will be given the responsibility of ensuring information in accurate	Tammy Davies	December 2017	n/a
SD70 (CO)	Senior staff should ensure all staff feel supported within their roles, providing support, training and guidance as required.	• Ensure all PDRs are completed – from Q1 under new approach called Aspiring to Excellence • Monthly 1-1 sessions with Ward Managers and Matron • PDR documentation to be reviewed during 1-1 sessions • Band 6 competencies to be developed and agreed to provide set development objectives • Role of the bleep holder to be formalised with SOP and training • Clinical supervision to be available for all staff as required	Ward managers	March 2018	100% appraisal compliance
SD71 (CO)	Wards should ensure that patients and their significant others have access to	• Introduction of “purple phones” initiative	Tammy Davies	March 2018	Purple phones available outside ward areas

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer[1]	By when?	How will successful completion be evidenced?
	information on how to provide feedback, positive and negative, on the service and care provided.	• Visible display board on each ward with information for patients / carers regarding how to leave feedback • All patients to be offered the opportunity to complete PEQ			
SD72 (CO)	Senior staff should ensure signage within ward areas is consistent and supports the needs of patients and visitors.	• Survey of all signage to be undertaken by Matron / Group Head of Nursing • Matron to ask for feedback from patients / carers regarding current signage • Required alterations to be made not later than March 2018	Tammy Davies	March 2018	Patient survey to be completed during Q1 2018-19
SD73 (CO)	The service should review how and when it reviews delays to patient care, and what aspects of patient care are monitored.	• Daily board rounds to take place with discussions to highlight any delays in care • The Trust collates Delayed Transfer of Care data and this is examined daily by senior staff. • All community wards will implement Red/Green approaches and improvement in reducing red days will be monitored via Group Performance Reviews. • EDD performance for all ward admissions will be tracked and made visible at ward level from March 2018. • Over 7 day LOS reviews to operate again across all Trust sites	Tammy Davies	December 2017	EDD compliance league table to demonstrate delivery of promises made to patients

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

2017 CQC Improvement Plan: Delivery 'at a glance' as at April 2018

131 Areas for improvement in the CQC report, **58** 'must dos' (MD) and **73** 'should dos' (SD)

106	23	2
Implemented actions	Part delivered actions and ongoing	Actions requiring external assistance

Urgent and Emergency Services	
MD1	1
MD2	1
MD3	1
MD4	1
MD5	1
MD6	1
MD7	3
MD8	2
MD9	2
MD10	1
MD11	1
MD12	1
MD13	2
MD14	1
SD1	1
SD2	1
SD3	1
SD4	1
SD5	2
SD6	1
SD7	1
SD8	1
SD9	1
SD10	2
SD11	1
SD12	1
SD14	1

Medical Care	
MD19	2
MD20	1
MD21	1
MD22	1
MD23	1
MD24	1
MD25	1
MD26	2
MD27	2
MD28	2
MD29	2
MD30	2
SD15	1
SD16	1
SD17	1
SD18	1
SD19	2
SD20	1
SD21	2
SD22	1
SD23	1

Surgery	
MD31	1
MD32	1
MD33	1
SD24	1
SD25	1
SD26	1
SD27	1
SD28	1
SD29	1
SD30	1
SD31	1
SD32	1
SD33	1
SD34	1
SD35	1
SD36	1
SD37	1
SD38	1

Outpatients and Diagnostic Imaging	
MD34	1
MD35	2
MD36	1
MD37	1
MD38	1
MD39	1
MD40	2
MD41	2
MD42	1
MD43	1
SD39	1
SD40	1
SD41	1
SD42	2
SD43	1
SD44	1
SD45	1
SD46	1
SD47	1
SD48	1
SD49	1
SD50	1
SD51	1
SD52	1
SD53	1
SD54	1
SD55	2
SD56	1
SD57	2
SD58	1

Unfilled middle-grade doctor posts in ED

Key: 1 Actions implemented | 2 Action taken, issue remains | 3 Actions outstanding, issue remains

2017 CQC Improvement Plan: Delivery 'at a glance' as at April 2018

Children & Young People *(BMEC)*	
MD44	1
MD45	1
MD46	1
MD47	2
MD48	2
MD49	1
MD50	1
SD59	1
SD60	1
SD61	1

BMEC ED	
MD15	1
MD16	1
MD17	1
MD18	1
SD4	1
SD6	1
SD7	2
SD8	2
SD13	3

Out-of-hours cover for paediatric ophthalmology emergencies

Community: Inpatients	
MD51	1
MD52	1
MD53	1
MD54	1
MD55	1
MD56	1
MD57	1
MD58	1
SD69	1
SD70	1
SD71	1
SD72	1
SD73	1

End of Life Care	
SD62	1
SD63	1
SD64	1
SD65	1
SD66	1
SD67	1
SD68	1

Key: 1 Actions implemented | 2 Action taken, issue remains | 3 Actions outstanding, issue remains

Paper ref:	TB (05/18) 011

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Maternity Summit - Improvement Actions Update		
Sponsoring Executive	Paula Gardner, Chief Nurse		
Report Author	Elaine Newell, Chief Nurse / Rachel Carter, Director of Midwifery		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

Further to discussion at Quality and Safety Committee, the Board is asked to note:

1. Completion of all actions relevant to the previous Perinatal Mortality Action Plan.
2. Progress on actions arising from the Maternity Summit - most notably related to the successful completion of early reviews.
3. Work has been initiated with support from the comm's team to focus on dissemination of learning, communication and staff engagement.
4. The Perinatal Mortality Review Board (PMRB) is now established (inclusive of patient representative and external expert representative), well ahead of other Trusts who have yet to implement.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	X	Public Health Plan	X	People Plan & Education Plan	X
Quality Plan	X	Research and Development		Estates Plan	
Financial Plan	X	Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

4. Recommendation(s)

The Trust Board is asked to:

a.	Recommend ongoing monitoring via the Q & S committee
b.	
c.	

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s): N/A					
Board Assurance Framework		Risk Number(s): N/A					
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Updated 16.04.18

PLAN TITLE:			Safety Summit Outcome: Perinatal Mortality and Governance Action Plan
LEAD			Neil Shah (Clinical Director) / Rachel Carter (Director of Midwifery)/ Gabby Downey (Group Director)/ Nicola Robinson (Directorate Risk and Governance Lead Midwife)
PLAN AUTHOR			Mr Victor Olagundoye, Ms Deepa Rajan, Lorraine Cardill, Mr Neil Shah, Dr Sivakumar, Rachel Carter
AIM OF PLAN			To ensure robust governance processes in line with local and national agenda; to ensure all possible learning is identified from incidences of perinatal mortality (and all adverse/ positive outcomes) and proactively shared across the multi-disciplinary team and thereafter to all staff to drive improvements in safety, care and patient experience.
DATE OF SUBMISSION OF ACTION PLAN			15/3/18
DATE OF ACTION PLAN COMPLETION			TBC
MEASURE(S) OF SUCCESS		• Use of standardised review tool for assessment of 100% of cases of perinatal mortality through the dedicated multidisciplinary review board, Perinatal Mortality Review Board (PMRB) • Report produced for all cases of perinatal mortality for use by the Directorate/Trust with appropriate action plan. Report to follow the Trust escalation policy for Amber or serious incident reporting. • Secondary report to be produced (through PMRB) which is patient-friendly and can be given to and discussed in full with the parents at time of Pregnancy loss review • PMRB meetings minutes, actions from cases with timelines for all cases and evidence of completed actions to be monitored with a monthly summary / themes to be escalated to Clinical Group management meeting. • Improved communication of outcomes and learning from perinatal mortality review across MDT and evidence of completed actions. • Lessons and learning from perinatal mortality reviews to be shared across all staff groups within Maternity & Perinatal Medicine. • All reports have Triumvirate sign off • Outcomes and completed actions of PRMG and PNRB are discussed/signed off at Group Governance Board	

PERFORMANCE MGMT		Perinatal Risk, Mortality and Governance Meeting Perinatal Mortality Review Board (PMRB) <u>Monitoring and escalations to:</u> Monthly Maternity and Perinatal Governance meeting Monthly Maternity and Perinatal Directorate Meeting Monthly Women and Child Health Governance Board Meeting Monthly Women and Child Health Management Board Meeting Bi-monthly Women and Child Health Group Review
Request for Action Plan		**Safety Summit convened on 20.02.18 by Trust Board to review actions and progress following 'spike' in perinatal mortality Q 4 2016/17. Action plan requested to reflect identified areas of need:** • **Evidencing recognition of root cause of perinatal mortality and through robust process** • **Robust Governance Processes** • **Improved communication and evidence of learning as a multi-Professional Team**

Rachel Carter	RC	Deepa Rajan	DR	Susan Smith	SSm	Neil Shah	NS
Lorraine Cardill	LC	Sivakumar	SS	Kathryn Gutteridge	KG	Victor Olagundoye	VO
Nicola Robinson	NR	Gabby Downey	GD	Vikranth Venugopalan	VV	Alison Macefield	AM

5. Completed
4. On track
3. Behind schedule
2. Significantly delayed
1. Not yet started

ACTION PLAN						
Ref	**Action**	**Lead**	**Timescale for completion**	**Progress**	**5/4/3/2/1**	**Mitigation if not "Green" (4/5) OR evidence of compliance**
Key Area1: Evidencing recognition of root cause of perinatal mortality and through robust process; is the process robust (from investigation to completion of actions)						
1.1	All cases of perinatal mortality* to undergo a '3 working day' review by identified member of MDT, using Amber Incident Report to capture review and forwarded to Group triumvirate/Clinical Director to 'sign off' for appropriate level of continuing investigation and on conclusion of Investigation. *exceptions are pre-identified fatal fetal abnormalities where outcome is anticipated; these cases do not require 3 working day but will progress for review at PMRB.	NR/ VO/ DR	31.03.18	Amber Incident Report template confirmed for use Template circulated Flow chart produced to reflect process and circulated	5 Evidence\KA 1.1	Amber Incidents completed Appropriate escalation of incidents identified as meeting SI criteria Incidents discussed and reviewed PRMG/ PMRB (Evidence: Amber incident log & reports)
1.2	Introduce national MBRRACE standardised review tool for 100% of perinatal mortality reviews	SSm/DR	01.03.18	Tool received and access gained. SWBH is one of the first Units in UK to pilot its use. Cases entered into tool	5 Evidence\KA 1.2	First cases to be reviewed using this tool at PMRB meeting 13/4/18 and thereafter at monthly meetings. (Evidence: Review PMRB case presentation and notes)

ACTION PLAN						
Ref	**Action**	**Lead**	**Timescale for completion**	**Progress**	**5/4/3/2/1**	**Mitigation if not "Green" (4/5) OR evidence of compliance**
1.3	Action plans that are generated for each case of perinatal mortality with evidence of completion will be presented at PMRB Monthly Directorate Governance Report will include summary of : • no. cases of perinatal mortality in previous month • CESDI / MBRRACE grading of care • Ongoing Summary of Themes identified • Summary of actions complete/ outstanding from cases reviewed	DR	30.04.18	All cases reviewed in PMRB have generated Action points with aligned named lead and timescale. Progress/evidence of completion recorded at next meeting. Completed case reports recorded.	5 Evidence\KA 1.3	This is ongoing since 2017. Trust templates for action plans and sign-off to be used from 1/4/18
1.4		NR/ LC / DR	30.04.18	To be commenced from PMRB meeting 13/4/18	5 Evidence\KA 1.4	Commenced PMRB 13.04.18 (Evidence: Review Board case presentation and notes)
1.5	PMRB ToR and attendance will reflect inclusion of professional peer reviewer (external to the Directorate/ Trust) and a parent representative in line with national agenda.	DR/ NR /NS	30.04.18	ToR in process of being reviewed Parent representative identified Peer reviewer sought	4 Evidence\KA 1.5	
1.6	Guidelines – PMRB to have access at meetings to all current Maternity Guidelines and to make recommendations regarding changes from ongoing case reviews.	SSm	30/3/18	In reviewing cases management should be compared against current Maternity Trust guidelines. From reviews where there	5 Evidence\KA 1.6	PMRB notes and actions

ACTION PLAN						
Ref	**Action**	**Lead**	**Timescale for completion**	**Progress**	**5/4/3/2/1**	**Mitigation if not "Green" (4/5) OR evidence of compliance**
				are deficiencies or gaps in guidelines, recommendations from PMRB can be actioned to change guidelines (via Directorate Policies & procedures Group)		
Key Area 2: Robust Governance Processes						
2.1	Revisit and recirculate the outline of Governance Processes and reporting responsibilities across the Directorate and group	NR/ RC	30.03.18	To be an information item at all Directorate meetings in March (Governance/Risk QIHD mtgs) to inform all staff/MDT	5 Evidence\KA 2.1	QIHD 16.03.18; Directorate meetings
2.2	Embed in practice the revised process of 3 working day review of all incidences of perinatal morbidity (or adverse outcomes) with Amber incident report or SI report, including escalation to Group triumvirate/CD	NR/VO/NS /SSm/DR	30.03.18	This is being practiced, since the change in Trust reporting of Amber/serious incidents Cases in March 18 followed this review pathway with appropriate level of continuing investigation:	5 Evidence\KA 2.2	Amber incident log and repository

ACTION PLAN						
Ref	**Action**	**Lead**	**Timescale for completion**	**Progress**	**5/4/3/2/1**	**Mitigation if not "Green" (4/5) OR evidence of compliance**
2.3	Escalate incidences of CESDI 2 & 3 (or equivalent in line with national tool definitions) to Group triumvirate with reports being forwarded for Group level sign off prior to circulation to team/ parents	NR/ VO /NS	30.04.18	Reporting in development Progress in line with revised Amber incident log	4 Evidence\KA 2.3	Progress in line with revised Amber incident log
2.4	Adhere to robust induction process for new staff, including locums, agency nurses and bank staff	NS/SS/LC/ AM	30.03.18	Newly updated induction pack and debrief for all new medical locums working in Unit – commenced 1/3/18 Trust wide Agency/ Bank nurse induction checklist revisited and circulated to all areas	5 Evidence\KA 2.4	Evidence of completion for new to area bank/ agency.
Key Area 3: Improved communication and evidence of learning from incidents and excellence as a multi-Professional Team						
3.1	Share opportunities for wider learning across the Local Maternity System and Neonatal Network (adverse and positive) to improve safe care	NS/ SS/ NR/ KG	30.03.18 & Ongoing	Attendance at: LMS Risk and Governance meetings, Neonatal Network meeting , Regional and National event attendance	5 Evidence\KA 3.1	Attendance, minutes and actions
3.3	Identified themes from PMRB to share quarterly at QIHD and monthly Open Perinatal Mortality Meeting with associated actions/recommendations	NS/SS/DR	01.02.18 – Initiated, ongoing	Ongoing action at monthly PNM meetings which are open to all staff to attend.	4 Evidence\KA 3.3	

ACTION PLAN						
Ref	**Action**	**Lead**	**Timescale for completion**	**Progress**	**5/4/3/2/1**	**Mitigation if not "Green" (4/5) OR evidence of compliance**
				From 01.04.18 these themes/recommendations for practice will be a standing agenda item at QIHD and mandatory midwifery mtgs quarterly		
3.4	Develop and implement communication strategy to improve cascade of learning from incidents with increased reach to wider teams: • QIHD • PROMPT team meetings • Risky Business • Communication board • Link staff member per team • Standing agenda item at team meetings • Introduce 'safety huddles' in maternity and neonatal units (Task team process) to share learning from incidents/ excellence and opportunity to listen to concerns or congratulations: 5 minute huddles	NR/VO/VV/ SSm	30.04.18 & Ongoing	NHSI toolkit resource review; New recommendation and action through the National Collaborative Group project Group-Wide communications workshop Part 1 completed 12.04.18.	4 Evidence\KA 3.4	Communication scoping and resource review collation. Actions from communication workshop
3.5	Introduce and embed philosophy and practice of learning from excellence to encourage positive practice and inspire improvements	NR/SSm/ RC	30.06.18	LfE training event places secured Positive feedback cards introduced Additional module being purchased on safeguard to capture positives- Directorate to pilot	4 Evidence\KA 3.5	QIHD agenda and attendance register: increased staff awareness of excellent practice from Risk/PNM case reviews

ACTION PLAN						
Ref	**Action**	**Lead**	**Timescale for completion**	**Progress**	**5/4/3/2/1**	**Mitigation if not "Green" (4/5) OR evidence of compliance**
3.6	Increase opportunities for MDT/ multi-professional learning: • PROMPT • Live skills drills training • Handover meetings • QIHD • Huddles • Staff forums • Consultant Forum meetings • Reflective learning • Virtual messages (video)	NS/SS/ MW clinical educators	30.06.18	Many of these mtgs/training are already ongoing (e.g. PROMPT started 1/2/18) but evidence of MDT learning to be collected on an ongoing basis and can be evidenced by timescale. Types and evidence of learning and staff accessed to be recorded.	4 Evidence\KA 3.6	Expansion of MDT learning/training opportunities (in line with agreed Directorate plans)

APPENDIX 4: Action Plan (individual case reviews & external review)

ACTION PLAN: Peer review Perinatal Mortality November 2017. UPDATED 16.04.18

Theme	Recommendation	Local Response	Actions	Responsibility	Timescale
1. Electronic and ultrasound fetal monitoring	Efm training standards to be agreed for all staff (mandatory with agreed compliance rates for midwives and medical staff)	EfM standards and compliance in place with monitoring for midwifery staff however was not available to the review team at time of visit.	Accuracy of findings raised with Review team; evidence available	Director of Midwifery	COMPLETE 03.11.17
			Standards and compliance for medical staff implemented.	Clinical Director	COMPLETE 06.10.17 Ongoing monitoring in progress
			Monthly evidence of CTG compliance to be reviewed at risk and governance meeting with associated actions to ensure compliance to agreed standard	Risk & Governance Lead Midwife	COMPLETE 06.10.17 Ongoing monitoring in Progress
	Clarify routes of communication and decision making when abnormal Doppler indicates need for intensive fetal surveillance	Individual care planning is in place with escalation to Consultant in practice. Revised guideline was implemented in practice to ensure consistency in care planning; not reviewed by review team at time of visit.	Accuracy of findings raised with Review team; evidence available	Director of Midwifery	COMPLETE 03.11.17
2. Incident investigation and reporting	Consider review of all SI events within 72hrs within Trust at senior level	This is the Trust pathway and decision had previously been taken for maternity incidents to be included alongside Trustwide process (shared with reviewers at time of visit).	Accuracy of findings raised with Review team; evidence available	Director of Midwifery	COMPLETE 03.11.17
			Trustwide implementation of revised process. Agreement by DDoG for local implementation of '3 working day review'; maternity/ Neonatal Amber incident pathway to be appendix in next update of Trust Policy.	Deputy Director of Governance	Complete 01.04.18
	RCA leads to be identified and trained in art of leading RCAs and report writing	RCA leads identified and training planned November 2017.	Complete scheduled Training	Director of Midwifery, Group Director & Risk & Governance leads	COMPLETE 02.11.17
	RCA to involve members of the team who were involved in incident and cover whole care pathway	Routine practice is for table top reviews to be convened and involve team members however perinatal	Review of process for RCA engagement; Trustwide implementation of revised model for review	Deputy Director of Governance & Group Director of Midwifery	COMPLETE 02.11.17

		mortality and risk Group has become the forum for this.			
	Midwives involved in incidents should have support from a professional midwifery advocate and doctors from an educational supervisor	This is in place (formally support afforded by Supervisors of Midwives); PMA training progressing.	PMA training commenced September 2017 – April 2018 (6 places). 5 ex-SoM midwives attended and successfully attended the training- notification of completion April 2018. Launch of PMA's at SWBH planned for May 2018 with selection process planned to increase PMA's incrementally and embed in practice.	PMA's and Director of Midwifery	PMA course completed, Implementation into practice May 2018
	RCA reports should be shared with staff	Summary reports are shared with whole teams through risk newsletter, QIHD, lessons learnt (effective handover). 1:1 debrief facilitated with staff involved.	Accuracy of findings raised with Review team; evidence available	Director of Midwifery	COMPLETE 03.11.17
	Reports should include areas of good practice, any deficiencies in staffing or organisational issues	New report template shared with reviewers which outlines requirement for good practice and organisational issues to be outlined.	Revised report used as standard for all reports	Risk & Governance Lead Midwife & Consultant :	COMPLETE from 01.06.17
	There must be an effective version control of RCA reports	Revised template introduced; version control requirement agreed.	Revised report used for all reports with version control as standard with corporate team oversight.	Risk & Governance Lead Midwife & Consultant :	COMPLETE from 01.06.17
	RCA reports should be reviewed and signed off within the organisation	SI reports are reviewed and signed off by executive lead, facilitated by corporate team; evidence demonstrated to review team during visit.	Issue to be raised with Review team	Director of Midwifery	COMPLETE 03.11.17
			Implement Group sign off process at Director level	Director of Midwifery, Group Director & Risk & Governance leads	COMPLETE 02.01.18
	Actions identified in reports must be tracked to ensure implementation	Process for tracked actions demonstrated to reviewers at time of review.	Issue to be raised with Review team	Director of Midwifery	COMPLETE 03.11.17
	The unit should undertake a review of all cases to identify the themes which must be addressed	Review team were informed of a new perinatal mortality board that was implemented in July 2017 and	Perinatal mortality Review Board implementation in line with SCOR process/ template	Lead Consultant for Perinatal Mortality	COMPLETE 01.07.17

		has reviewed all cases from May 2017 using the SCOR template to ensure objectivity and thematic review.	All 2017 cases not reviewed in line with SCOR process to be re-reviewed with external to Group clinical expert to validate CESDI grades	Group Director	COMPLETE January 2018
	The unit should report its perinatal mortality to the Board in relation to both stillbirths and neonatal deaths as separate rates	Rates are reflected separately on the obstetric dashboard however combined on integrated performance report which is available to all CLE members.	Request to IPR to reflect stillbirths and neonatal deaths as separate rates.	Director of Midwifery	COMPLETE 23.10.17
3. Duty of candour	Duty of candour to be documented to a consistent standard as in SI4	SI4 used new template; reviewers advised this has afforded standardised approach for consistency and has been implemented across the Trust but was not evident in earlier reviews.	Issue to be raised with Review team	Director of Midwifery	COMPLETE 03.11.17
4. Guidelines	Must be authored in a consistent template and reflect external standards	Guideline revision meeting convened with involvement of clinical effectiveness; planned method for guideline review in place including review against NICE guidelines	All guidelines are in the process of being converted into new Trust template. Evidence : Evidence\Theta 4	Lead for Guidelines and policies As guidelines reviewed and revised.	In progress (up to date Jan 2018)
	The guidelines for Day Assessment Unit and management of SRoM after 34 weeks must be updated	The reviewers were informed that both guidelines were under review pending sign off at time of visit; guidelines in place at time of care provision re. incident were shared with reviewers	Reviewers were informed of progress of guideline review during visit; raised with review team. Evidence available of revised guidelines in practice Evidence: Evidence\Theta 4	Director of Midwifery	COMPLETE 03.11.17 **NOTE: Management of SRoM (Pre- Labour Rupture of Membranes) guideline recently updated but needs to be converted to the New Trust Template - KG**
	Fetal growth guidelines must be consistent with diagrams	Review of guideline in progress at time of review and since, completed.	Revised guideline implemented into practice. Evidence: Evidence\Theta 4	Director of Midwifery	COMPLETE
5. Clinical	The unit should review the entire	Neither of the reviewers were	Regular review and introduction of	Project lead midwife for	IN PROGRESS

records	process of recording clinical pathway in clinical record and use by staff to be assured that there are no aspects that may present a risk to patients or to the organisation	familiar with the BadgerNet system. SoPs or staff training programme were not requested or shared during the visit. A review of the SoPs is already in progress, as shared with the reviewers. N.B: Badgernet is widely recognised as a EPR for maternity and is an accepted maternity care record nationally	Standard operational policy in line with upgrades and changes to BadgerNet and compliance monitoring.	maternity EPR:	
	CTGs must be stored securely in patient records.	1 set of records had been returned from case note scanning team and were returned without any documents having been secured. Incident raised and reported however CTG and all records had been scanned onto CDA and were available for viewing.	Escalation of incident to lead for Digital programme implementation	Director of Midwifery	COMPLETE 08.09.17

Paper ref:	TB (05/18) 012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Amenable Mortality and Learning from Deaths Trajectory		
Sponsoring Executive	David Carruthers, Medical Director		
Report Author	Carol Cobb, Consultant Gastroenterologist		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

The paper reminds the Board of work done previously, much of which was discussed at the last meeting. The Board is invited to consider:

- The pace of implementation of the replacement mortality review system, which involves medical examiners (noting the site differential)
- The necessity to remedy our coding arrangements to ensure compliance with prior agreed changes to practice
- The work to be done understanding underlying amenable mortality causes
- And the commitment to tackle excess mortality in specified areas, outlined in the quality plan, and still relevant – of which tackling sepsis is the most material.

A monthly discussion at the executive quality committee will take place on the list of actions outlined in this paper such that CLE and then the Board can be informed of progress and address any slippage on this critical issue.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan		Public Health Plan		People Plan & Education Plan	
Quality Plan	**x**	Research and Development	**X**	Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Submitted to Quality and Safety Committee on 27/04/2018

4. Recommendation(s)

The Trust Board is asked to:

a.	Confirm the timescales for delivery that are required for the key items of the plan
b.	Set a clear aim for the organisation's improvement during 2018/19
c.	Agree how delivery of the Learning from deaths agenda will come to the Board

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s):						
Board Assurance Framework		Risk Number(s):						
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed		
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed		

Plan to review and modify factors influencing Trust mortality data
May 2018

Introduction

Mortality data shown in National statistics is an important measure of Trust performance but should not be used to compare organisations due to the nature of the data collection. It can however be used to identify clinical areas where there may be concern about higher than expected patient mortality. In addition it can show trends in mortality rates which can be looked at in relation to hospital site and the day of the week on which admission occurred.

With a site specific and weekend differential in mortality data for SWBHT it is appropriate to set in place an action plan to examine the reasons behind the change in data and address any issues identified. There is overlap with the recently re-activated Quality Plan, where the aim is to provide improvement in patient outcomes in a number of general and disease specific clinical areas.

Background

Some areas of possible high mortality have been identified from mortality parameters and are included in the Quality Plan for improvement. The approach to delivery of the quality plan is being re-examined with a proposal to work with the improvement team, clinical specialty and trainees to deliver quality improvement projects in the identified areas (sepsis, pneumonia, CVA, MI, hip fracture as examples). A sepsis improvement project is due to get underway shortly.

Mortality data are expressed by different indices (HSMR, RAMI, SHMI) providing a comparison of observed against expected deaths (table 1). Data can also be analysed for specific diagnostic groups. The data can be influenced by several factors such as levels of local community deprivation (measured by the Carstairs index), accurate coding of comorbidities, palliative care and death certification. Mortality rates can thus be influenced by the process aspects mentioned above. Previous Trust reports (2014 and 2016) have analysed mortality data, discussing the factors that may contribute to the differential mortality data seen between sites and when comparing weekend v weekday admissions.

Table 1. Indices used for demonstration of mortality data

Indices	Comparator	Measure	Specific data
HSMR	Compares different years or different subpopulations in the same year. Considers local population deprivation	Observed/expected rate	Identifies disease groups with increase mortality
RAMI	Risk of death based on clinical and hospital comparison data Considers local population deprivation	Observed/expected rate	Allows weekday and weekend comparison
SHMI	Compares trust with average England figures, based on characteristics of patients treated there.	Observed/expected rate	Includes death of patients 30 day post discharge as well as palliative care patients

Aims

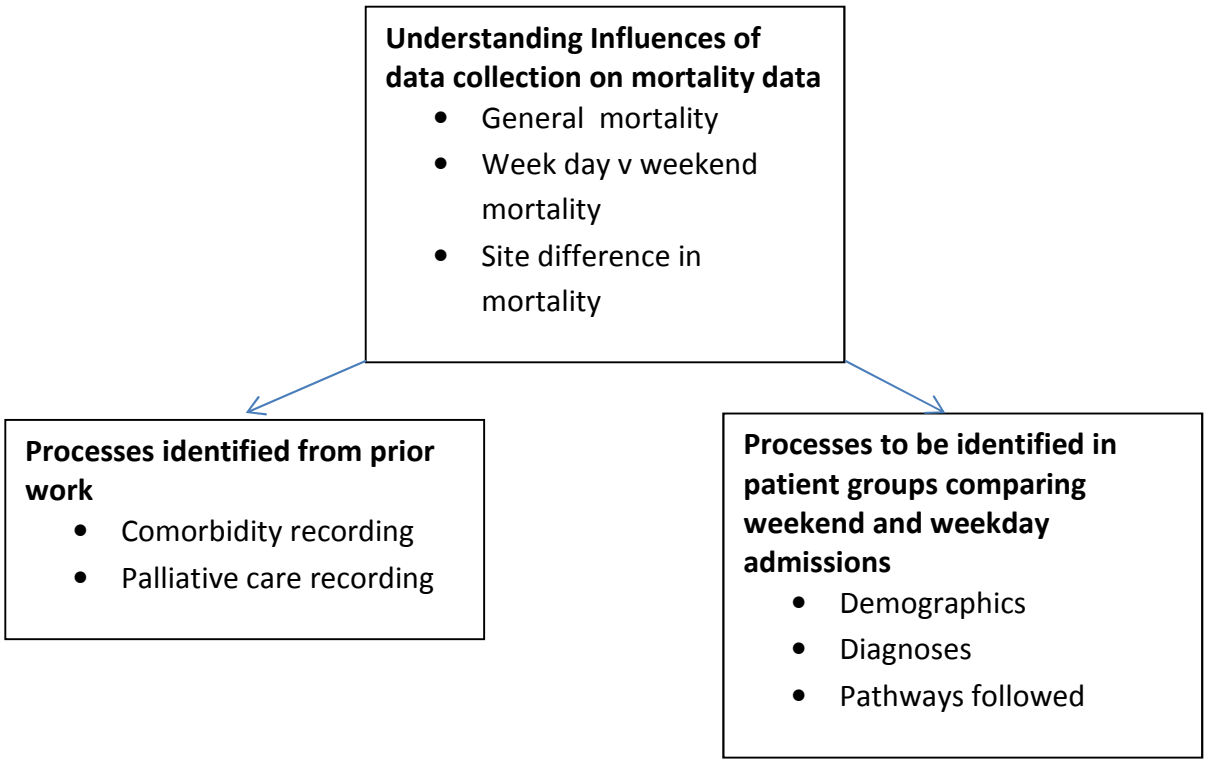
The plan proposed here is to work towards a fall in mortality rates and will look at several approaches which broadly speaking examine:

- how the process and type of data collected influences mortality
- disease specific groups where action can influence outcome

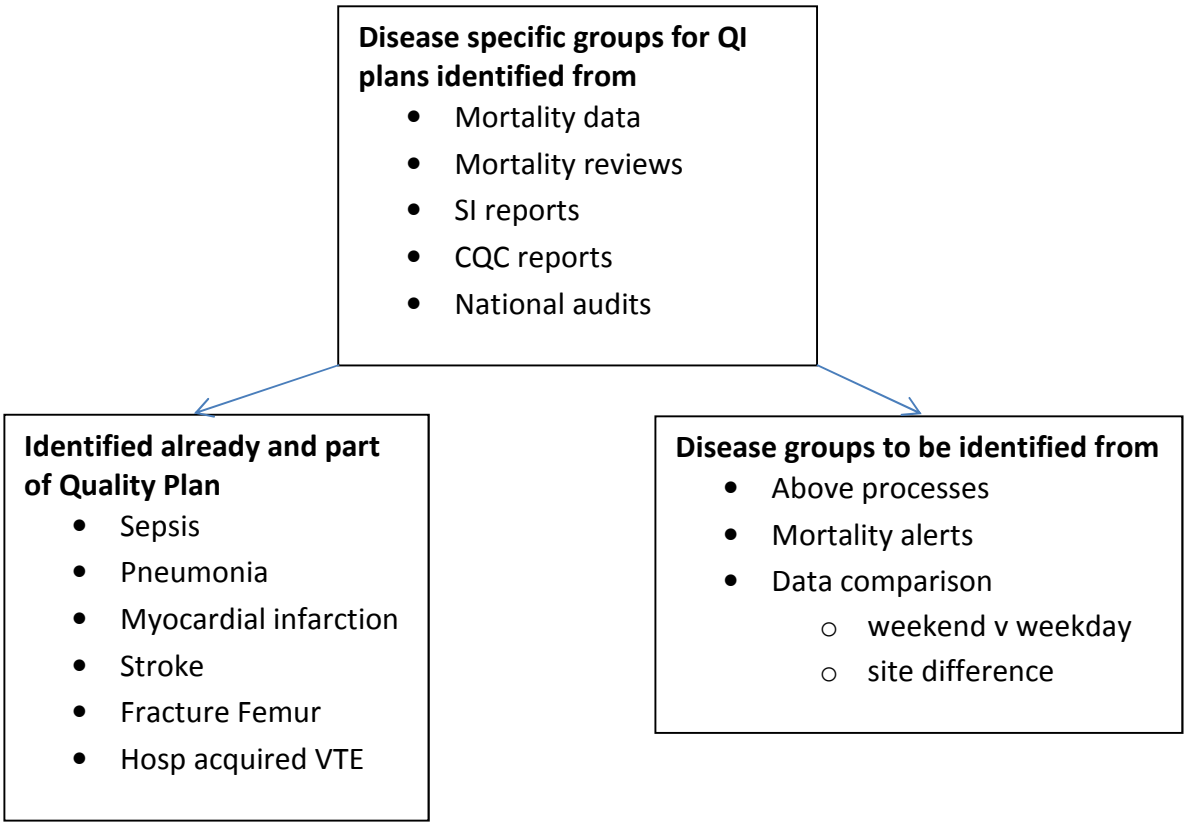
The former clarifies the influences of comorbidity recording and site specific services, the latter identifies disease groups with higher than expected mortality for further investigation. Successful introduction of the medical examiner process will facilitate this work through improved accuracy of death certification, identification of disease specific groups for investigation and liaise with the public, coroners and staff to contribute to the plan..

1) Understand the influences of data process on mortality data
    a. Correct any identified data collection processes
    b. Understand the site specific and weekend/weekday influences
2) Identify individual disease groups where mortality is high
    a. Identify information and actions from SI and mortality reviews
    b. Set in place disease specific actions to reduce mortality in these groups

a) How process of data collection influences mortality



b) Disease specific groups where action can be taken to improve mortality



1) Understand the influences of data process on mortality data

Planned improvement	Lead	Completion date	Evidence	Position statement
Access mortality data regularly - RAMI, SHMI, HSMR, HED, CHKS. National Audits	MG	Monthly review	LfDC minutes	Data outputs will be used to monitor Trust wide mortality. Provides baseline data for improvement to measured against. A number of additional outputs can be used to create bespoke reports for the Trust.
To understand the factors that influence mortality data for our patient population (expected number of deaths)	MG. CC	June 2018	LfDC minutes	Identify and examine influences on expected mortality rates such as levels and types of comorbidities recorded, patients receiving palliative care, accurate death certificate completion and where symptoms as opposed to diagnoses are recorded.
Understand the influence of discharge location and site specific services on mortality data	MG	June 2018	LfDC minutes	Patients discharged from acute medical units are more likely to have a symptom rather than a defined diagnosis than those from wards. Reconfiguration of services has seen stroke and surgery based at Sandwell and cardiology at City.
Death certificate (MCCD) accuracy	Lead Medical examiner	May - Dec 2018	Monitor mortality performance data	Medical examiner introduced April 23rd 2018 to maintain accuracy and oversight of MCCD completion. To develop training programme where needed.

2) Correct any identified data collection processes

Planned improvement	Lead	Completion date	Evidence	Position statement
Review data collection processes to better reflect local patient demographics	MM	June 2018	From LfDC and change in expected mortality rate	Look at process for coding, the documentation of co-morbidities and palliative care in conjunction with informatics. Consider effect of UNITY and change of coding where SNOMED prompts to be used. Education programme to be developed if needed
MCCD accuracy	Lead Medical examiner	Start April 2018	LfDC	Medical examiner to undertake training and support of medical staff

3) Understand the site specific and weekend/weekday influences

Planned improvement	Lead	Completion date	Evidence	Position statement
Site differences seen on mortality data to be examined	LfDC CC MG	June 2018	Report from LfDC	Identify and compare top causes death between sites: Examine patient specific details such as: • Demographics • Any delays to admission • Time to senior review • Readmission • Whether Pathways followed • Time to death from admission
Weekend/weekday variation analysis	LfDC MG CC	June 2018	Report from LfDC	Identify and compare top causes death on different days of the week: Examine patient specific details such as: • Demographics • Any delays to admission • Time to senior review • Readmission • Whether Pathways followed • Time to death from admission
Identify where specialty alert or local data analysis highlights higher mortality rate requiring action	CC MG RD GH KS	On going	LfDC Minutes Report to LfDC Report EQC quarterly	Data analysis showing high mortality in specific disease groups will be examined in more detail, in parallel with the actions within the Quality plan.

4) Identify individual disease groups where mortality is high

Planned improvement	Lead	Completion date	Evidence	Position statement
External alerts of high mortality rates in specific diagnostic groups	MG CC	As received	On going monthly	Internal alerts should have identified high risk areas. Detailed response needed to requests from CQC
Identification of cases for review based on Individual cases, diagnostic groups and Specialty themes	CC	Monthly On going	Reports LfDC Minutes Medical Examiner performance audit	Medical examiners introduced April 23rd 2018, to review all deaths and identify selection of cases for detailed structured review by case reviewers

5) Identify information from SI and mortality reviews

Planned improvement	Lead	Completion date	Evidence	Position statement
Introduction of LfD process with Medical examiners directing Mortality review performance	LfDC CC MG HM	Monthly On going	Reports Minutes M Ex audit. MRS /SJR outputs. Group reports	Medical examiner will identify cases for review and monitor timeliness of review by case reviewers. Specialty/directorate/group mortality performance will be fed back via EQC. SWBH have SJR webtool (and 2 Tier 1 Trainers) which will replace MRS after reviewer identification and training.
Monitor output from SI reports	MD	Monthly On going	EQC	All SI reports into deaths have action plans that need to be followed up and linked with other indicators of harm

6) Set in place disease specific actions to reduce mortality in identified disease groups

Planned improvement	Lead	Completion date	Evidence	Position statement
Diagnostic group analysis where identified as high mortality rate	Lead Med examiner CC	Start Aug 2018	Output from Quality Plan	High mortality groups identified to undergo systematic analysis of care pathway to look for improvement opportunity. • To link with Quality plan and areas already identified (sepsis, VTE, MI, CVA, hip fracture). • Pneumonia, acute myocardial infarction and COPD are the diagnosis groups with highest observed v expected number of deaths at weekends.
Integrating QI projects across trust	DC	Start Aug 2018	QI office	Working with QI office and Clinical staff to have corporate supported QI projects that benefit trainees and service managers and lead to improvements in care.
Communicating/ Sharing learning - Internal, Local and national	LfDC CC	Start Aug 2018	E bulletins Death matters quarterly QIHD Team talks WM NHSE	Improving the learning from mortality reviews is an important component to improving mortality and a variety of processes will be developed to disseminate information internally and locally.

Summary:

The above action plan is aimed to identify and modify factors that may improve Trust mortality data. Contribution of each step in the plan to a reduction in mortality will not be clear until analysis is undertaken of data related to the various steps. Current data suggests a focus on pneumonia, sepsis and acute cardiac ischaemia may have the largest impact in the disease specific group at weekends, but a likely sizeable contribution from changes in the process of data collection (palliative care code, reduction in signs and symptoms recorded rather than diagnosis) for some of the mortality indices. This will be under continual review and modification as the work progresses.

Paper ref:	TB (05/18) 013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Sepsis		
Sponsoring Executive	David Carruthers, Medical Director		
Report Author	Dr Roger Stedman, Consultant Anaesthetist Michelle Harris, Group Director of Operations Medicine & Emergency Care		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

Sepsis is an important cause of morbidity and mortality in the Trust. Early identification and commencement of treatment for infection is key to improving outcomes in adults, children and especially in those with the added risk of being neutropenic. Improvement in management of sepsis will contribute to an improvement in Trust mortality data and is a key part of the Quality and Safety plans.

Here we consider the key action points for a pathway to improve outcome in the groups described above.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	x	Public Health Plan		People Plan & Education Plan	
Quality Plan	x	Research and Development		Estates Plan	
Financial Plan	x	Digital Plan	x	Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Quality and Safety on 27/04/2018

4. Recommendation(s)

The Trust Board is asked to:

a.	Review and accept the action plans for improving sepsis management
b.	
c.	

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s):					
Board Assurance Framework		Risk Number(s):					
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

Sepsis

In this paper we will consider 3 main sepsis areas – those relating to adult sepsis, sepsis in neutropenic patients and paediatric sepsis. Initiatives already undertaken, current sepsis audit data and a management plan for improving sepsis outcomes are presented here.

1) General initiatives to improve sepsis management

Initiatives to improve sepsis management:
Local initiatives around sepsis management have been communicated via Hot topics and focus on a sepsis awareness campaign.

The Deteriorating Patient & Resuscitation Team have developed an adult sepsis screening sticker that may help aid the screening of sepsis on acute ward settings and meet national guidelines. This could reduce paperwork, safeguard staff and promote appropriate escalation of patients.

Sepsis screening by the ward nursing staff, recognition of possible sepsis and use of the sepsis 6 bundle in a timely fashion are key factors in effective sepsis management.

These features are discussed in more detail in the improvement programme section for sepsis that follows.

2) Audit data for sepsis management

Current Performance – Sepsis Screening and Sepsis Six Bundle Delivery. The tables show the Trust sepsis CQUIN returns for Q1-3 this FY

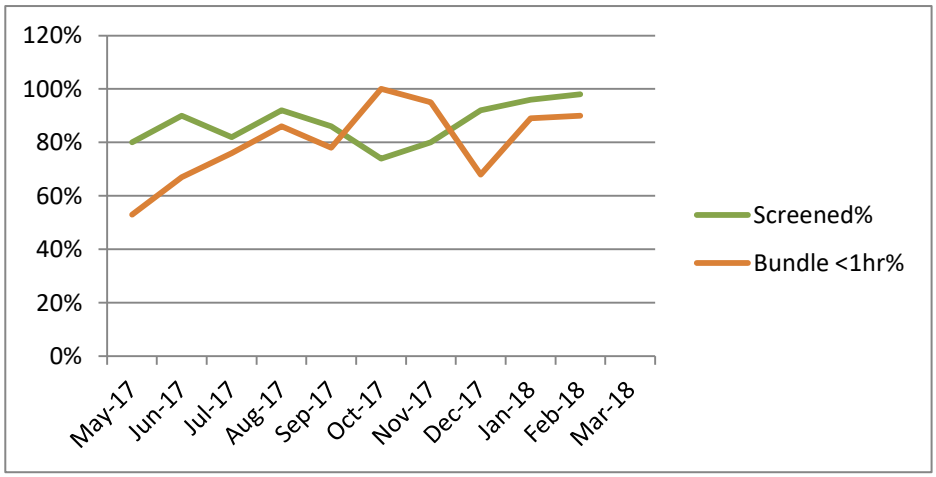
	Number of patients that NEEDED sepsis screening based on NEW score >5 (random selection from A+E/AMUs and wards)	Number of patients that NEEDED sepsis screening and RECEIVED sepsis screening (assessment of whether sepsis a likely cause of high NEW score)	%
Q1	300	222	74%
Q2	300	197	66%
Q3	300	192	64%

	Number of patients that RECEIVED sepsis screening and were positive for sepsis	Number of patients that NEEDED sepsis screening and RECEIVED sepsis screening who received Antibiotics within one hour	%
Q1	56	32	57%
Q2	76	59	78%
Q3	58	50	86%

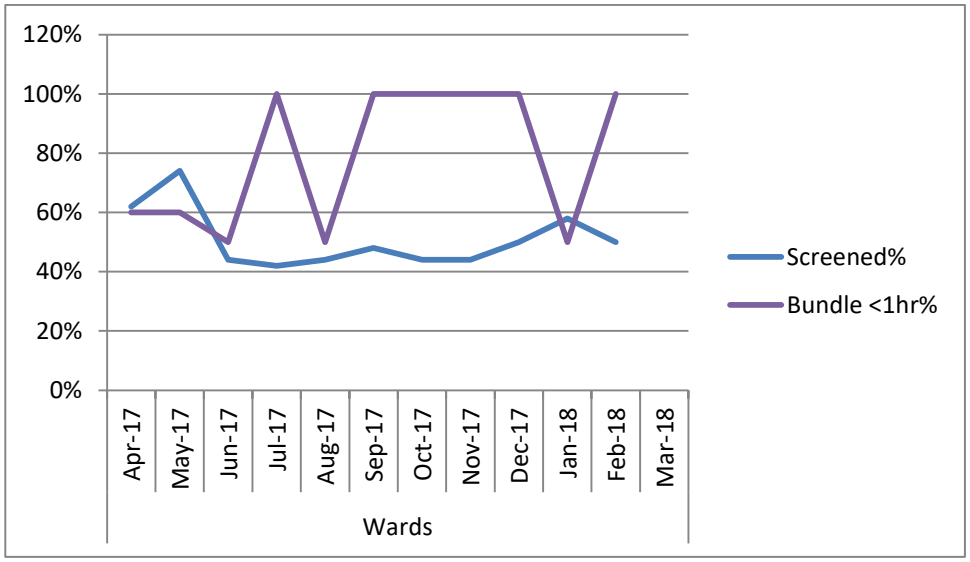
	Number of patients in sample	Number of Antibiotic Prescriptions in sample (Minimum of 30 patients) - *see guidance for definitions*	Number of antibiotic prescriptions reviewed within 72 hours - *see guidance for definitions*	%
Q1	25	41	41	**100%**
Q2	40	67	63	**94%**
Q3	27	40	38	**95%**

Sepsis screening and sepsis six bundle by ward area

a) Admitting Areas (ED, AMU, SAU)



b) Ward areas



The graphs show monthly performance split by admitting areas and wards. Overall performance has improved significantly in ED and the admission units over the course of 17/18. However ward performance has remained static and poor.

c) A Plan for improved management of Sepsis

Background

Sepsis is one of the commonest causes of death in hospitalised patients. Sepsis is a condition that is the result of the body's inflammatory response to infection. It causes progressive organ failure and ultimately death if not identified and treated early.

Sepsis is ubiquitous, it can occur in any healthcare setting – medical, surgical, planned care, emergency care, paediatric, maternal, hospital and community services. Sepsis is a condition that is treated by everyone – but 'owned' by no one.

Sepsis is not infection. It is a dysregulated response to infection. There are lots of infections that do not cause sepsis.

Sepsis is subject to huge variation in the way it presents and its severity. This is because there is both variation in the body's response due to genetic and other factors (such as age, co-morbidities and other treatments) as well as a large variety of different infecting organisms and potential sites of infection. The same organism infecting the same site in two different people can be a minor illness in one and cause serious critical illness in the other.

Sepsis does not discriminate. Whilst the extremes of age are more vulnerable, sepsis can occur in any age and in any state of underlying health. Being fit and young does not protect you from the fatal effects of untreated sepsis.

Sepsis is a medical emergency. Once established it progresses rapidly. The mortality from sepsis increases by 7% every hour. Early recognition and treatment saves lives. The treatment for sepsis in the early stages is relatively simple; it gets progressively more complex and expensive the later it is identified.

Sepsis is difficult to recognise in its early stages. The early signs of sepsis are non-specific and difficult to distinguish from other less serious illnesses. It is easy to ascribe the signs of sepsis to the effects of other conditions – such as trauma, recent surgery, being in labour, or a viral illness.

If sepsis is recognised and treated promptly and correctly – then the serious consequences can be avoided, lives can be saved. Having a plan for sepsis that is owned by the organisation and delivered by everyone will result in a reduction in sepsis related mortality.

Sepsis at SWBH

SWBH have been pioneers in the delivery of sepsis care in the acute setting. Long before it became mandated nationally we had a locally developed and delivered CQUIN for sepsis care. This is down to the ambition and drive of the previous sepsis lead, consultant microbiologist Dr Natasha Ratnaraja and the sepsis team (lead nurse Paul Drew). This plan aims to build on this legacy as well as integrate a plan for sepsis into the first objective of the Trust's Quality Plan; to reduce amenable causes of mortality.

Components of the Plan

To deliver effective sepsis care we need to monitor inputs and measure outcomes.

Inputs:

1) Early Identification
2) Timely treatment
3) Correct treatment
4) Appropriate and Timely de-escalation

Outcomes:

1) Deaths reviewed where sepsis was a contributory / causal factor
2) Patients admitted with a sepsis diagnosis that go on to die

Early Identification

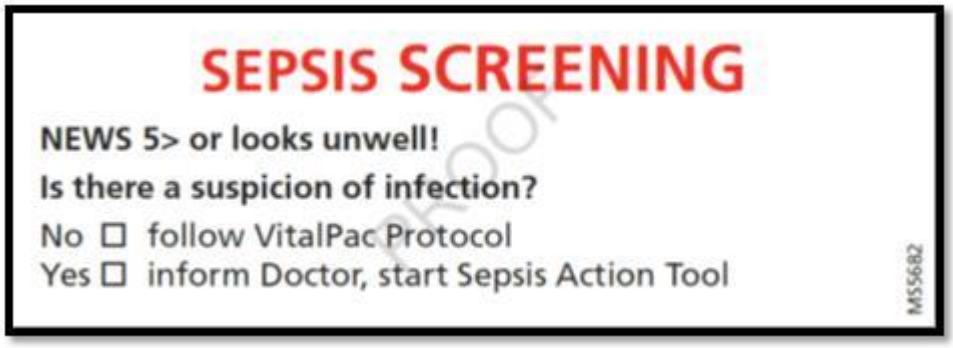
The early identification of sepsis relies on having a reliable system of:

Vital signs monitoring
Calculation of early warning scores
Triggers for screening
Accurate screening and escalation

These tasks are the responsibility of nursing staff. Vital signs and early warning score monitoring are key components of the trust's 'Safety Plan' and are performance managed through that mechanism.

The screening for and escalation of potential sepsis is tracked through performance of element 2a of the Sepsis CQUIN:
'The number of patients receiving screening for sepsis as a % of patients needing it'

- Patients that need screening are any patient that has a NEWS of 5 or more that hasn't screened negative for sepsis in the last 12 hours
- Patients are identified as having been screened by the use of the sepsis screening sticker:

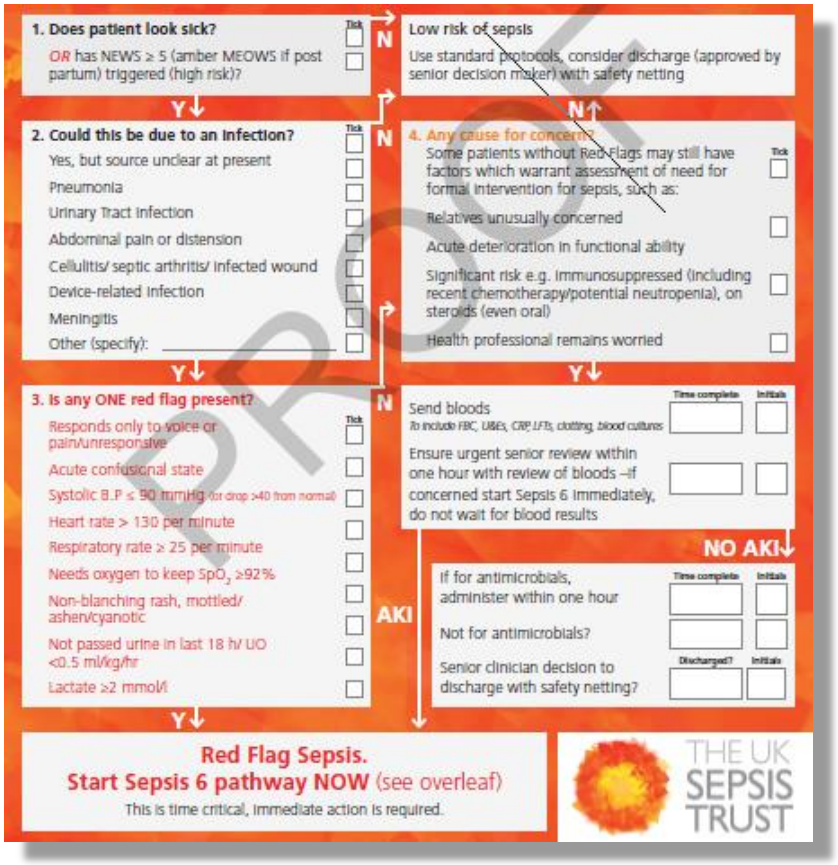


- Or in A&E the use of sepsis screening section of the triage tool
- Currently our performance in assessment areas of the hospital (A&E, AMU and SAU) is 80 – 90%. These areas are where the bulk of sepsis is seen and treated (over 60%).
- Our performance in the admitted areas (wards) of the hospital is less good at around 50%.

Objective 1 in the sepsis plan is to improve the **screening for sepsis** to be consistently above **90%** in all areas of the Trust.

Timely Treatment

For sepsis care to be delivered in a timely way escalation to the medical team must occur and a diagnosis of sepsis made. The use of the sepsis action tool assists doctors in making a diagnosis of sepsis. Our data indicates that in assessment areas 30% – 50% of patients that screen positive for sepsis meet the criteria for treatment of sepsis. In admitted (ward) areas this figure is only 5% - 15%.



If the patient meets the criteria for treatment of sepsis then they must be treated within one hour. The immediate treatment of sepsis is the 'Sepsis 6 Bundle':

Action (complete ALL within one hour)	Time complete	Initials	Reason not done
1. Administer oxygen Aim to keep saturations > 94% (88–92% if at risk of CO_2 retention e.g. COPD)			
2. Take blood cultures At least a peripheral set. Consider e.g. CSF, urine, sputum Think source control! Call surgeon/ radiologist if needed CXR and urinalysis for all adults			
3. Give IV antibiotics According to Trust protocol Consider allergies prior to administration			
4. Give IV fluids If hypotensive/ lactate >2mmol/l, 500 ml stat. May be repeated if clinically indicated – do not exceed 30ml/kg Call Critical Care/Outreach now if >2.5L administered			
5. Check serial lactates Corroborate high VBG lactate with arterial sample If lactate ≥4mmol/l, call Critical Care and recheck after each 10ml/kg challenge. If not reducing call Critical Care			Not applicable – initial lactate <2 ☐
6. Measure urine output May require urinary catheter Ensure fluid balance chart commenced and completed hourly			

The most important element of the bundle is the delivery of antibiotics within 1 hour. Our current performance for delivery of antibiotics within 1 hour of a diagnosis of sepsis is 89% (assessment and admitted areas combined).

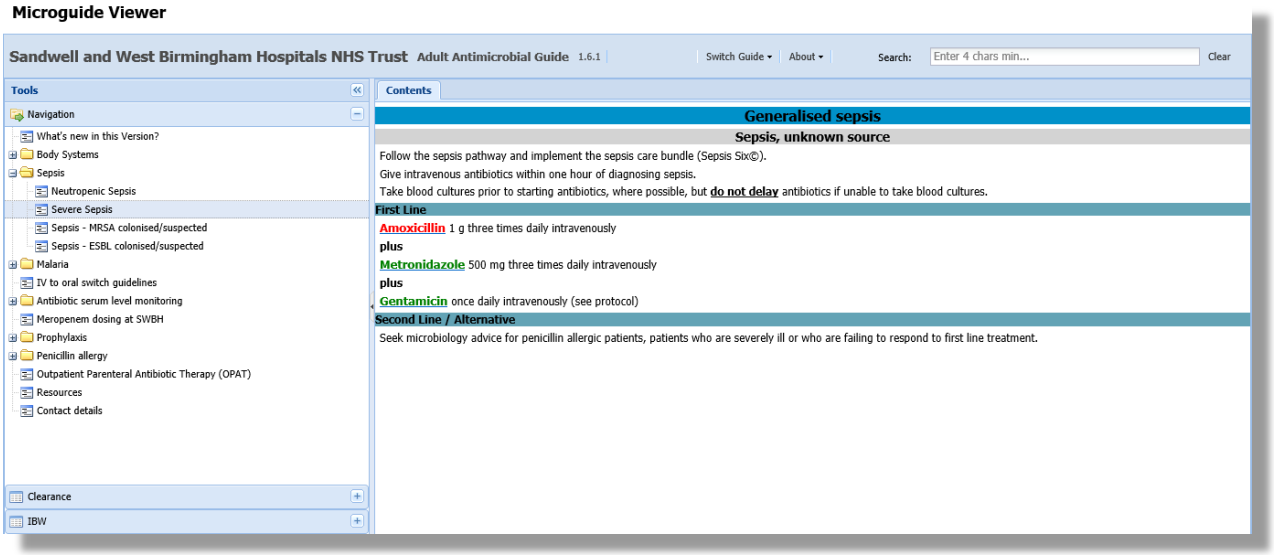
Objective 2 in the sepsis plan is for the **delivery of antibiotics within 1 hr** for patients diagnosed with sepsis to be consistently above **90%** in all areas of the Trust.

Currently most sepsis care in the trust is delivered without the use of the sepsis tool. The delivery of the sepsis 6 bundle is commonly achieved without the use of the tool – however monitoring of completeness and timeliness of the bundle delivery would be better achieved if the action tool and bundle documentation were consistently used.

Objective 3 in the sepsis plan is for the **Sepsis Action Tool** and **Sepsis 6 Bundle** to be consistently used in patients suspected of sepsis above **90%** in all areas of the Trust.

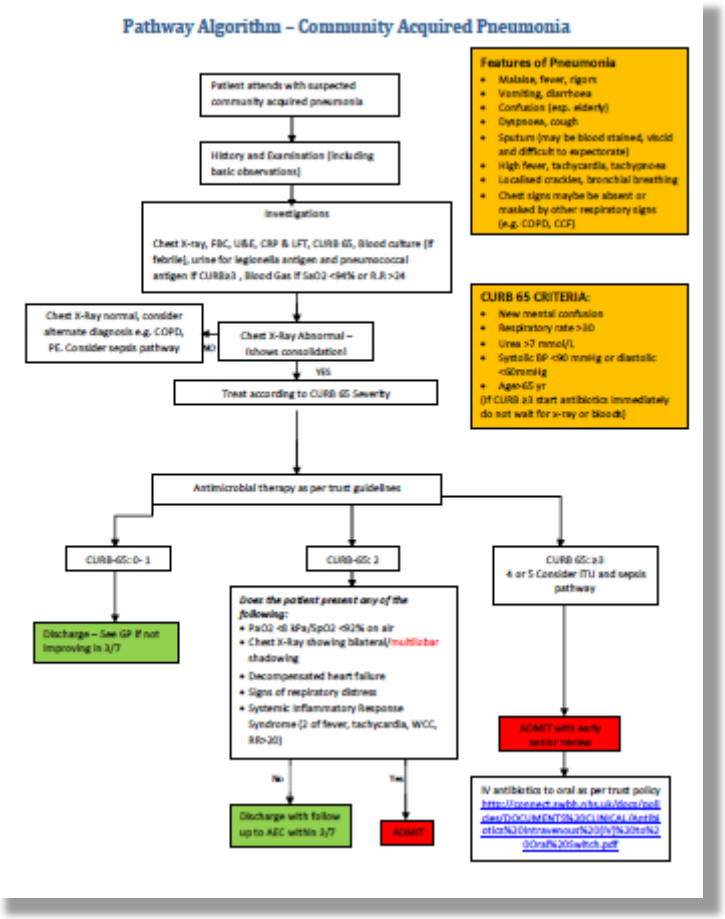
Correct Treatment

The principle of antibiotic treatment in the early stages of sepsis is to treat it 'broad and hard'. This involves the use of very powerful antibiotics which if misdirected can in themselves be harmful. It is important that antibiotics are chosen that best fit the clinical picture for the cause of the sepsis, and that local antibiotic guidelines are followed.



Objective 4 in the sepsis plan is for **All Antibiotics Administered** for the treatment of sepsis should **Follow the Trust Guidelines** or have a **documented discussion** with **microbiology** for **planned deviation**

Whilst antibiotics are important for the treatment of sepsis – they are not definitive treatment. It is vital that a diagnosis of the source of sepsis is made and that if possible the source is controlled. Definitive treatment depends on the source of infection – for example in surgical sepsis this might require surgery. For common sources of sepsis there are pathways that should be followed to ensure accurate diagnosis and timely treatment – for example the **Emergency Laparotomy** pathway or **Community Acquired Pneumonia** pathway.



Objective 5 in the sepsis plan is where there is a pathway for managing **Definitive Treatment** that pathway should be followed **In All Cases**

Appropriate and Timely De-escalation

Although the principal for treating early sepsis is ‘broad and hard’ it is important to avoid the complications of overtreatment with antibiotics. As soon as there are laboratory results available to direct specific antibiotic therapy then it should be instituted. It is an important principal of good **Antibiotic Stewardship** that all IV prescriptions of antibiotics should be reviewed in the first 72 hours. Currently we are achieving 95%.

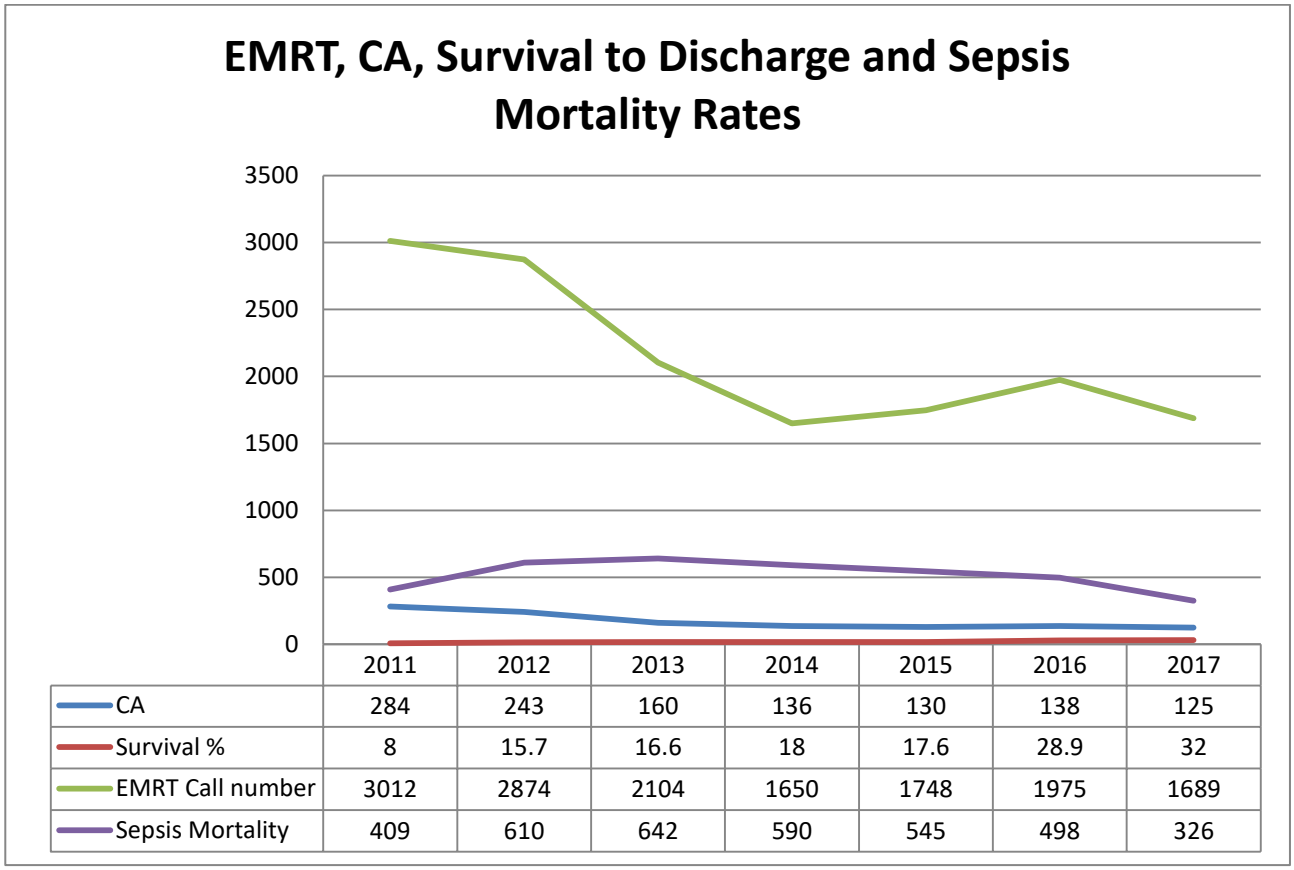
Objective 6 in the sepsis plan is that **All IV Antibiotic Prescriptions** will be reviewed within **72 Hours**

Deaths from Sepsis

The sepsis plan is an important element of the first objective in the Trust’s Quality Plan. Whilst we can measure inputs into the care of patients with sepsis, it is important that we measure the impact they have on outcomes which have meaning for patients. Survival is a meaningful outcome for patients, and measures of mortality tell us if we are having an impact.

There are two ways of looking at mortality, reviewing the records of patients that have died and looking to see if sepsis was a causal or contributory factor. This graph shows that over

the last 6 years the number of deaths reviewed where sepsis was a causal or contributory factor has fallen (red line).



	2011	2012	2013	2014	2015	2016	2017
CA	284	243	160	136	130	138	125
Survival %	8	15.7	16.6	18	17.6	28.9	32
EMRT Call number	3012	2874	2104	1650	1748	1975	1689
Sepsis Mortality	409	610	642	590	545	498	326

Objective 7 in the sepsis plan is to maintain the **downward trend in deaths** where **Sepsis was a Causal or Contributory Factor**

The other way to look at deaths from sepsis is to identify patients in whom sepsis is diagnosed and look at their outcomes and complications – i.e. did they survive, were they admitted to ICU with organ failure, did they develop acute and/or chronic kidney injury. There isn't an easy way to get this data from our current information systems. However the introduction of Unity will enable us to identify all patients in whom sepsis is diagnosed or suspected and their outcome.

Objective 8 in the sepsis plan is that we will use the introduction of the **Unity EPR** to collect data on outcomes such as **death, admission to ICU or development of AKI** for patients **diagnosed with sepsis** at or during admission to hospital

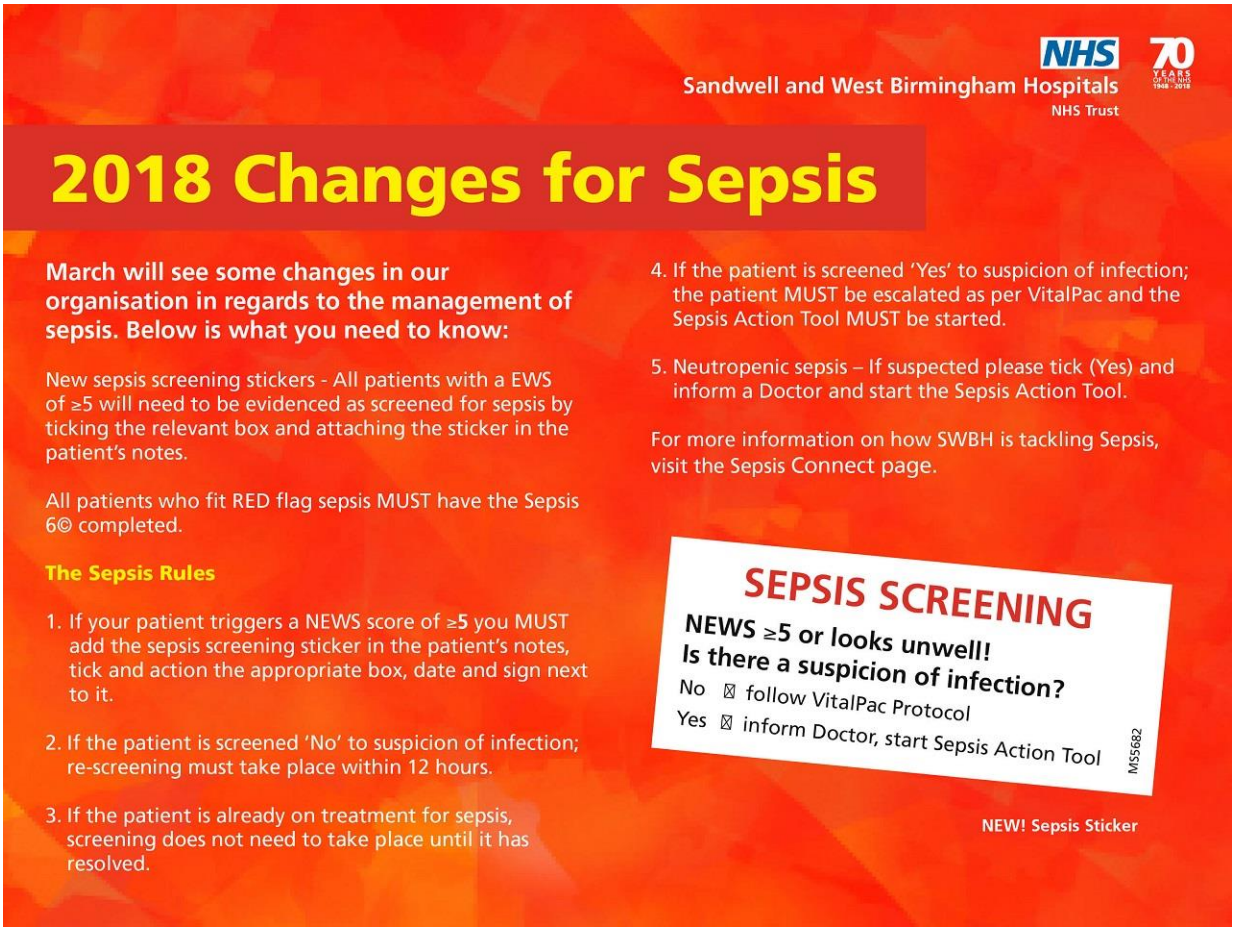
Education

A vital element of the sepsis plan is the raising of awareness of sepsis, its early signs and symptoms and how to intervene in a way that makes a difference to outcome. The sepsis education plan includes all types of health professional, all levels of training and all healthcare settings. We currently provide sepsis training to:

- Final year medical students using simulation based training methods
- Foundation Year 2 doctors
- All doctors and nurses at trust induction
- Community and Midwifery staff

- Local GPs

We also have regular awareness campaigns at the trust through posters, heart beat articles, death matters articles, screen savers &c.



We will continue and expand the education programme as resources allow.

Conclusion

Sepsis is a common condition in hospital patients; it is a potentially fatal condition with an outcome that is amenable to intervention. This is the case if it is recognised early and interventions are timely and appropriate.

This plan has laid out eight objectives aimed at improving:

Early recognition
Correct and Timely intervention
Appropriate de-escalation
Measuring mortality and other outcomes from two perspectives

Dr Roger Stedman
Consultant Anaesthesia & Critical Care Medicine
Trust Sepsis lead
Monday, 23 April 2018

Action plan summary:

	Aim	Target performance
Objective 1.	to improve the **screening for sepsis**	consistently above **90%** in all areas of the Trust
Objective 2	the **delivery of antibiotics within 1 hr** for patients diagnosed with sepsis	consistently above **90%** in all areas of the Trust.
Objective 3	the **Sepsis Action Tool** and **Sepsis 6 Bundle** to be consistently used in patients suspected of sepsis	above **90%** in all areas of the Trust.
Objective 4	**Antibiotics Administered** for the treatment of sepsis should **Follow the Trust Guidelines** or have a **documented discussion** with **microbiology** for **planned deviation**	100% of patients
Objective 5	Patients with a defined pathway for managing with a **Definitive Treatment** should have that pathway followed	100%
Objective 6	**IV Antibiotic Prescriptions** will be reviewed within **72 Hours**	100%
Objective 7	to maintain the **downward trend in deaths** where **Sepsis was a Causal or Contributory Factor**	Monthly data review
Objective 8	we will use the introduction of the **Unity EPR** to collect data on outcomes such as **death, admission to ICU or development of AKI** for patients **diagnosed with sepsis** at or during admission to hospital	100% of patients

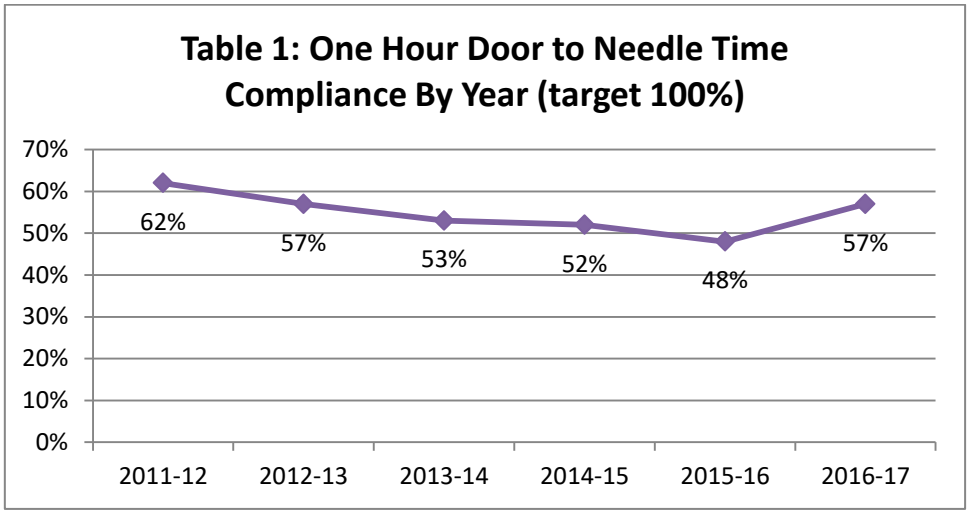
3) Neutropenic sepsis

1. Introduction

This briefing paper outlines the most recent audit results of the national measure of one hour door to needle time for patients with potential neutropenic sepsis to receive intravenous antibiotics. Chemotherapy patients are advised to ring the 24 hour helpline (managed by Acute Oncology Service [AOS] in hours and Newton 5 staff out of hours) if unwell, and from there they are advised where they should attend for urgent treatment. Since 16th September patients have been treated on the chemotherapy units, or have been referred to A & E departments via the alert phone, with the admitting department being advised of the imminent arrival of a patient with potential neutropenic sepsis, and the need for these patients to be treated as a medical emergency.

2. Current state

Table 1 demonstrates trust wide compliance with the one hour door to needle time since the audits began in 2011. This showed a gradual deterioration in compliance over the past 5 years, until 16-17.



This deterioration is despite the introduction of the AOS team, who have displayed posters, and educated nursing and medical staff in all emergency departments about the importance of treating these patients as medical emergencies. During 2016 the compliance in one hour door to needle time continued to decline until July. Table 2 demonstrates compliance, showing a recent improvement, but with work still to do with an average compliance of 85%.

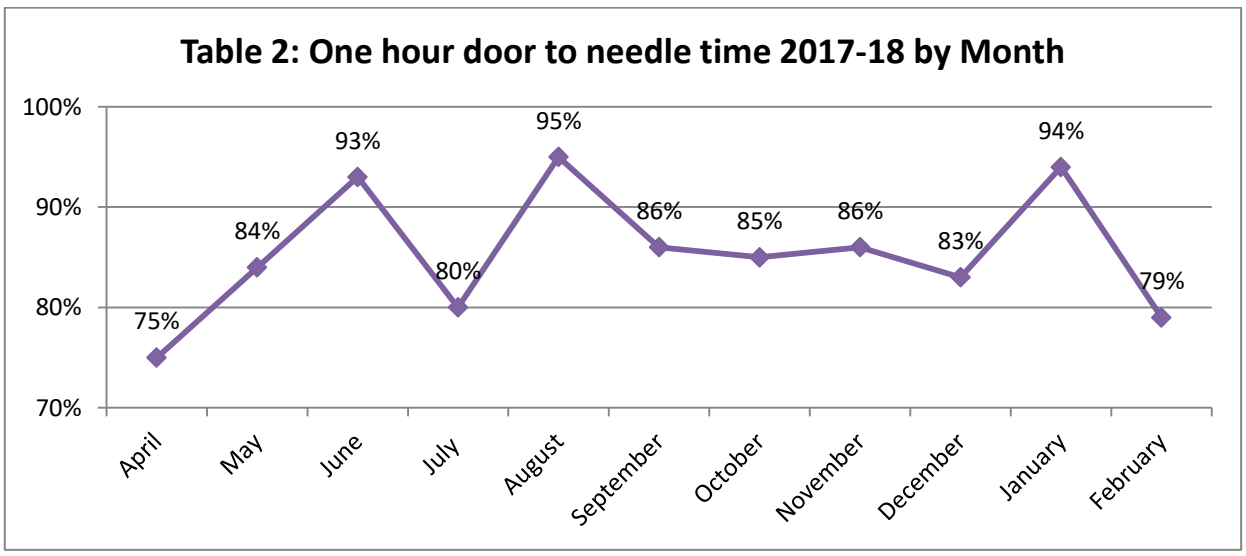


Table 3 below shows compliance for all relevant departments for February.

Table 3	February			
	Total Pts	**Number Compliant**	**Percentage**	**Average DTNT**
A & E SGH	21	14	67%	53 mins
A & E City	17	15	88%	43 mins
Newton 5	1	1	100%	15 mins
BTC Onc	2	2	100%	50 mins
Total	**41**	**32**	**78%**	**48 mins**

These results show a sustained improvement in the number of patients receiving antibiotics within an hour of arrival over the last year, an average compliance in 2017 of 85%.The average door to needle time for the trust is 48 minutes in February, with a reduced compliance this month of 78%, with the compliance at Sandwell A&E only 67%, possibly due to capacity issues on the Sandwell site.

The reason for breaches since April have been analysed in an attempt to further improve compliance, and the results can be seen in table 4.

Table 4	Triage	Dr Review	Prescribing	Administration	Multifactorial
In Hours	3	2	4	11	10
Out of Hours	1	5	7	7	13

During this time 29% of all breaches have been due to administration issues (there is not enough documentation available to identify if cannulation issues are a recurrent theme, but this has been audited since January 2018), 37% of all breaches had more than one reason for the delay, and 29% were caused by a delay in the doctor seeing the patient or prescribing the antibiotics.

3. Future State

All patients with suspected neutropenic sepsis who do not receive their antibiotics within an hour of arrival are discussed with staff from the relevant departments the following day in order to identify where the hold ups in the pathway are, with individual nurses and doctors caring for patients who do not receive their antibiotics within the hour being educated by their line manager. Data is circulated to all relevant departments on a weekly basis, with a monthly summary also completed. The cumulative data since August 2016 has demonstrated a 79% trust wide compliance for the last 16 months. It is hoped that compliance will continue to improve and the Oncology Department will continue to undertake its quarterly breach meeting, with all stakeholders invited. One aspect of communication that could be improved is that departments that have had breaches feedback to the acute oncology team in order to complete the audit process. Oncology receives no feedback now with individual departments requested to submit their own incident form following a breach.

4. Summary

Compliance with the one hour door to needle time hit a 5 year low in July 2016, with only 13% of patients receiving antibiotics within the hour. Daily analysis of sepsis patients has been implemented, and compliance has improved to an average compliance of 84% in 2017, but dropped back to 78% in February with an average door to needle time of 48 minutes.

5. Recommendations

- Analysis of breaches has identified a lack of awareness of neutropenic sepsis with primary care and the ambulance service. AOS lead to discuss educational strategy with representatives from each group. All policies and pathways are currently under review, and will be available in the community when agreed. **Timescale for completion: 31st March 2018**

- Acute Oncology Service working with ED matrons and PDN's to implement patient group directive (PGD). All band 6 and 7 to be competent in its use. This was due to be completed by end March 2017, but updated PGD currently awaiting discussion at drugs and therapeutics committee. **Timescale for completion now: Ongoing**
- Weekly audit of neutropenic sepsis implemented with results circulated to all key stakeholders. The names of nurses and doctors involved in the care of patients who breach are recorded in order that these staff can receive further education and training from their line manager. All breach patients will be discussed by AOS and Matron on the next working day to identify why the breach happened and address. All breach patients have incident forms completed, and will be discussed by the wider team at the monthly breach meeting. Report to be sent to OMC monthly. **Timescale for completion: Data daily, summary weekly, report monthly**

Neutropenic Sepsis Action Plan – March 2018

5	Complete
4	On track
3	Expect to be completed as planned
2	Significant delay/unlikely to be completed as planned/will have explanation attached
1	Not yet commenced
0	Objective revised

JRT: Jenni Thomas (AOS Lead) **SW:** Sarah Wiltshire (Matron Oncology), **AB**: Annabel Bottrill (Matron ED SGH), **AC:** Antoinette Cummings (Matron ED City)

Issue	Action	By	Date
Raise awareness of the 1 hour door to needle time in these patients	• Neutropenic sepsis posters to be redesigned to ensure the message is clear, and circulated to admitting departments	JRT	completed
	• AOS to liaise with ED matrons and professional development nurses to ensure up to date information is available, and staff are aware of the PGD • All appropriate staff trained in the use of the PGD • All trained staff assessed as competent in the use of PGD • AOS to continue to educate junior doctors on the Trust induction programme and emergency department staff on local induction		on-going
	• AOS lead to meet with representatives of primary care and ambulance service to discuss educational needs. Teaching planned when pathways updated		28/02/18
Monitor performance against the 1 hour door to needle time	• Weekly audit of neutropenic sepsis patients to continue, with results circulated to the Chief Operating Officer and Group Director of Nursing for Medicine, monthly report to be compiled • AOS and Matrons to discuss each breach patient next working day, with improvements to be documented on daily form. • Incident forms to be submitted for all breach patients • Results to be available monthly for OMC	JRT/JT/SW/AB/AC	On-going

4). Summary of Paediatric sepsis

1. There is a sepsis screening tool as part of the admission documentation so should be completed on all children admitted (appendix 1)

2. completion of the tool and management of sepsis is audited on a weekly basis on all three paediatric wards - 5 cases at random are chosen for review per ward (appendix 2)

3. The completed audit tools are sent to the Sepsis team weekly –which is at 85% compliance in Q4. This is a fall and has been noted but the clinical teams have been notified and changes instituted in the process to make this happen.

4. There is a full sepsis guideline available on the intranet (https://connect2.swbh.nhs.uk/wp-content/uploads/2016/07/Sepsis-in-Children-Screening-Tool-and-Algorithm-SWBH.pdf?x70949)

5. If there are any deaths from sepsis in a child (or indeed death due to any cause) then these are reviewed internally (within the department) within two weeks and then as an incident form is filled in there is usually a formal table top as well. Only one death due to sepsis in the last 12 months known about but risk lead looking to see if there have been any other sepsis deaths in the last 12 months

6. If a death has occurred in another hospital after transfer (usually to PICU) then these are also reviewed internally as noted above and there MAY be a table top dependent on both our internal review and that of the receiving hospital.

7. Number of transfers out of SWBHT for sepsis is being explored.

Appendix 1

Consider Paediatric Sepsis

Sepsis Recognition – Suspected/Proven Infection with at least 2 of the following:

- Temperature <36.0°C or > 38.0 °C — □ Yes □ No □ n/a
- Tachycardia / Bradycardia (see normal ranges table in full guideline) — □ Yes □ No □ n/a
- Vasomotor change* Peripheral Vasoconstriction (signs of poor perfusion) — □ Yes □ No □ n/a
  Peripheral Vasodilatation with bounding pulses
- Tachypnoea (see normal ranges table in full guideline) — □ Yes □ No □ n/a
- Acutely altered central nervous system state — □ Yes □ No □ n/a

**Hypotension (is a late sign and is not necessary to diagnose shock but is confirmatory if present)*

Sepsis Response (all elements to be completed in 1 hour)*

1. Give Supplemental Oxygen □
2. Intravenous / Intraosseous access and take bloods □
3. Give Antibiotics □
4. Fluid Resuscitation □
5. Ensure senior clinicians / specialists are contacted early □
6. Consider early inotropic support □

See full guideline in induction book / on intranet

Appendix 2.
Paediatric Sepsis CQUIN Audit 2018
Ward: **Completed By :**
Patient meets local protocol to be screened for SEPSIS.

RXK	Date / Time of Completion of Paediatric Sepsis screening tool	If NOT completed why was screening not carried out?	Time of Septic diagnosis or N/A if not septic	Septic: IV ABX in 1hr Y or N?	IV fluids administration Y or N?	Oxygen administration Y or N?	ABG Lactate Y or N?	Catheterisation / Fluid balance Y or N?	Blood cultures Y or N?	If deteriorated did they get a consultant review in 1hr	If the child is on day 3> of antibiotics has an appropriate review been doc in the notes at day 3

1) **Audit sheet should be completed during ward round**
    a. **Lyndon 1 / Lyndon G – on 2nd on ward round day**
    b. **D19 – every Wednesday**
2) **Once complete – hand to ward clerk - Ward clerk to input data onto electronic version of sheet on SAME DAY**
3) **The electronic sheet to be emailed to:**
    a. **DP&RT** swb-tr.SWBH-GM-Resuscitation-Team@nhs.net **(NEW eMAIL!)**
    b. **Jez Jones** jez.jones@nhs.net **and Ward manger**

Appendix 1

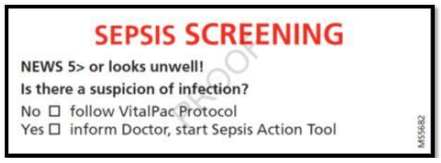
Sepsis assessment pathway and current data

Patient assessments

Sepsis assessments tools

Patient looks unwell or NEWS observation score > 5

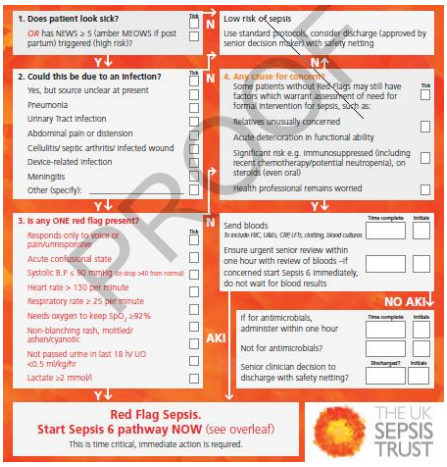
Nursing



SEPSIS screening

Is Infection a likely cause?

Doctor



No

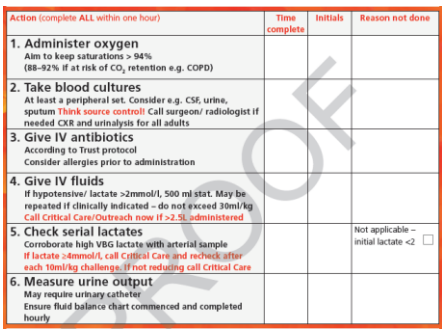
Yes

Any other cause for concern?

Consider senior review within 1 hour

Start Sepsis 6 Bundle

Doctor



Current Sepsis Data	
Assessment areas A+E/AMU	Admitted areas Wards
Percent of Trust sepsis	
60%	40%
Screening compliance	
80-90%	50%
Patients meeting criteria for treatment of sepsis	
30-50%	5-15%
Sepsis 6 Bundle delivered	
90%	45%

Paper ref:	TB (05/18) 014

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Responding and Learning from Serious Incidents		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author	Allison Binns, Deputy Director of Governance		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Committee should focus on]*

Two areas which have been identified as trends from our serious incident investigations are head injuries and metastatic spinal cord compression. Both require a revision and relaunch of the practices undertaken to care safely for patients and both are in train.

A common theme through some of our serious incidents is one the Board will be aware of, results acknowledgment, due to this being on the Trust Risk Register. Ahead of Unity, specialties are being asked to look at and advise on their process for assurance that this occurrence will reduce.

Changes, previously outlined have been made to the process and appear to be the correct ones. Learning is still a challenge and will be the area for focus through the next 12 months.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	X	Public Health Plan		People Plan & Education Plan	
Quality Plan	X	Research and Development		Estates Plan	
Financial Plan	X	Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

None

4. Recommendation(s)

The Trust Board is asked to:

a.	**ACCEPT** that the changes made to the serious incident investigation process are being consistently applied, noting the planned developments.
b.	**APPROVE** the plan for developing a more robust method of sharing and learning.
c.	

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s): 2642					
Board Assurance Framework		Risk Number(s):					
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 3 May 2018

Responding and Learning from Serious Incidents

1. Introduction

1.1 In the autumn of 2016 a review of the way we conducted our Serious Incident (SI) investigations was carried out with a view to strengthening our processes and approach.

1.2 The main focus of the changes made was to ensure patients and relatives were included in the investigation, actions were more focused on the improvements required to prevent recurrence and that the process was done in a timely way.

1.3 A report detailing some of the changes was presented to the Board in March 2017

2. SI process improvements

2.1 The national requirement for undertaking serious incident investigations, as set in the National Framework, is 60 working days. Our Trust target was agreed at 50 working days.

2.2 Patients and relatives have been involved and interviewed as part of the investigation process, where they have wished to be involved, and reports are written aimed at them, ensuring technical language is explained and kept to a minimum.

2.3 A two day training programme was provided to twelve senior clinicians who were either identified to be or self nominated to be a serious incident investigator. Revised templates and guidance have been developed for investigation leads for consistency.

3. Learning from SIs

3.1 **Appendix A** summarises the 14 serious incidents reported during the financial year 2017/18. Seven further SIs were reported during the year and are being investigated. One incident has not been included, as with further information this is no longer a missed diagnosis.

3.2 Identifying trends and themes from serious incidents can either come from the type of incident or some of the causative factors and generally are seen over a period of more than one year.

3.3 Over the past two years two types of incidents are standing out in terms of themes; issues with getting patients onto the pathway for **Metastatic Spinal Cord Compression** (MSCC) and patients dying after **sustaining a head injury** whilst in hospital.

3.4 The MSCC pathway has been revised as an outcome of this trend to further assist clinicians to identify patients at risk of MSCC and get them the correct treatment at the

right time. Imaging have made MRI scanning slots available at weekends and, where identified, will flag imaging reports if a MSCC is highly suspicious which alerts the requester. This is followed up with a phone call.

3.5 The Head Injury (HI) pathway guides clinicians in the Emergency Departments on the care and treatment of patients brought into hospital with a head injury. This pathway was not written for patients who sustained a head injury whilst in hospital, although much of the information on treatment and monitoring is relevant. As a consequence of the trend seen the HI pathway is being revised to cover: <u>all</u> patients with a head injury, the NICE guidance issued in July 2017 and to link with the Trust's Falls Policy.

The revised pathway will provide clinicians with a proformas for assessment and examination for any patient with a HI and indicate where neck imaging is required and when and what neurological observations are expected and the imaging required.

3.6 A theme identified from a number of investigations is that **acknowledgement of results** arising after a patient has had tests carried out has factored in their outcome. It is understood that different specialties may have different methods and processes for acknowledging that results have been reviewed and acted upon. The Trust is currently reviewing these processes to ensure they are robust, well understood and well communicated, whilst at the same time ensuring that our electronic patient record can facilitate this requirement.

3.7 Improvements have been made following SI investigations including:

- holding a stock of neck collars and training orthopaedic nursing staff how to fit them.
- surgical procedures not being commenced until all staff are present and the "stop before you block" posters are of a size and in a position where they are a reminder to staff.
- ophthalmology amending their practice for consenting both eyes for a procedure to doing one at a time and now mark the eye to have the procedure.
- Dermatology placing wristbands on patients attending for an outpatient procedure to help differentiate them from patients waiting for an outpatient appointment.

3.8 Actions identified from SI investigations either affect a local area or have a wider impact on the Trust. Implementation is monitored corporately by the Patient Safety Team and any areas overdue for completion are discussed with the relevant Groups in Executive committees.

3.9 Whilst this process works well to ensure that actions are taken, the wider learning from such events remains challenging.

4. Next steps

4.1 The process for carrying out an investigation is now embedding with the nominated lead investigators and through scheduled sessions will together continue to learn from each other and improve the process.

4.2 From May increased attention will be given to monitoring delivery of the agreed SI actions, with the relevant Group Directors presenting the plan, once signed off by the Medical Director, to the Executive Quality Committee (EQC) and providing assurance that the implementation dates will be met. The EQC will track progress and hold the Group Directors to account for any deadline slippage.

4.3 What is clear is that we need to focus on ensuring that learning is shared across all teams. A learning hub is being created on Connect to provide a repository of information on improvements made, not only from SIs but any investigations, complaints, mortality reviews etc.

The learning hub will contain messages in different media but will require staff to look for information so a suite of methods for getting messages to the right staff is being developed using different forms of media, one of which will be the newly launched app 'myConnect' which enables colleagues to access information from their smartphone at a time that suits them.

4.4 Incidents which are graded as 'amber' require investigation by the associated Clinical Group. These are not monitored centrally so the robustness of the process, the effectiveness of the investigations and hence the learning is not known and as a consequence there is lost opportunities for further shared learning.

In 2018/19, the corporate Patient Safety Team will focus on these incidents to ensure we support patients affected and improve learning, adding trends and themes to those identified through SIs.

4.5 Changes in process resulting from SI investigations are communicated through a number of channels within the Trust. We need to develop a more assured way of knowing that those staff who undertake processes are aware of and understand the changes they personally need to make to their practice.

5. Conclusion

5.1 The process for carrying out SI investigations with a small number of dedicated investigators seems to be embedding. Whilst the new investigators have been carrying out their first investigations there have been some slippages with time which are being managed.

5.2 The involvement of patients and families is now a given within the process and the report following the investigation is written for them at a suitable level.

5.3 Changes to services, care and the way staff carry out processes are happening due to the learning from investigations. What is not evident is that changes made in one team have been shared with or translated to other teams, regardless of any similarities in activity.

5.4 During this year, the focus of all learning is that it is shared across the Trust through multimedia and there are robust assurances that lessons have been learned.

5.5 Those trends and themes identified through the SIs reported and investigated are having the associated pathways and procedures revised and they will be re-launched.

6. Recommendations

6.1 The Board is recommended to **ACCEPT** that the changes made to the serious incident investigation process are being consistently applied, noting the planned developments.

6.2 The Board is also recommended to **APPROVE** the plan for developing a more robust method of sharing and learning.

Allison Binns
Deputy Director of Governance

25 April 2018

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Serious Incident Summary 1 April 2017 – 31March 2018

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Root Cause(s) and Contributory Factors	Summary of key changes agreed
1.	19/04/2018	2017/11362 & 166299	Surgery	T&O	Delay in treatment. Provision of anticoagulants.	**Root Cause -** Failure to recognise the patient had a mitral valve replacement **Contributory Factors-** • Failure to undertake full clerking (history and examination) of patient overnight (waited until the next morning) • Failure to coroborate patient's medical history • Failure to follow trust guidance on the management of patients on anti-coagulation	• Medical clerking audits and raising awareness in place as audit showed compliance was poor. • Induction for junior doctors now includes how to corroborate medical history for patients unable to give a full history themselves (wherever possible). **All Actions completed**
2.	24/05/18	2017/13504 & 168323	Surgery	Anaesthetics	Wrong side procedure, anaesthetic block – **Never Event**	**Root Cause-** Failure to complete WHO Safe Surgery "Sign In" **Contributory Factors** • The "Stop Before You Block" standard operating procedure not followed • No consistent practice regarding who completes the "Sign In". • No consistent practice regarding when anaesthetists actually stop before they block. • The "Stop Before You Block" poster very small and not very prominent. • Practitioner performing procedure not present the start of the process.	• The essential requirements of WHO Safe Surgery proceduresreinforced. • Poster for "Stop before you Block" displayed in anaesthetic rooms in prominent position • Responsibility for completion of "Sign In" mandated. • Procedures not started until all staff are present. **All Actions completed**

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Root Cause(s) and Contributory Factors	Summary of key changes agreed
3.	13/06/17	2017/15098 & 169397	Surgery	Ophthalmology	Wrong side procedure, eye laser – **Never Event**	**Root cause-** This error was caused by human error of not following the correct procedure of reviewing the management plan prior to the intervention. **Contributory factors-** • Single handed clinic • Equipment not available in the clinic room: - Slit lamps - Prescriptions - Iopidine - Diamox • Patient booked who didn't require laser, taking time to sort out.	• The practice of consenting for sequential procedures has changed so they are done at different times. • Stamp in use covering positive patient identification and correct site surgery • Site marking and included in WHO checklist **All Actions completed** • Produce pre-printed consent forms for SLT procedures **Action on-going / in progress**
4.	19/06/17	2017/21603 & 169722	Women & Child Health	Obstetrics	Neonatal death	**Root cause-** Failure to recognise and act appropriately on a compromised pre-term baby, resulting in a notable delay in delivery which may have contributed to the outcome.	• Pre term CTG interpretation alongside management of IUGR & escalation (case presentation) training implemented. **All Actions completed** • Escalation of Midwifery concerns to be instigated via Midwifery mandatory days. • Review of policy for treating patients at risk of increased T21 who decline pre-natal diagnosis. **Action on-going / in progress**

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Root Cause(s) and Contributory Factors	Summary of key changes agreed
5.	26/07/17	2017/23557 & 174685	Medicine & Emergency Care	Emergency Medicine	Diagnostic incident (failure to act on test results)	**Root cause-** The failure of the referring clinician to follow up the requested x-ray and to review and act on the results accordingly. **Contributory factors-** • The CXR not acted upon in clinic. • No documentation from clinic attendance • No documentation available to ED on reattendance. • The CXR was interpreted by the ward team as showing infection rather than cancer progression. • The potential for further treatment in patients with EGFR mutation was not clearly documented in all the Oncology clinic letters. • The indications for flagging the radiology report was not understood by the Oncology team. • The Oncologist was not aware of the electronic results acknowledgement (eRA) system on CDA. • Delays in reporting x-rays onto CDA	• Visiting consultants informed of and use the results acknowledgement processes at SWBH. • Delays in reporting of x-rays reduced. • Programme Director for Oncology advised of the Oncology Registrar's failure to document findings in clinic. **All actions completed**

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Root Cause(s) and Contributory Factors	Summary of key changes agreed
6.	31/07/17	2017/23990	Surgery	General & Colorectal	Surgical/invasive procedure	**Root cause-** intraoperative anaemia. **Contributory factors-** • Significant, undiscovered cardiovascular disease • Second sample for cross match not sent pre-operatively	• All APR cases to be considered for pre-operative exercise testing to establish cardiovascular reserve. • Minimum APR anaesthetic monitoring to include the use of an arterial catheter for continuous intra-arterial blood pressure monitoring and regular ABG analysis during surgery. • Baseline ABG when the patient is in the anaesthetic room to establish Hb at the start of surgery. • Second sample for blood cross match to be sent before induction of anaesthesia. • Cross match requirements to be discussed at "Team Brief". • Cross matched blood to be immediately available for APR, in keeping with Trust "Maximum Surgical Blood Ordering Schedule". • Regular "time outs" during prolonged surgery for the surgeon and anaesthetist to discuss progress. **Action on-going / in progress**

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Root Cause(s) and Contributory Factors	Summary of key changes agreed
7.	03/08/17	2017/19699 & 172475	Primary Care, Community & Therapies	Dermatology	Wrong patient – **Never Event**	**Root Cause-** Failure to positively identify the patient prior to an intervention, as per Trust Policy. **Contributory factors-** Safer Surgery policy not followed with respect to WHO checklist and team briefing.	• PPID video re-circulated to all staff • All staff in dermatology attended training on PPID and use of WHO checklists. • Patient ID bracelets introduced for those attending for OPD theatre session in dermatology as an additional trigger. **All actions completed**
8.	22/09/17	2017/23909 & 175037	PCC&T/Imaging	Oncology/Imaging	Diagnostic incident (failure to act on test results)	**Root cause-** Difference in expectation between clinician and reporting radiologist as to whether the findings on imaging were significant to warrant flagging. **Contributory factors-** Failure to use the Trust Radiology results acknowledgement system Lack of knowledge regarding the use of the Trust Radiology results acknowledgement system Consultant not being primarily based at SWBH.	• Criteria for when to use the flagging system agreed and communicated to all clinicians. • System in place to automatically send results to visiting Consultants. **All actions completed**

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Root Cause(s) and Contributory Factors	Summary of key changes agreed
9.	23/09/17	2017/23923 - 175060	PCC&T	District Nursing	Medication error	**Root cause-** The patient's identity was not checked in accordance with the Positive Patient Identification policy. **Contributory factors-** • The key safe, while convenient, allowed the nurse to gain access to the house and make inaccurate assumptions about the identity of the patient she encountered. • The Positive Patient Identification Policy (PtCare014) is inadequate in its coverage for community patients	• Electronic record has a photo of the patient. • All staff have revisited the PPI policy and viewed the video. **All actions completed** • Positive patient ID policy to be amended to outline the specific procedure foridentifying a patient in the community setting. **Action on-going / in progress**
10.	8/10/17	2017/24900 & 175698	Medicine and Emergency Care	Acute Medicine	Fall with Head Injury	**Root cause-** failure to adequately complete a falls risk assessment. **Contributory factors-** • Out of date policy. • No auditable care standards in the policy for patients assessed as "moderate risk". • Inadequate nursing supervision in AMU Bays	• Patient Falls Prevention Policy (Pt Care 03) revised • Nurse staffing improved. • Review DNACPR form completion process and the accuracy of information • Medical Examiners introduced. • ED falls risk assessment checklist included in falls prevention policy. **All actions completed** • Include auditable care standards for patients with a "moderate risk" of falls in Pt Care 03 - • Audit completion of handover documentation from ED to AMU **Action on-going / in progress**

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Root Cause(s) and Contributory Factors	Summary of key changes agreed
11.	8/11/17	2017/27628 & 177425	Women & Child Health	Neonatology	Unexpected neonatal death	**Root cause-** Unable to determine a root cause **Contributory Factors –** • Masimo machines were used to monitor saturation levels but they do not monitor heart rates or respiratory rates **Post Mortem Report** • Cause of death as unascertained, sudden unexplained death of an infant (SUDI).	• All babies on high flow oxygen have continuous saturation monitoring and an ECG monitor **All actions completed** • Audit of all babies on high flow oxygen focussing on monitoring (checking compliance) **Action on-going / in progress**
12.	28/11/17	2017/29467 & 178607	Medicine & Emergency Care	Emergency medicine	Diagnostic incident (failure to act on test results)	**Root cause-** Failure to obtain and acknowledge all blood test results before discharging from the department. **Contributory factors-** • It appears that there is no robust mechanism for communicating the tests requested or for obtaining the results in a timely fashion. • The Consultant was not aware of the existence of the GP letter and had not seen this before assessing the patient. • Documentation does not evidence the full discussions between the Consultant and the patients wife.	• All discussions held with the patient need to be documented in notes. • All clinicians must be informed of the blood tests requested/taken by the triage nurse on arrival. These should then be acknowledged on the system and acted upon when necessary. • Referral documentation needs to be clearly visible to the A&E doctors. This is to be attached to the patient documentation. **Action on-going / in progress**

	Date of Incident	Reference	Clinical Group	Specialty	Type of Incident	Root Cause(s) and Contributory Factors	Summary of key changes agreed
13.	27/11/17	2017/29479& 178510	Medicine & Emergency Care	Elderly care	Diagnostic incident (failure to act on test results)	**Root cause -** Failure to correctly assess the injuries of the patient in ED **Contributory factors-** • The bleed on the first CT head scan was subtle and difficult to identify. • Unexpectedly high number of admissions meaning that patients had to be cared for on a surgical ward. • Unexpected sickness absence in Orthotics team coinciding with departmental move from City to Sandwell site	• Miami J collar stock now available • Nursing staff in orthopaedics trained to fit collars **All actions completed** • Head Injusry pathway to be revised to assist with identifying patients requiring C Spine imaging. **Action on-going / in progress**
14.	18/12/17	2018/497 & 180021	Medicine & Emergency Care	Emergency medicine	Diagnostic incident (failure to act on test results)	**Root cause-** The assessing doctors were unaware of the implications of possible spinal cord compression due to non-malignant causes and due to metastatic disease. **Contributory factors-** • Findings on examination (full muscle power) were wrongly interpreted as reassuring. • It was not recognised that sensory symptoms or increasing back pain in isolation is a red flag for MSCC. • An oncology specialist nurse saw the patient after the initial assessment and documented her concerns but this was not seen and acted upon by the doctors.	• Revise and relaunch the MSCC pathway • AOS Nurses to be able to commence patients on MSCC pathway. • Where oncology specialist nurses suspect malignant spinal cord compression, they must be empowered to ensure that the MSCC pathway is followed, if necessary by involving palliative care consultants or the Medical Director. • Teaching sessions must continue to inform medical staff of this uncommon but important condition. **Action on-going / in progress**

Paper ref:	TB (05/18) 015

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Financial Plan 2018-20 update		
Sponsoring Executive	Tony Waite, Finance Director		
Report Author	Dinah McLannahan, Deputy Director of Finance		
Meeting	Trust Board	**Date**	3 May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

- [Re-]confirmation of the decision of the FIC to accept a revised financial control total for 2018.19. That control total is for a pre-PSF deficit of £(7.5)m and opportunity to earn £14.7m of PSF through financial control total [c£11m] and ED 4hr wait [c£4m] compliance.
- To consider and confirm the 'conditions precedent' in respect of that acceptance. The financial plan requires savings / margin generation of c£37m. There are granular and firm plans for c£28m of that requirement and specific opportunities to bridge the 'gap' of c£9m. To do that shall require satisfactory resolution with NHSE Specialised Commissioning financial arrangements in respect of Oncology, Gynae-Oncology & neonatal services and the realisation of one or more 'commercialisation' opportunities previously reported.
- To consider and confirm the capex, cash and potential revenue loans in the plan. The capex is as per the multi-year programme previously considered by the Board. The Board has previously considered the [cash] risks to affordability of that programme & potential moderations. The 2017.18 STF 'bonus' of £10m provides some scope for flexibility in that.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan		Public Health Plan		People Plan & Education Plan	x
Quality Plan		Research and Development		Estates Plan	x
Financial Plan	x	Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Finance and Investment Committee 27th April 2018.

4. Recommendation(s)

The Trust Board is asked to:

a.	To note & [re-]confirm the decision of the FIC, taken in line with the delegation confirmed by the Board at its April meeting, to accept a revised 2018.19 Control Total offered by NHSI and which was confirmed in the trust's plan submission made on 30th April.
b.	To require that the Executive develops and presents specific and firm plans to close the residual financial plan CIP challenge of c£9m at the June meeting of the FIC & Board.

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s):						
Board Assurance Framework		Risk Number(s): BAF 5 and BAF 6						
Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	25.04.18	
Quality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	25.04.18	

FINANCIAL PLAN 2018.19

Summary

The slides accompanying this presentation at Appendix 1 provide an update on the planning and budget setting process for 2018.19.
In considering whether to accept the control total offered by NHSI, the key issue for the trust is cash.
Cash sufficient to afford its necessary forward investment programme.
That cash can be generated if the trust balances its books year on year and through that secures year on year STF funds.

To do that requires the trust to achieve very significant year on year improvements in productivity with consequent reduction in costs and to secure margin on additional work. That to be complemented with a series of commercial opportunities bringing either significant one-off gains or recurrent revenue streams.

The sufficiency and robustness of those improvements is key to the governance question of whether the trust accepts, or rejects, its financial control total for 2018.19.

The in-year delivery of those improvements, specifically in Q1, shall be key to the Board's re-consideration and re-commitment to its investment programme. The five year programme totals £105m but £65m of that is contractually committed as we enter the new financial year. Of the residual £40m management has identified tranches of that investment which could be culled.

The Trust has done better than plan during 2017.18, managing to over achieve by circa £5.1m against control total. This has generated an indicative total of £17.9m STF, of which £7.7m is core STF, the balance being a bonus of £10.2m (timing of receipt to be confirmed, but expected July 2018). The Trust ended the year with £9.7m of cash in the bank, which was considerably better than expected.

Control Total 2018.19

The initial offer from NHSI to the Trust for 2018.19 control total was a deficit of £2.567m excluding STF, and £14.742m of STF, taking the Trust to a surplus including STF of £12.175m. Board members will remember that this created a 2018.19 challenge of £42.292m, being a normalised Month 12 x 12 deficit of £22.7m, stranded costs for Oncology of £3.45m, and new 2018.19 cost pressures of £18.7m, to create the deficit of £2.567m.

Recent discussions with NHSI have centred around a possible adjustment to control total, culminating in a revised offer letter (included at Appendix 2), adjusting the Trust's control total to a deficit of £7.567m. The letter also outlined a reduction in STF. The Trust has challenged this and is expecting that the STF offer will be reinstated to £14.742m. The Trust is building the plan submission on this basis.

The revised control total offer means that the ask for the Trust in 2018.19 is c£37m (see Appendix 1, slide 2).

2018.19 current plan position

Appendix 1 to this report sets out the current I&E plan position of the Trust. It also details the CIP development progress against the £37m target. The Board is receiving a separate paper to the May meeting that goes in to detail on the development of Trust plans. These have in the main been split by clinical directorate for budget setting and accountability purposes.

Key features of the plan so far and Trust plan development are as follows;

- Trust Board has been sighted previously on the scale of the financial challenge, with the change in the control total now £53m (was £58m) over 2018.19 and 2019.20; assuming an underlying exit 2017.18 deficit of £26m, incremental costs of circa £18m in 2018.19, less a now £7m notified reduction in the 2018.19 control total, and £16m incremental cost in 2019.20. This assumes no additional or incremental costs in respect of the Midland Met new hospital project before 31st March 2020. Any subsequent costs incurred will be the subject of an additional taper relief / transitional support bid with NHSE via NHSI.
- The plan proposes solutions to the ask; with CIP capped at 4% average across the two years, but front loaded into 2018.19 to address cash-flow issues, a contribution from contracted income, and then a gap / further commercialisation opportunities.
- If assumptions within the plan are delivered; this would result in control total achievement, and at least £10.3m of STF (as in 2017.18, 70% of the total STF available, being the element relating to financial plan compliance, the other 30% being attached to aspirational A&E 4 hour performance improvement). Achieving this would likely mean that the capital programme would not require external borrowing during 2018.19. ***An addendum to this report to be circulated following final plan submission on the 30th April outlining cash flow timings and possible borrowings.***
- The Trust has, at the date of writing this report, plans totalling £28.7m. This is made up of;
    - £6.8m contracted income over budgeted expenditure (allows for £7.5m for cost of contract expenditure);
    - £1.8m of other income plans;
    - £9.3m of pay plans;
    - £10.8m of non-pay plans
- Whilst there is a relatively robust degree of granularity behind these plans, they are not without risk, and there remains a lot of work to translate into delivery commensurate with these values.
- As previously reported to the Board, a control total compliant financial plan would fund the current capital programme for 2018.19 and beyond, based on assumptions relating to spend, STF and internal funding sources. It is possible that the capital programme may slip in 2018.19, and/or full STF is not earned, which could result in external loan financing being required. This could be a time consuming process that puts the timing of and sequencing of the capital programme and Midland Met project delivery at risk.

- Also as previously reported to Board, a control total compliant plan with full delivery in Q4 of 2018.19 could result in in year revenue borrowing to supplement the timing of cash flows, with the majority of the borrowing being repaid by the end of the financial year with the "gap" or commercial element of the CIP plan phased to deliver in Q4.
- It is proposed that a plan is submitted which provides for a scale of borrowing consistent with not securing STF funding such that there are no surprises with regulators as to the potential scale of such borrowing. This is consistent with the approach adopted in 2017.18 and which was acceptable to & appreciated by NHSI.
- As routinely challenged and confirmed by the FIC, this borrowing is relatively straightforward to secure, on the submission of cash flow forecasts that demonstrate effective treasury management and a genuine need to continue effective and safe operations.

<u>Control total compliance</u>

- The question of whether the trust accepts or rejects its financial control total for 2018.19 can appropriately be considered as representing two discrete matters – financial incentives and good governance.
- In respect of the former there is clear merit to accepting the control total – it provides access to a potential £14m of STF payments and moderation of exposure to contract fines & penalties.
- This is not, however, sufficient and good governance requires that acceptance be based on a credible financial plan. That could appropriately be a plan with risk but requires at least one plausible route to control total achievement to be determined.
- The above paragraphs set out the progress on CIP development and the plausible commercialisation opportunities that are work in progress. The Board will also consider a separate paper on CIP plans. At the current time, adopting the aforementioned assumptions relating to Control Total moderation and assuming CIP plans deliver, there is an £8.6m gap remaining to be closed.
- Identified opportunities to close that gap are as follows;
    - Funding for Oncology stranded costs and block contract for Gynae-oncology services – c£4m
    - Commercialisation opportunities – c£5m (e.g. car parking)
    - Further stretch on pay and non-pay - £5m – but very risky given the levels of assumed CIP
    - Avoidance of reserves spend - £3m – also very risky given headroom that may be required
    - Further technical opportunities - £2m maximum

- It is deemed that the first two items are key in providing opportunities to close the gap to control total compliance.
- The FIC has previously challenged and confirmed that there is no compelling reason for rejection of the control total at this time, however, the output of further work was necessary to inform a final determination and the matter should necessarily further be considered by the full Board.
- The Trust will need to work through for final plan submission the impact of the above cash performance and determine the likelihood of needing to secure revenue and/or capital borrowing – either for short-term timing or to cover any deferred delivery of improvements. This will be shared with the Board as an addendum following final plan submission on 30th April in advance of the meeting on 3rd May.
- The draft financial plan was prudent in its approach to the presentation of that potential borrowing such as to avoid any surprises for regulators, and the final plan submission will reflect the same prudent approach.

Capital

Please refer to slide 9 of Appendix 1.

The plan submission will reflect £34.671m of capital expenditure for 2018.19 of which £30.4m will require cash (the balance being non-cash items), £34.671m being the Board approved capital programme.

With funded depreciation at circa £17m for 2018.19, this will require additional cash of circa **£16.4m**, to be funded from cash reserves. (It should be noted that the current CIP plans include an asset life extension which would reduce funded depreciation by £3m. hence we have assumed that this is not a funding source for prudence)

The Trust ended the 2017.18 financial year with cash of £9.5m.

It will expect on current plans to generate £7.5m of cash backed surplus, assuming the Trust earns £14.7m of STF (A&E 30% £4.4m is at risk). In addition to this, the Trust will receive (subject to audit) an STF bonus of £10.2m.

This suggests cash to fund capital (subject to timing and in year liquidity borrowing requirements to be confirmed at final plan submission) of **£26.7m** if the Trust delivers all CIP and achieves I&E plans, earning all STF associated with this.

Appendix 1

SWBH 2018.19 Plan update slides

Current plan on a page

	1 - Contract PRI	1c - Other PRI	2 - Other Income	3 - Pay	4 - Non Pay	5 - Non Operational Costs	Grand Total	*Memo CIP 18/19*	
March x 12 (ie £1,890 x 12)	413,489	**6,148**	**49,450**	**(313,854)**	**(153,325)**	**(24,584)**	**(22,677)**		
2018/19 Income Changes									
Oncology	(10,714)			2,017	5,247		**(3,450)**		£3,540 Stranded Costs Oncology, dealt with by ask below
Gynae Oncology	(1,888)			1,322	566		**0**		£332 Stranded costs shown in plan changes section below
	0								
IK Normalisation	(1,200)			900	300		**0**		
IK Full Year Effect	1,318			(988)	(330)		**0**		
IK Data Chalenges	(2,126)			1,595	531		**0**		
Movement to IK Normalised Position	872			(654)	(218)		**0**		
	0								
Normalised Position March Return	399,751	**6,148**	**49,450**	**(309,663)**	**(147,227)**	**(24,584)**	**(26,126)**		
Movement to IK April Contract Income Position	17,341			(6,206)	(4,335)		6,800	*6,800*	£6m Margin plus £800K PTS
Nb Gynae onc now in contract at £1.4m, cost of contract has increased by £1.755m									
	417,092	**6,148**	**49,450**	**(315,869)**	**(151,563)**	**(24,584)**	**(19,326)**	***6,800***	
2018/19 Plan Changes									
Taper Relief Income/Expenditure					(100)		**(100)**		
National Inflation				(5,926)	(3,017)	(1,232)	**(10,175)**		
Local Inflation				(600)	(127)	(1,000)	**(1,727)**		
Developments					(1,950)		**(1,950)**		
Investments				(1,000)			**(1,000)**		
Planning Contingency					(2,000)		**(2,000)**		
Gynae Onc Stranded Costs				(332)			**(332)**		Total = £17,284
Additional STF Cost Reserves (CNST)					(1,449)		**(1,449)**		New
	417,092	**6,148**	**49,450**	**(323,727)**	**(160,206)**	**(26,816)**	**(38,059)**	***6,800***	
2018/19 Savings									
TPRS Schemes (excludinhg PTS £800K, shown above)	68	437	1,292	9,314	7,894	2,875	**21,879**	*21,879*	
Balance to Original ask of £24.2m for Groups					2,321		**2,321**	*2,321*	
Commercialisation			11,292				**11,292**	*11,292*	
Reduce Commercialisation by £5m			(5,000)				**(5,000)**	*(5,000)*	
GRAND TOTAL	**417,160**	**6,585**	**57,033**	**(314,412)**	**(149,991)**	**(23,941)**	**(7,567)**	***37,292***	TOTAL CIP
STF			14,742				**14,742**		
SURPLUS/(DEFICIT)	**417,160**	**6,585**	**71,775**	**(314,412)**	**(149,991)**	**(23,941)**	**7,175**	***37,292***	

CIP IDENTIFIED

Group/Directorate	Opex Total*	CIP Identified	% Of Opex
Medicine & Emergency Care			
Admitted Care Directorate	(73,389)	3,134	-4%
Emergency Care Directorate	(36,412)	1,123	-3%
Group Management Directorate	(1,031)	55	-5%
Total	**(110,832)**	**4,312**	**-4%**
Primary Care, Community and Therapies			
Ambulatory Therapies Directorate	(9,614)	146	-2%
Community Medicine Directorate	(19,292)	0	0%
Group Management Directorate	(2,159)	132	-6%
iBeds Directorate	(12,708)	1,062	-8%
iCares Directorate	(12,315)	187	-2%
Total	**(56,088)**	**1,527**	**-3%**
Surgical Services			
Anaesthetics, Pain Management and Critical Care Directorate	(18,942)	539	-3%
General Surgery Directorate	(20,644)	347	-2%
Group Management Directorate	(2,584)	2	0%
Ophthalmology Directorate	(21,434)	243	-1%
Specialist Surgery Directorate	(12,266)	251	-2%
Theatres Directorate	(19,687)	128	-1%
Total	**(95,558)**	**1,511**	**-2%**
Women's & Child Health			
Acute & Community Paediatrics Directorate	(16,320)	277	-2%
Group Management - W&CH Directorate	(414)	40	-10%
Gynaecology, Gynae-Oncology & GUM Directorate	(4,304)	86	-2%
Maternity & Perinatal Medicine Directorate	(28,736)	1,122	-4%
Total	**(49,773)**	**1,526**	**-3%**
Imaging			
Breast Screening Directorate	(2,876)	58	-2%
Diagnostic Radiology Directorate	(11,814)	673	-6%
Group Management - Imaging Directorate	(1,102)	24	-2%
Interventional Radiology	(495)	2	0%
Nuclear Medicine Directorate	(2,775)	42	-2%
Total	**(19,062)**	**799**	**-4%**
Pathology			
Biochemistry Directorate	(7,821)	433	-6%
Group Management - Pathology Directorate	(1,152)	12	-1%
Haematology Directorate	(5,144)	12	0%
Histopathology Directorate	(2,204)	24	-1%
Immunology Directorate	(3,240)	9	0%
Microbiology - Directorate	(3,620)	13	0%
Total	**(23,182)**	**503**	**-2%**
Corporate			
Strategy and Governance	(8,525)	843	-10%
Strategy and Governance (CNST)	(10,608)	0	0%
Corporate Nursing & Facilities	(14,552)	478	-3%
Estates & New Hospital Project	(19,056)	1,776	-9%
Finance	(4,586)	435	-9%
Medical Director	(10,141)	729	-7%
Operations	(23,658)	1,283	-5%
People and Organisation Development	(8,093)	582	-7%
Total	**(99,220)**	**6,126**	**-6%**
Central			
Central Directorate	(13,461)	2,700	-20%
Total	**(13,461)**	**2,700**	**-20%**
Total	**(467,177)**	**19,004**	**-4%**

**Grossed up for Imaging and Pathology Internal Trading*

	Non Opex Total	CIP Identified	% Of Opex
Central			
Central Directorate	(24,584)	2,875	-12%
Total	**(24,584)**	**2,875**	**-12%**
Total Non Opex	**(24,584)**	**2,875**	**-12%**
TOTAL CIP IDENTIFIED		**21,879**	

2018/19 Control Totals by Group/Directorate

Group/Directorate	Annual Contract PRI Total	Annual Other PRI Total	Annual Other Income Total	Annual Pay Total	Annual Non Pay Total	Annual Non Opex Total	Annual Control Total	Phasing TOTAL Q1	Phasing TOTAL Q2	Phasing TOTAL Q3	Phasing TOTAL Q4	Phasing TOTAL Total
Medicine & Emergency Care												
Admitted Care Directorate	89,634	1,555	712	(45,368)	(24,803)	0	**21,730**	4,813	5,367	5,764	5,787	**21,730**
Emergency Care Directorate	54,892	764	(33)	(30,361)	(4,903)	0	**20,358**	5,147	4,839	5,272	5,101	**20,358**
Group Management Directorate	0	0	0	(783)	49	0	**(734)**	(165)	(184)	(193)	(193)	**(734)**
Total	**144,526**	**2,319**	**679**	**(76,513)**	**(29,657)**	**0**	41,354	**9,795**	**10,022**	**10,842**	**10,695**	41,354
Primary Care, Community and Therapies												
Ambulatory Therapies Directorate	10,341	80	8	(7,116)	(2,334)	0	**978**	187	386	153	253	**978**
Communty Medicine Directorate	12,446	0	734	(7,621)	(11,671)	0	**(6,113)**	(1,663)	(1,317)	(1,608)	(1,525)	**(6,113)**
Group Management Directorate	0	0	0	(641)	(1,386)	0	**(2,027)**	(507)	(507)	(507)	(507)	**(2,027)**
iBeds Directorate	12,090	0	8	(9,137)	3,757	0	**6,719**	1,550	1,764	1,652	1,754	**6,719**
iCares Directorate	19,228	0	69	(9,919)	(2,187)	0	**7,191**	1,652	2,182	1,533	1,825	**7,191**
Total	**54,105**	**80**	**819**	**(34,434)**	**(13,820)**	**0**	6,749	**1,219**	**2,507**	**1,223**	**1,799**	6,749
Surgical Services												
Anaesthetics, Pain Management and Critical Care Directorate	11,804	0	0	(17,526)	(1,109)	0	**(6,831)**	(1,752)	(1,659)	(1,711)	(1,709)	**(6,831)**
General Surgery Directorate	40,520	0	1,360	(18,146)	(2,708)	0	**21,026**	4,933	5,578	5,248	5,268	**21,026**
Group Management Directorate	0	0	0	(2,373)	138	0	**(2,235)**	(559)	(559)	(559)	(559)	**(2,235)**
Ophthalmology Directorate	32,606	90	686	(13,555)	(8,334)	0	**11,493**	2,567	3,384	2,658	2,884	**11,493**
Specialist Surgery Directorate	22,070	0	123	(11,000)	(1,332)	0	**9,861**	2,263	2,500	2,552	2,546	**9,861**
Theatres Directorate	0	0	257	(9,348)	(11,082)	0	**(20,174)**	(4,971)	(5,050)	(5,076)	(5,076)	**(20,174)**
Total	**106,999**	**90**	**2,426**	**(71,947)**	**(24,427)**	**0**	13,141	**2,481**	**4,195**	**3,111**	**3,353**	13,141
Women's & Child Health												
Acute & Community Paediatrics Directorate	21,165	22	567	(14,766)	(1,299)	0	**5,689**	1,308	1,547	1,351	1,483	**5,689**
Group Management - W&CH Directorate	0	0	0	(207)	(2)	0	**(210)**	(52)	(52)	(52)	(52)	**(210)**
Gynaecology, Gynae-Oncology & GUM Directorate	9,606	17	9	(3,997)	(265)	0	**5,370**	1,226	1,444	1,352	1,348	**5,370**
Maternity & Perinatal Medicine Directorate	46,015	578	113	(19,071)	(8,578)	0	**19,057**	4,646	5,061	4,654	4,696	**19,057**
Total	**76,786**	**617**	**689**	**(38,041)**	**(10,144)**	**0**	29,906	**7,127**	**7,999**	**7,305**	**7,474**	29,906

2018/19 Control Totals by Group/Directorate

Group/Directorate	Annual Contract PRI Total	Annual Other PRI Total	Annual Other Income Total	Annual Pay Total	Annual Non Pay Total	Annual Non Opex Total	Annual Control Total	Phasing TOTAL Q1	Phasing TOTAL Q2	Phasing TOTAL Q3	Phasing TOTAL Q4	Phasing TOTAL Total
Imaging												
Breast Screening Directorate	3,714	21	693	(2,274)	(541)	0	**1,612**	403	403	404	403	**1,612**
Diagnostic Radiology Directorate	2,734	0	149	(8,128)	(2,753)	0	**(7,999)**	(2,045)	(1,991)	(1,982)	(1,981)	**(7,999)**
Group Management - Imaging Directorate	0	0	0	(958)	(120)	0	**(1,078)**	(269)	(269)	(269)	(269)	**(1,078)**
Interventional Radiology	348	2	0	(305)	(190)	0	**(146)**	(43)	(33)	(34)	(36)	**(146)**
Nuclear Medicine Directorate	371	22	1,872	(1,544)	(1,225)	0	**(504)**	(129)	(128)	(124)	(124)	**(504)**
Total	7,167	45	2,713	(13,209)	(4,829)	0	**(8,113)**	(2,083)	(2,018)	(2,005)	(2,007)	**(8,113)**
Pathology												
Biochemistry Directorate	1,119	0	5,822	(4,310)	(3,187)	0	**(556)**	(169)	(105)	(148)	(133)	**(556)**
Group Management - Pathology Directorate	9,009	0	305	(955)	(185)	0	**8,173**	2,042	2,042	2,045	2,043	**8,173**
Haematology Directorate	1,769	0	187	(2,016)	(3,116)	0	**(3,176)**	(819)	(746)	(817)	(794)	**(3,176)**
Histopathology Directorate	0	0	139	(1,992)	(192)	0	**(2,045)**	(511)	(511)	(511)	(511)	**(2,045)**
Immunology Directorate	2,960	0	473	(1,053)	(2,165)	0	**216**	9	129	24	55	**216**
Microbiology - Directorate	42	0	153	(2,012)	(1,594)	0	**(3,412)**	(856)	(852)	(852)	(852)	**(3,412)**
Total	14,899	0	7,079	(12,339)	(10,439)	0	**(800)**	(304)	(43)	(260)	(192)	**(800)**
Corporate												
Strategy and Governance	0	2,483	556	(5,269)	(16,866)	0	**(19,097)**	(4,871)	(4,737)	(4,745)	(4,745)	**(19,097)**
Corporate Nursing & Facilities	1,371	228	912	(12,131)	(1,936)	0	**(11,555)**	(2,890)	(2,886)	(2,891)	(2,889)	**(11,555)**
Estates & New Hospital Project	0	0	5,094	(5,069)	(12,497)	0	**(12,473)**	(3,120)	(3,129)	(3,112)	(3,112)	**(12,473)**
Finance	0	0	180	(3,211)	(1,027)	0	**(4,057)**	(1,069)	(990)	(1,006)	(992)	**(4,057)**
Medical Director	(0)	0	2,149	(6,281)	(4,267)	0	**(8,399)**	(2,125)	(2,100)	(2,087)	(2,087)	**(8,399)**
Operations	4,045	5	2,588	(16,282)	(5,393)	0	**(15,037)**	(3,868)	(3,867)	(3,731)	(3,572)	**(15,037)**
People and Organisation Development	46	0	2,544	(6,339)	(1,436)	0	**(5,185)**	(1,293)	(1,308)	(1,282)	(1,302)	**(5,185)**
Total	5,461	2,716	14,023	(54,582)	(43,422)	0	**(75,804)**	**(19,236)**	**(19,017)**	**(18,853)**	**(18,698)**	**(75,804)**
	0	**0**	**0**	**0**	**0**	**0**	**0**					
Central												
Central Directorate	7,216	719	28,606	(13,346)	(13,250)	(23,941)	(13,996)	(6,076)	(5,605)	(5,475)	3,160	(13,996)
Total	**7,216**	**719**	**28,606**	**(13,346)**	**(13,250)**	**(23,941)**	**(13,996)**	**(6,076)**	**(5,605)**	**(5,475)**	**3,160**	**(13,996)**
TRUST TOTAL BEFORE STF	**417,160**	**6,585**	**57,034**	**(314,412)**	**(149,988)**	**(23,941)**	**(7,567)**	**(7,077)**	**(1,959)**	**(4,112)**	**5,585**	**(7,567)**

RESERVES POSITION

	Group/Dir	Pay	Non Pay	Non Operational Costs	Total
Startpoint					
Taper Relief Income/Expenditure	Central		(100)		**(100)**
National Inflation	Central	(5,926)	(3,017)	(1,232)	**(10,175)**
Local Inflation	Central	(600)	(127)	(1,000)	**(1,727)**
Developments (£1050 to EPR)	Central		(1,950)		**(1,950)**
Investments	Central	(1,000)			**(1,000)**
Planning Contingency	Central		(2,000)		**(2,000)**
Gynae Onc Stranded Costs	Central	(332)			**(332)**
Additional STF Cost Reserves (CNST)	Central		(1,449)		**(1,449)**
Cost of Contract	Central	(4,031)	(3,485)		**(7,516)**
Total		**(11,889)**	**(12,128)**	**(2,232)**	**(26,249)**
Allocated to date					
CNST - STF Funded	Strategy and Governance		1,449		**1,449**
EPR - Development Reserve	Medical Director		1,050		**1,050**
CNST - Cost of Contract	Corporate/Governance	2,027			**2,027**
Production Plan - Cost of Contract	Surgery/W&C		2,676		**2,676**
PDC/Depreciation	Central			2,232	**2,232**
Total		**2,027**	**5,175**	**2,232**	**9,434**
Revised					
Taper Relief Income/Expenditure	Central		(100)		**(100)**
National Inflation	Central	(5,926)	(3,017)	0	**(8,943)**
Local Inflation	Central	(600)	(127)	0	**(727)**
Developments (£1050 to EPR)	Central		(900)		**(900)**
Investments	Central	(1,000)			**(1,000)**
Planning Contingency	Central		(2,000)		**(2,000)**
Gynae Onc Stranded Costs	Central	(332)			**(332)**
Additional STF Cost Reserves (CNST)	Central		0		**0**
Cost of Contract	Central	(2,004)	(808)		**(2,813)**
Total		**(9,862)**	**(6,952)**	**0**	**(16,815)**

We have set directorate level budgets

- Based on new directorate structure
- Using information on directorate level CIP from TPRS (as at 20.4.18)
- Using latest contract and income plan (as of 23.4.18)
- Baseline budgets are set at normalised forecast outturn (which shows a £22.7m underlying deficit).
- Underspends made good; relevant overspends funded.
- Baseline challenged & confirmed by GSFMs as sustainable & deliverable
- Other movements such as forecasts to deliver 1819 CIP early which have not transpired, have also been funded
- This gives directorates and groups a “clean” start as possible for 1819 through budgets

What is still to do, and when?

What	When reflected in budgets
Split the £2m procurement workplan into directorates - this is done, just not yet reflected in the budgets (central in the model)	25.4.18
Requests to fund cost pressures	Month 1
Split out income to match cost in for pass through	Month 1
Cost of contract reserve for Gynae Oncology services	Month 1
Developments on Allergy and SH, ward clerks	Month 1
Confirm baseline startpoint (see narrative on previous page)	Month 1
Non pay inflation	Month 1
Further changes to contract income	Months 1-2
Pay award confirmation	Month 4
Internal trading budgets`	Month 4
Allocate out Group Management cost centres - this could be done for Month 2, 3 or left until Month 4. Nomenclature for Clinical directorates agreed.	Month 4

Planned capital expenditure

HEADLINES All PROGRAMME	CAPITAL PROGRAMME					TIMELINE	Additional Plan Year	
	2017/2018 £000's	2018/2019 £000's	2019/2020 £000's	2020/2021 £000's	2021/2022 £000's	TOTAL £000's	2022/2023 £000's	Plan Total 18/19 to 22/23
REVISED EMERGING NEEDS								
ESTATES CAPITAL PROGRAMME	£14,340	£18,336	£8,904	£1,050	£1,754	£44,384	£2,800	32,844
IT CAPITAL PROGRAMME	£8,330	£8,442	£1,766	£2,485	£2,513	£23,536	£1,000	16,205
EQUIPMENT CAPITAL PROGRAMME	£2,266	£3,533	£5,989	£1,772	£4,122	£17,682	£4,280	19,696
TECHNICAL CAPITAL PROGRAMME	£1,064	£4,361	£10,565	£1,714	£2,136	£19,840	£2,000	20,776
TOTAL CAPITAL PROGRAMME	£26,000	£34,671	£27,224	£7,021	£10,525	£105,441	£10,080	89,521
		Plan	*Plan*	*Plan*	*Plan*		*Plan*	

Our Ref: Y55/RXK/L1

Sent via Email

24 April 2018

Finance and Analytics

Wellington House
133-155 Waterloo Road
London
SE1 8UG

Toby Lewis
Chief Executive

Tony Waite
Finance Director

Revised financial control total and PSF allocation for 2018/19

Sandwell and West Birmingham Hospitals NHS Trust

Further to recent discussions, a non-recurring revision to your control total for 2018/19 has been agreed. The reduction in your control total is accompanied by a reduction in your previously notified share of the Provider Sustainability Fund (PSF). I am writing to confirm your control total and PSF allocation have been formally amended; the changes are outlined in Appendix 1.

Next Steps

We will issue a macro fix for the financial planning template shortly which will update the 2018/19 control total and PSF values within your template. Please confirm in your financial planning template, due to be submitted by 12 noon on the 30 April, that you accept the revised control total set out in Appendix 1 and the associated conditions.

Yours sincerely

Elizabeth O'Mahony
Chief Financial Officer

Copy to:
Ian Dalton, Chief Executive, NHS Improvement
Kathy McLean, Executive Medical Director and Chief Operating Officer, NHS Improvement
Dale Bywater, Executive Regional Managing Director (Midlands and East), NHS Improvement
Mark Mansfield, Regional Director of Finance (Midlands and East), NHS Improvement

Appendix 1

Revisions to your financial control total and PSF allocation for 2018/19

In the table below we set out the adjustment we have made to the control total and PSF allocation issued to your trust, culminating in a revised financial control total for 2018/19.

	£ million
Current 2018/19 control total (including allocated PSF)	**12.175 Surplus**
Non-recurring reduction in control total	-5.000
Reduction in PSF allocation	-3.686
Revised 2018/19 control total (including allocated PSF)	**3.489 Surplus**

Current 2018/19 PSF allocation	**14.742**
Reduction in PSF allocation	-3.686
Revised allocated PSF (included in revised 2018/19 control total above)	**11.056**

Paper ref:	TB (05/18) 016

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Bed Base Risk Mitigations / Closing Unfunded Beds		
Sponsoring Executive	Rachel Barlow, Chief Operating Officer		
Report Author	Rachel Barlow, Chief Operating Officer		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

At the last Trust Board the decision was made to implement a bed closure trajectory of unsubstantiated beds by the end of Quarter 1. This decision was made based on the perceived improvement opportunities and proposal to change the improvement approach and oversight team to support safe bed closures thereby mitigating the 2 associated risks on the Trust risk register.

This paper provides an update on the approach to bed closures, forward delivery trajectory and implementation approach. The key focus should be on reaching 41 beds by 13th May 2018.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	X	Public Health Plan		People Plan & Education Plan	X
Quality Plan		Research and Development		Estates Plan	
Financial Plan	X	Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Regular subject matter at Trust Board over winter period.

4. Recommendation(s)

The Trust Board is asked to:

a.	Consider the improvement approach and trajectory for closure of unsubstantiated medicine beds
b.	
c.	

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register	X	Risk Number(s): 1643 and 2849					
Board Assurance Framework		Risk Number(s):					
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	2017

Bed Base Risk Mitigations / Closing Unfunded Beds Introduction

1. Introduction

The impact of admission demand and higher than planned Length of Stay (LOS) results in unsubstantiated beds which is referenced twice on the Trust Risk Register:

Risk 1643 Unfunded beds with inconsistent nursing and medical rotas are reliant on temporary staff to support rotas and carry an unfilled rate against establishment. This could result in under performance of the safety plan, poor documentation and inconsistency of care standards.

Risk 2849 Continued spend on unfunded beds will impact on the financial delivery of CIP and the overall Trust forecast for year end. Deviation from the financial plan will impact on STF which is assumed in the financial outturn forecast. This could result in a significant financial deficit year end.

The Trust Board considered in March the opportunities for remaining LOS improvement, resource investment particularly in the Consultant of the Week and safety indicators. Based on this triangulation, the Trust Board is holding the leadership team to account for an unsubstantiated bed closure trajectory to be completed by the end of Quarter 1.

This paper provides an update on the approach to bed closures, forward delivery trajectory and implementation approach.

2. Current position and trajectory

At the time of writing there are 62 unsubstantiated beds open in Medicine.

Surgery closed the unsubstantiated 22 beds on time in April. The work to open a 23 hour elective unit in May is on track and is mitigation to balance the emergency and elective surgical demands that have proved problematic over winter. Primary Care, Community and Therapies have a separate bed closure programme which is on track to close 8 beds in April**.**

Medicine's bed closure trajectory is cluster based with a trajectory to close all unsubstantiated beds by the end of June.

Intervention	April				May					June			
Week ending	8/4	15/4	22/4	29/4	6/5	13/5	20/5	27/5	3/6	10/6	17/6	24/6	1/7
Bed reduction	**Surgery closed 22 beds – achieved**					17 Resp/ Gastro cluster wards				23 Cardio/ Stroke and Haem cluster wards			22 Elderly cluster wards
Cumulative medicine unsubstantiated beds						45				22			0
Unfunded costs ('000)	73	73	45	45	45	31	31	31	31	19	19	19	0
Cumulative unfunded costs	73	146	191	236	281	312	343	374	405	424	443	462	462

3. Change in improvement approach

The oversight of the improvement approach to achieve bed closures has been affiliated with the Consistency of Care oversight team whose membership includes the Director of Governance (chair), Chief Executive Officer, Chief Operating Officer, Chief Nurse, Group Director, Director of Operations and Director of Nursing for Medicine and key clinical and operational Directorate leaders. The Executive will hold the Medicine team to account for local changes whilst also ensuring support and oversight of the delivery of the necessary local improvements. The alignment with the Consistency of Care programme is specifically related to 'the ask' of clinical ward teams to design and deliver cluster level changes in approaches to care and patient pathways which safely reduce LOS and where possible improve the patient experience. The senior clinical and non-clinical membership will also take on a role of sponsorship, empowerment through permissions, coaching and visibility at ward level.

An LIA event in April was successful in engaging ward clinical leadership teams in Medicine and Primary Care, Community and Therapies in effective team discussions to improve multi professional working aimed to achieve improved patients experience and reduced LOS. The session used coaching style conversations and identified themes for improvement opportunities of which the main ones are summarised below:

Theme	**Improvement**	**How will this be measured?**
Rhythm of the day was not fully implemented with the afternoon ward clinical team activities being absent or inconsistent	All clinical teams to localise the rhythm of the day by early May	Morning discharges LOS reduction
Consultant of the week rosters were in place but the expected behaviour changes had not been realised in terms of demonstrating in situ leadership throughout the day to progress planning and advancement of care to discharge in a timely way. Afternoon ward presence perceived as variable.	Chetan Varma to ensure all Consultants understand and are trained in the Consultant of the Week role (including TTA prescription) Consultants to be based on ward areas for the entirety of the week maintaining visibility and in situ leadership both clinically and from and administration perspective	Day before discharge TTA availability
Much of the clinical teams focus was on today rather than the next few days of patient pathway plans particularly discharge planning	Clinical ward teams to consider as a leadership team and with junior doctors/supporting staff, how they work to plan ahead for effective and timely patient care. This should include localising red to green	Morning discharges LOS reduction Eliminate non clinical bed moves after 10pm
Despite some progress in ward based TTA medicines, the prescription of medicines and decision to discharge is often made on the day of discharge. Morning discharge rates are low.	Create work processes to prescribe TTAs day(s) in advance of discharge. Work to achieve morning discharge rates.	Morning discharges

Expected discharge dates have various definitions and are applied inconsistently eg EDD = date of discharge or transfer from acute ward, EDD = date of discharge to final destination, EDD = medical fitness for discharge. The confusion contributes to a culture where it is common practice to adjust the EDD rather than coordinate MDT planning and practice to achieve a specific discharge date with the patient	Toby Lewis and Chetan Varma to agree an approach to engage clinical teams in collating views on EDD definition and approach. The outcome of the informed decision will be put into practice in May	KPI to be confirmed once decision made on approach
Social service input is still perceived as inadequate in some areas	LIA with elderly care, community and social care scheduled for May to determine solution and embed new approaches in Q1	KPI to be agreed in LIA
Over and under 75 bed model is not in place	Capacity team and medicine leadership team to ensure patients flow to the correct wards. Data to be reported weekly	Number of over/under 75 year old outlying patients
Admit pull model is not effectively implemented and redesign has not yet incorporated a review of the capacity management approach to fit a new model into the day to avoid creating a 2 tier process	Michelle Harris and Caroline Rennalls to design and propose new approach to capacity management combining an effective admit/ pull model for implementation in May	Number of over/under 75 year old outlying patients

Since the LIA Claire Hubbard, Director of Nursing for Medicine has progressed the development of rhythm of the day work with the clinical teams which details role specific tasks and timelines to progress the planning of care and discharge preparation; see Appendix 1. This work which is standardising the rhythm of the day at cluster level is underpinned by clear standard operating procedures for each task which describes well the expectations for individual team members and is clear on 'what good looks like'. This timeline for the day will be extended through to 8.30pm, completing the day's multi professional activities and ensuring all inpatient bed moves are completed with the aim to eliminate out of hours, non-clinical bed moves.

Evidence of impact of this coordinated effort is already apparent at City where for example the Senior Nurse of the Week and capacity team have reset the patient flow to ensure the over 75 year old patients are consistently admitted to the elderly care wards unless their clinical needs require speciality based ward care. Data demonstrates this has been effective over the past 2 weeks with only 6 patients over 75 being in speciality beds for the right clinical reasons. The same focus will be made on the Sandwell site where there are currently 15 patients over 75 outside the elderly care bed base and 28 under 75 year olds on the elderly care wards. The reset ensures the right patient is with the right clinical team and undoubtedly will contribute to better care planning and reduced LOS. .

A data set at ward level is reviewed weekly at the Consistency of Care oversight group for accountability and progress against relevant ward level KPIs.

Local improvement

Each ward clinical team must lead local improvement initiatives aligned to their local patient pathways as well as deliver on the cross cutting themes. Clinical Group and Clinical/Corporate Directorate leaders must be visible and engage with and coach ward clinical teams to succeed in achieving improvement outcomes, whilst demonstrating accountability.

D15 and D16 have demonstrated this effectively at a small scale after the LIA by engaging their local multi professional team to design and try out a new initiate aiming to prescribe and dispense TTAs the day before discharge. By ensuring the Consultant of the Week leads an afternoon review and confirms intended discharge plans, as well as giving the junior doctor team a protected hour each afternoon to write TTA prescriptions and discharge letters, the ward are achieving up to 3 discharges before lunch and their overall discharge rates have more than doubled last week. Local clinicians describe improved decisive decision making by consultants being key to enabling them to proceed with timely discharge and the team feel positive about the early results. This success demonstrates with coaching and support teams can be empowered and be effective to lead change at a local level. This needs replicating in terms of pathway redesign and other improvements.

Each Cluster is expected to consider their approach to:

- How they can make better use of GP slots and hot clinics to reduce admissions and avoidable stays?
- What would they change about the local current rhythm and way of working to ensure the team coordinate care and discharge planning towards an EDD?
- Speciality specific pathway improvement eg; D15/16 and P5 are focussing on psychological support for haematology pathways and mapping acute pathways to a Directory of Community services to reduce LOS through more effective discharge planning.

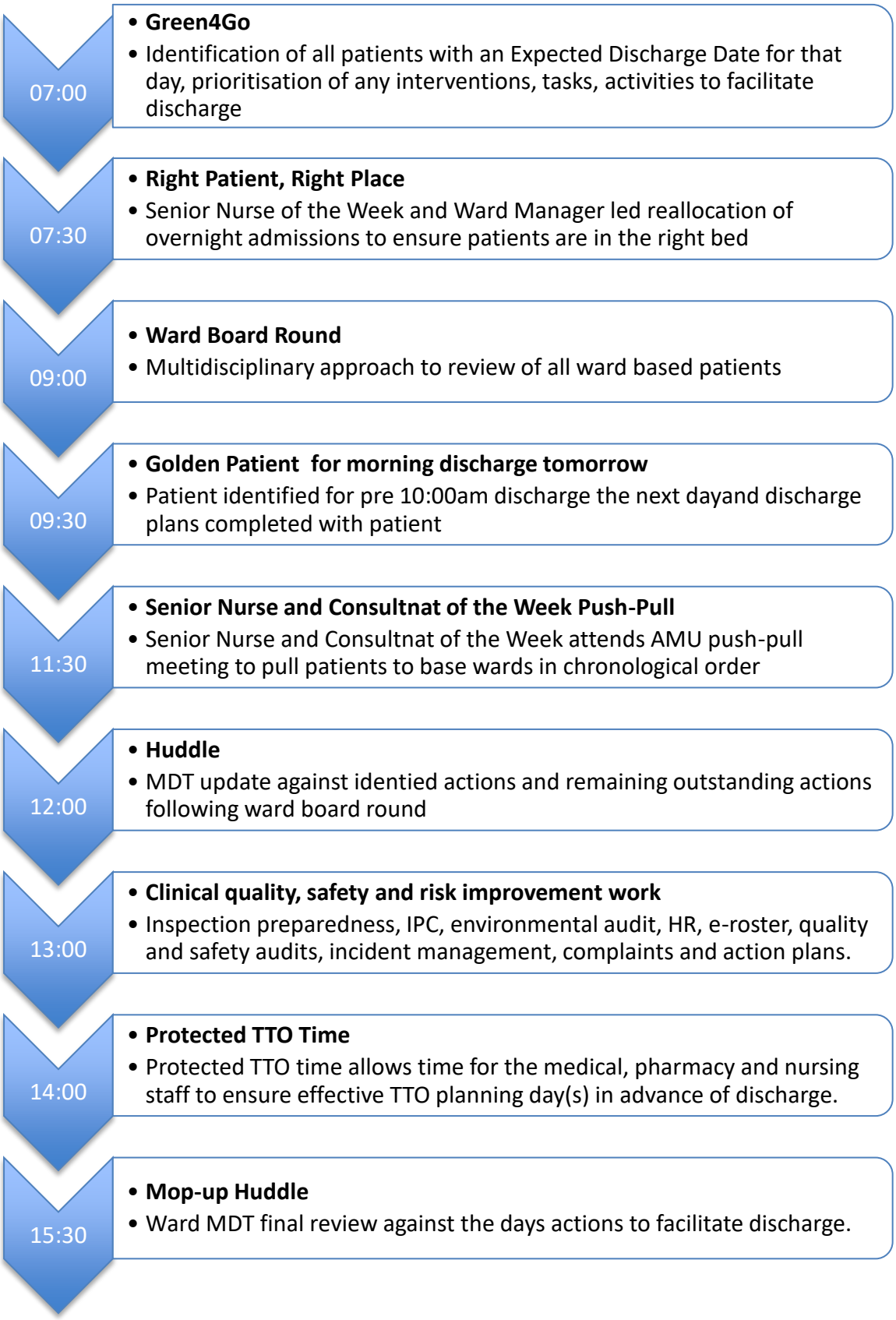
Whilst weekly assurance and oversight will be achieved through the Consistency of Care oversight group, a further LIA is planned for 31st July, 2018.

4. Conclusion

Since the last Trust Board the leadership buy in to achieve the changes set out in the bed closure trajectory is more evident. The LIA was a positive event which engaged clinical ward teams in the improvement approach, recognising there was more to achieve from the resources that have been enabled at ward level. Middle managers and senior managers are mobilising themselves into the clinical areas to support change. The new governance aligned with the Consistency of Care oversight team is a positive move broadening executive and senior clinical leadership involvement and strengthening the accountability framework.

The Trust Board are asked to note progress to date and discuss the forward plans, improvement ideas and approach to improvement outlined in this paper.

Appendix 1 Group of Medicine: Patient Flow and multi professional timeline



…….next stage of development to add timeline and key activities up to 8.30pm at night, ensuring all patients moves to the ward bed base are made and patients are settled for the night

Paper ref:	TB (05/18) 017

Sandwell and West Birmingham Hospitals NHS Trust

Report title	Reducing Sickness Absence and Improving Well Being		
Sponsoring Executive	Raffaela Goodby, Director of People & Organisation Development		
Report author	Lesley Barnett, Deputy Director Human Resources		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Board should focus on]*

- note the improvements made since Board Scrutiny in January 2018 (5.2% - 4.1%)
- outlines the rhythm of sickness management in a given month by way of grip and control
- The specified approach to how we will road test a line managers stress assessment in a specific area in June and July for further Board consideration in August 2018
- sets out actions sufficient to reduce sickness by 1% including timeline for developing specific ward trajectories in line with new establishments

2. Alignment to 2020 Vision *[indicate with an **'X'** which Plan this paper supports]*

Safety Plan	**X**	Public Health Plan	**X**	People Plan	**x**
Quality Plan		Research and Development		Estates Plan	
Education Plan		Digital Plan		Financial Plan	**X**

3. Previous consideration *[Where has this paper been previously been discussed?]*

People and OD Committee. Public Trust Board, November, December, January, April

4. Recommendation(s)

The Board is asked to:

a.	Note the absence improvements and actions for grip and control
b.	Support the approach to testing a line manager's stress risk assessment
c.	Discuss actions to reduce sickness by a further 1% including developing specific trajectories

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register	X	Risk 114						
Board Assurance Framework	X	BAF 8 and BAF 9						
Equality Impact Assessment	Is this required?		Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N	X	If 'Y' date completed	

1.0 Introduction

The Trust's People Plan (theme 3) has an extremely ambitious aim to reduce its sickness absence levels to 3% and dramatically increase levels of well-being, measured through CQUIN's, the Staff Survey and Your Voice engagement levels.

1.1 Cost of sickness absence

Sickness absence costs the Trust approximately £9m per annum in lost days and an additional £4.2m temporary pay spend to cover staff away from work. (based on shifts coded to sickness in 2017/18). The board is well sighted on the importance of reducing sickness absence and improving health and well being, in particular mental health and well being. This topic has been discussed at the People and Organisation Development Committee, as well as Public Trust board over the past 12 months, and remains a key issue for the Trust and clinical groups.

The Trust Board are therefore well sighted on the solutions put forward to tackle sickness, and since the board scrutiny in January, sickness absence has decreased by 20% from 5.2% in January 2018 to 4.1% in March 2018. A significant achievement considering winter pressures, extra capacity open, inclement weather impact and flu and D&V. Thanks and appreciation is given to the teams, line managers and corporate teams that have supported this reduction .

1.2 Regional Context

The latest set of national figures were published recently by NHS Digital. They confirmed a deteriorating position in the West Midlands standing at 4.91% in March 2018. That SWBH has reduced during the same winter period adds confidence to our forward trajectory of making further reductions when others are increasing. The Black Country position is as follows:

Royal Wolverhampton Trust	4.7%
Walsall	5.88%
Dudley	5.07%
SWBH	4.1%

The yearly position via directorate is set out in Appendix 1. This information is available every month on the Trust Intranet, Connect, and includes information on cost, return to work interviews, hot spot areas and trend information. Appendix 2 is broken down via long term sickness and short term sickness.

2.0 Grip and Control

Sickness is managed and led locally, and has a monthly rhythm that is led by the data produced by HR / ESR / rostering for the group and directorate management teams. This is reconciled each month to ensure that the rostering information is correctly reported in the ESR position at the end of the month.

Sickness is directly managed through the line manager, supported by colleagues in the People and Organisation Development Directorate, Occupational Health and multiple initiatives from the health and well-being team, which the board scrutinised at the April meeting.

Clinical groups are held accountable for sickness grip and control through their clinical group reviews (every 8 weeks). Corporate directorates are held accountable by the Chief Executive in Corporate Performance Reviews (every 8 weeks).

The systems are all aligned to be reported to the Trust board each month, with information available for the Trust QIPR on the last Wednesday of the month.

2.1 Line Manager Support

- Monthly data produced for PMO and all line managers to enable proactive and timely management of sickness absence. Available https://connect2.swbh.nhs.uk/esr/esr-workforce-information/
- Sickness absence policy and guidance toolkit available to all staff
- Stress at Work policy and risk assessment tool (see section 3)
- Mandatory Sickness absence training for all managers through Accredited Manager programme including proactively managing well-being and holistic health
- Bespoke sickness absence workshops for managers in hot spot areas (rolling programme)
- Monthly newsletter to line managers (see appendix 2)
- Provision of monthly sickness 'clinics' to provide HR advice and support to line managers
- Sickness pipeline – line managers are individually notified of actions to take where they have short-term sickness cases before they become long-term cases
- Group confirm and challenge, Group triumvirate oversight and agenda item during Group review process
- Monthly sickness absence reports on Connect and access to ESR for local interim reports 'on demand'.
- Occupational Health and Well Being Service – assessment of individual cases and launch of pro-active health and wellbeing programme in December 2017.
- Fast track service for employees to access diagnostics and appointments to reduce waits and facilitate an earlier return to work
- Advice and guidance for line managers on rehabilitation to other areas to facilitate an earlier return to work
- Mental health first aid training available
- Mental health support for line managers from Occupational Health
- Muscular-Skeletal Physiotherapy Led Staff service (will report to board in summer 2018)

3.0 Line Managers Stress Risk Assessment

The Trust Board scrutinised the increased support to mental health related absence, and noted the assumed under reporting of mental health absence during April Board. The Trust plans to pilot a programme of line management support using the stress risk assessment process already in place within the Trust (see appendix 3).

The Trust already has an established stress risk assessment process that is agreed by Staffside and this is well used within the organisation. The intention is to refresh this agreed policy to focus on supporting line managers who are particularly at risk of stress from working in high risk areas. This will be piloted during June and July, and recommendations made to the August 2018 Trust Board.

3.1 Road Test Line Manager Stress Risk Assessment

The intention is to identify managers who are at risk of developing stress related illness or absence, and to work with relevant internal and external bodies, to develop a bespoke package of support for those line managers. This will be supported with a robust communications and engagement campaign, to encourage people to take part, and access the considerable support on offer. This will also reduce the stigma associated with mental health, especially across our line manager population.

4.0 Trajectories to 3%

The Trust starts the financial year in a positive position at 4.17% sickness absence rate. The breakdown of the calendar year to date is detailed below in long term sickness and short term sickness.

Group	**Long Term Sickness (%)**			**Short Term Sickness (%)**			**Total Sickness (%)**		
2018	*Jan*	*Feb*	*Mar*	*Jan*	*Feb*	*Mar*	*Jan*	*Feb*	*Mar*
Corporate	2.34	2.25	2.58	2.33	2.15	1.35	4.67	4.40	3.93
Imaging	0.91	2.07	2.57	2.77	2.03	2.18	3.68	4.10	4.75
Medicine & EC	3.00	2.34	2.23	2.79	2.31	2.11	5.79	4.65	4.35
Pathology	3.36	2.88	0.99	2.19	1.86	1.45	5.55	4.75	2.44
PCCT	2.59	2.37	2.43	2.48	2.10	1.53	5.04	4.48	3.96
Surgical Services	3.02	2.96	3.13	2.33	2.24	1.65	5.36	5.20	4.78
Women & Child Health	2.70	2.65	2.48	2.65	2.46	1.66	5.35	5.11	4.14
Total	**2.68**	**2.50**	**2.51**	**2.50**	**2.21**	**1.67**	**5.17**	**4.71**	**4.17**

In order to reach the target 3%, improvement needs to be made in both long term and short term sickness rates, in particular in long term sickness that is rating above 2 % and short term sickness above 1%. The percentages are calculated on the number of hours per cost code available to work against the number of hours registered as absent from work. This takes all working patterns in to account. This is detailed in the example below in paediatrics with a 2.83% sickness rate.

Acute & Community Paediatrics	NYSAL - Children's Therapy Service	1444hrs	408.22 hrs lost	2.83%

4.1 specific trajectories

The lost hours then translate in to FTE lost. E.g. 408 hours lost in a month would equate to 2.72 FTE lost for a month. Or 4 FTE for a part time worker who works 20 hours per week. In order for line managers to effectively manage to 3%, each ward manager will need to understand the target number of people that need to return to work, in order to reach their target. HR will ensure that clinical group leads understand this data through the HR Business partners, and are building their trajectories accordingly.

Each ward will be asked to produce a personalised trajectory for managing their establishments to the 3% target. This will happen during Q1 and be built in to the clinical group performance reviews.

The following warded areas are within or near the target range:

Leasowes Ward 2.42%
Opthalmology Ward 2.34%
EGAU 1.84%
Lyndon 5 3.13%

Conclusion

The intense focus on sickness absence that is evident from the recent improvements will continue throughout quarter one, with additional well being interventions being implemented. This will enable the organisation to work towards and achieve its target of 3% absence rate, and improved health and well being, with all its benefits, for the good of SWBH patients and their families.

Raffaela Goodby
Director of People and Organisation Development
25th April 2018

	Directorate	Directorate FTE as % of Trust total	Overall Target (Mar 2018)	Previous Month's Sickness (Feb 2018)	Sickness Target (Mar 2018)	Current Sickness (Mar 2018)	On Target?		FTE Returners Needed*
Corporate	Corporate Nursing & Facilities	12.04	2.50	5.87	4.18	5.82	OMT		
	Estates & New Hospital Project	1.31	2.50	4.85	3.67	4.92	OMT		
	Finance	1.21	2.50	2.48	0.00	2.36	TTM		
	Medical Director	2.43	2.50	3.58	3.04	3.79	OMT		
	Operations	4.31	2.50	4.60	3.55	4.33	OMT		
	People & Organisation Development	2.23	2.50	3.19	2.84	2.93	OMT		
	Performance & Insight	0.50	2.50	1.99	0.00	2.12	TTM		
	Strategy & Governance	0.97	2.50	2.89	2.69	2.91	OMT		
Imaging	Breast Screening	0.85	2.50	2.82	2.66	3.01	OMT		
	Diagnostic Radiology	2.09	2.50	2.77	2.64	2.73	OMT		
	Group Management - Imaging	0.65	2.50	6.91	4.70	7.62	OMT		
	Interventional Radiology	0.16	2.50	11.31	6.91	10.81	OMT		
	Nuclear Medicine	0.37	2.50	1.99	0.00	2.03	TTM		
Medicine & Emergency Care	Admitted Care	11.56	2.50	4.82	3.66	4.75	OMT		
	Emergency Care	7.73	2.50	4.89	3.70	4.78	OMT		
	Group Management - Medicine	0.07	2.50	2.47	0.00	2.36	TTM		
Pathology	Biochemistry	1.76	2.50	4.60	3.55	4.54	OMT		
	Group Management - Pathology	0.73	2.50	4.27	3.38	4.00	OMT		
	Haematology	0.80	2.50	3.26	2.88	3.33	OMT		
	Histopathology	0.54	2.50	1.41	0.00	1.48	TTM		
	Immunology	0.33	2.50	2.25	0.00	2.22	TTM		
	Microbiology	0.64	2.50	3.93	3.21	3.79	OMT		
Primary Care, Community and Therapies	Ambulatory Therapies and Community Medicine	3.60	2.50	3.05	2.77	3.21	OMT		
	iBeds	5.29	2.50	5.00	3.75	5.11	OMT		
	iCares, Diabetes & Endocrinology	5.45	2.50	3.95	3.23	3.80	OMT		
Surgical Services	Anaesthetics, Pain Mgt and Critical Care	3.59	2.50	4.53	3.52	4.50	OMT		
	General Surgery	5.21	2.50	4.38	3.44	4.53	OMT		
	Group Management - Surgical Services	0.41	2.50	6.69	4.59	7.13	OMT		
	Ophthalmology	3.61	2.50	2.20	0.00	2.15	TTM		
	Specialist Surgery	3.06	2.50	5.68	4.09	5.86	OMT		
	Theatres	3.23	2.50	6.40	4.45	6.42	OMT		
Women's & Child Health	Acute & Community Paediatrics	5.55	2.50	3.71	3.11	3.92	OMT		
	Group Management - W&CH	0.03	2.50	0.31	0.00	0.30	TTM		
	Gynaecology, Gynae-Oncology & GUM	1.42	2.50	3.47	2.99	3.32	OMT		
	Maternity & Perinatal Medicine	6.26	2.50	5.16	3.83	5.06	OMT		
			2.50	**4.50**	**3.50**	**4.48**	OMT		**0.00**

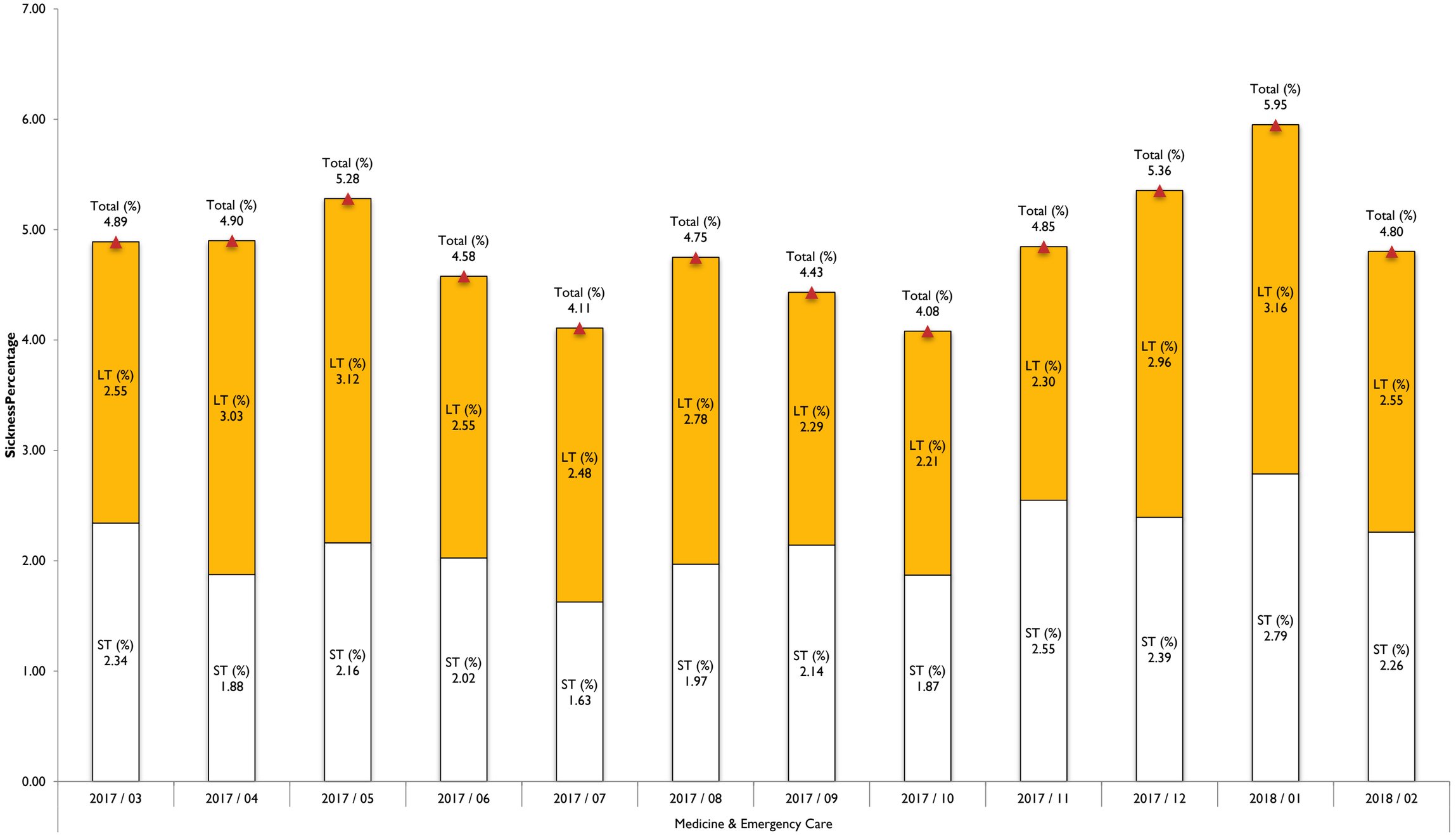
On Target? RAG Descriptions:

UMT: Under Monthly Target
TTM: Trust Target Met - Already under the 2.50% target
OMT: Over Mont

Icon		Value	Type
when value is	>=	80	Percentile
when < 80 and	>=	60	Percentile
when < 60 and	>=	40	Percentile
when < 40 and	>=	20	Percentile
when < 20			

FTE Returners Needed*

In-month Sickness (Group)



Appendix 4

INDIVIDUAL STRESS RISK ASSESSMENT/CHECKLIST

(to be used by managers when individual reports they are experiencing excessive pressure/stress)

Employee name…….. **Job title……**

Ward/Department…… …. **Division……**

Name and job title of manager completing checklist……..

What was the trigger for completion of this risk assessment
(e.g. one to one discussion, PDR, sickness absence process)…….
……

Section 1:

Using the table below, take each of the 6 key areas/risk factors for stress (and 'other stressors', including personal stressors) and identify where concerns/stressors exist. Review/assess existing controls and consider what more the organisation needs to do (action plan, as per section 2). (Refer to the Stress at Work Policy, including appendix 1 'The Trusts Management Standards for Work related stress' and section 7.3 'controlling risks', which details possible solutions/things to consider if problems have been identified).

1. Key area/risk factor for stress: Demands (includes issues such as workload, work patterns and the work environment)

The standard is that:
Individual indicates that are able to cope with the demands of their job, and systems are in place locally to respond to any individual concerns.

Stressor (current state/areas of concern):…….....
……
……
……
……

Existing controls (detail of any existing controls/adjustments already made):……..
……
……

Assessment of existing controls/adjustments already made and consider what more needs to be done (i.e. 'reasonably practicable control measures', this will include reviewing the impact on other staff/service provision, effectiveness (any benefit for the individual), practicality (easy/difficult), cost implications, availability of other resources/assistance):……..
……..
……

……
……..

For each action/adjustment identified, complete action plan (section 2), as appropriate.

2. Key area/risk factor for stress: Control (How much say the individual has in the way they do their work)

The standard is that:
Individual indicates they are able to have a say about the way they do their work and systems are in place locally to respond to any individual concerns

Stressor (current state/areas of concern):…….....
……
……
……
……

Existing controls (detail of any existing controls/adjustments already made):……..
……
……

Assessment of existing controls/adjustments already made and consider what more needs to be done (i.e. 'reasonably practicable control measures', this will include reviewing the impact on other staff/service provision, effectiveness (any benefit for the individual), practicality (easy/difficult), cost implications, availability of other resources/assistance):……..
……..
……
……
……..

For each action/adjustment identified, complete action plan (section 2), as appropriate.

3. Key area/risk factor for stress: Support (includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues)

The standard is that:
Individual indicates that they receive adequate information and support from their colleagues and superiors and systems are in place locally to respond to any individual concerns

Stressor (current state/areas of concern):…….....
……
……

……
……

Existing controls (detail of any existing controls/adjustments already made):……..
……
……

Assessment of existing controls/adjustments already made and consider what more needs to be done (i.e. 'reasonably practicable control measures', this will include reviewing the impact on other staff/service provision, effectiveness (any benefit for the individual), practicality (easy/difficult), cost implications, availability of other resources/assistance):……..
……..
……
……
……..

For each action/adjustment identified, complete action plan (section 2), as appropriate.

4. Key area/risk factor for stress: Relationships (includes promoting positive working to avoid conflict and dealing with unacceptable behaviour)

The standard is that:
Individual indicates that they are not subjected to unacceptable behaviours (e.g. bullying) and systems are in place locally to respond to any individual concerns

Stressor (current state/areas of concern):…….....
……
……
……
……

Existing controls (detail of any existing controls/adjustments already made):……..
……
……

Assessment of existing controls/adjustments already made and consider what more needs to be done (i.e. 'reasonably practicable control measures', this will include reviewing the impact on other staff/service provision, effectiveness (any benefit for the individual), practicality (easy/difficult), cost implications, availability of other resources/assistance):……..
……..
……
……

……..

For each action/adjustment identified, complete action plan (section 2), as appropriate.

5. Key area/risk factor for stress: Role (whether individuals understand their role within the organisation and organisation ensures that the individual does not have conflicting roles)

The standard is that:
Individual indicates that they understand their role and responsibilities and systems are in place locally to respond to any individual concerns

Stressor (current state/areas of concern):…….....
……
……
……
……

Existing controls (detail of any existing controls/adjustments already made):……..
……
……

Assessment of existing controls/adjustments already made and consider what more needs to be done (i.e. 'reasonably practicable control measures', this will include reviewing the impact on other staff/service provision, effectiveness (any benefit for the individual), practicality (easy/difficult), cost implications, availability of other resources/assistance):……..
……..
……
……
……..

For each action/adjustment identified, complete action plan (section 2), as appropriate.

6. Key area/risk factor for stress: Change (How organisational change is managed (large and small) and communicated in the organisation)

The standard is that:
Individual indicates that the organisation engages them frequently when undergoing organisational change and systems are in place locally to respond to any individual concerns

Stressor (current state/areas of concern):…….....
……
……
……
……

Existing controls (detail of any existing controls/adjustments already made):……..
……
……

Assessment of existing controls/adjustments already made and consider what more needs to be done (i.e. 'reasonably practicable control measures', this will include reviewing the impact on other staff/service provision, effectiveness (any benefit for the individual), practicality (easy/difficult), cost implications, availability of other resources/assistance):……..
……..
……
……
……..

For each action/adjustment identified, complete action plan (section 2), as appropriate.

7. Other stressors (e.g. personal issues)

Stressor (current state/areas of concern):…….....
……
……
……

Existing controls (detail of any existing controls/adjustments already made):……..
……
……

Assessment of existing controls/adjustments already made and consider what more needs to be done (i.e. 'reasonably practicable control measures', this will include reviewing the impact on other staff/service provision, effectiveness (any benefit for the individual), practicality (easy/difficult), cost implications, availability of other resources/assistance):……..
……..
……
……
……..

For each action/adjustment identified, complete action plan (section 2), as appropriate.

…….

SECTION 2:

ACTION PLAN			
ACTION	**BY WHEN**	**BY WHOM**	**DATE ACHIEVED**

ACTION PLAN REVIEW DATE:..:……

(Managers must keep written evidence of the actual date on which the action plan review took place (and detail of this review) on the employee's personal file, with a copy given to the employee. This is required to ensure appropriate documentation/evidence that actions identified have been undertaken)

……

Managers Signature:…… Date:……

Employees signature…….....Date:……

Manager: Copy to be given to employee and copy to be retained on employee's Personal File.

Email the following details* to 'SWBH-GM-IndividualStressRiskAssessments'** ***(available via global email address list)
- name of employee, employee personal number, Dept and division, date individual stress risk assessment/checklist was carried out, name and job title of manager who completed Individual stress risk assessment/checklist (do not send a copy of the individual stress risk assessment/checklist itself).

Paper ref:	TB (05/18) 018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Integrated Quality & Performance Report (IQPR) March 2017-18		
Sponsoring Executive	Dave Baker, Director of Partnerships and Innovation		
Report Author	Yasmina Gainer, Head of Performance & Costing		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

To note the year-end delivery of performance across the IQPR summarised in the supplement summary: the Trust completes the year with some very robust and sustained delivery across the year in a number of key areas along with some challenges. Successes include: Infection control: success with CDiff target (29 v 30 target) and MRSA (0v0); RTT (routinely succeeds); Cancer which has had a couple of dips but has achieved each quarter; and persistent Reds (see paper). Challenges include: A&E (83.3% v 87.2% prior year); cancelled operations (1.2% v 0.8% target) and workforce compliance around sickness (4.5% versus 2.5% target) and nursing turnover rates (12.5% v 10.7% target).

CQUINs 2017-18 Q4 reporting due at the end of April. Expectation is delivery of 90% (£8.8m) which is a strong result. Risks identified have largely materialised to a potential value of £850k; most of the financial impact is against the Health & Wellbeing CQUIN in respect of Staff Survey results not demonstrating the required improvement.

IQPR was issued in April on WD5 to key stakeholders with some gaps. Most are resolvable.
New indicators for inclusion into the Apr18 IQPR are: Patient Notification <3wks (patients receiving notification re appointment/procedure); Elective & Non-Elective Theatre In-Session Utilisation, Learning Disabilities project milestones

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	x	Public Health Plan		People Plan & Education Plan	x
Quality Plan	x	Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Monthly item

4. Recommendation(s)

The Trust Board is asked to:

a.	Note year end performance summary
b.	Note progress and process on Persistent Reds; identify other indicators it wishes to add to this improvement process

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s):					
Board Assurance Framework		Risk Number(s):					
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

IQPR Cover Sheet Supplement _ TRUST BOARD

Key indicators Summary for Year Ending 2017-18 as at March 2018 :

Infection Control :

- □ A robust performance throughout the year despite hospital pressures and all IQPR indicators delivering to or above required standards.
- □ The Trust has experienced 29 CDIFF cases versus the target of 30 cases, so achieves the set target
- □ There were zero MRSA cases full year and MRSA screening, electively and non-electively, over-achieves targets routinely.

Harm Free Care :

- □ A strong performance on VTE assessments completing the year at 96.1% despite failing March month at 93.9%. This performance has been relatively stable for the last 18 months. Missed assessments being monitored via the Safety Plan.
- □ Safety Thermometer at 94.5% full year against the standard of 95%; whilst recent months see positive improvement, we continued throughout the year to marginally fail standard.
- □ WHO Safer Surgery compliance is stubborn in certain areas delivering however a steady, small improvement month on month with 99.4% at March, performance under-delivery will continue to be actively monitored and addressed
- □ On a full year basis there were 143 pressure sores reported with 1xGrade4;
- □ x943 falls reported full year against an annual trust target of 804; Deputy Chief Nurse confirms that SWBH is comparing very well against peers despite these levels of falls against which there were small number of falls with serious harm (x14 full year).
- □ In March we have seen an increased level of falls (x112) which is the single, biggest month in the last 18 months; hotspots have been identified and discussed with GDN for D47 and Leasowes.

Access Targets :

RTT

- □ RTT incomplete achieves 92% standard routinely for the last 13 months, although the latter months are achieving the standard itself, whereas previous periods have been over-performing. This however, has been impacted by the trust's ability to reduce the IP backlog due to bed pressures during the winter months.
- □ The Trust has seen its waiting list reducing to around 30,100 patients in March and recent months, previously more stabilised around 32,000 patients.

- 52 week breaches continue, but are supported by a training programme to educate relevant staff on RTT rules and application. 2x 52 week breaches have been reported in March.
- Acute Diagnostics (DM01) has under-delivered in 3 months over the year, challenged mainly in Imaging. This includes the under- performance in March at 98.34%. 138 breaches in month, mainly due to Cardiac CT diagnostics which is now subject to an improvement plan supported by the COO.

Cancer

- Recognised as a delivering Trust; meeting routinely most of the cancer standards, with the exception of 62 days which has failed only in 2 months, but never compromised a quarterly delivery.
- The Trust completes the year having achieved each quarter in 2017/18 and therefore delivers full year compliance across all cancer standards.
- The challenge now is to deliver the inter-tertiary transfers within the 38 day target and this is already being progressed with clearly identified areas for improvement.
- Neutropenic sepsis continuous to improve with only 4 patients breaches in March (4/46), patients missing their treatment by an average of 6 minutes above the required hour. This is a significant improvement to previous years and especially year on year aiming to achieve the full 100% compliance.

A&E

- Full year performance of 83.39%. 36,380 breaches have been experienced on a full year basis.
- WMAS handover delays have been on the whole managed very well considering the pressures on the hospital. Delays of >60 minutes are at 0.14% on a full year basis, based on 52,483 total conveyances in the year.
- DTOCs complete the year at 2.3% vs target of 3.5%.
- Bed moves (excl assessment areas and transfers for clinical reasons) are monitored closely and scrutinised routinely. On a full year basis we report 562 cases, but the reporting is still subject to defining for moves for absolute clinical reasons.
- Neck of Femur (surgery in 36 hours) performance is 85% in March but full year has been impacted by previous under-performance and reports at 69.4%.

Obstetrics:

- C Sections full year are at 25.6% versus the target of 25%. Very slightly over target, caused by higher than average non-elective cases in several periods. In March we can see that both, elective and non-elective case, are more closely aligned to long term averages.
- Breastfeeding compliance achieved full year at 76.7% vs target of 74%.

Stroke & Cardiology:

- □ Sentinel Stroke National Audit Programme (SSNAP) reports Trust service under B rating, which indicates a well-run service.
- □ All IQPR indicators generally deliver to standard or above.
- □ Thrombolysis within the hour is affected by clinical reasons and some operational processes, which are RCAed routinely and managed.
- □ Admissions to Stroke Ward within 4 hours remain challenging and inconsistent, but when on the ward patients do spend more than 90% of their stay there.
- □ Worth noting that TIA performance has been impacted in March, potentially due to increased levels of patients coming to our Trust impacted by the Walsall to Wolverhampton service transfer. The group is investigating this.

Workforce :

- □ Mandatory training delivers incredible improvement achieving 91.5% at the end of March against the 95% target.
- □ Sickness rates in-month for March are at 4.17%; the Trust is running at 4.5% cumulative sickness rate position against the ambitious target of 2.5%. Short term sickness particularly driving this performance.
- □ Turnover rates are above the Trust's ambition at 12.8% on a full year basis against the 10% ambition, with nursing running at 12.7% against the 10.7% target.
- □ PDR rates for all staff and specifically for medical staff is at 81.9% and 81.4% respectively at the end of the year against the 95% targets and demonstrate still room for improvement.

Mortality:

- □ Mortality indicators are in line with confidence limits against most of the mortality indicators, but our HSMR is currently reported (November 2017 – latest data) 119 for SWBH and outside statistical confidence limits. There is ongoing Trust scrutiny and oversight of mortality statistics at the Mortality and Quality Alerts Committee. A report was commissioned with HED, analytics provider, which concluded: Sandwell General Hospital is a statistically significant HSMR outlier. City Hospital remains within expected limits.
- □ Following MDO review of emergent divergence between weekday and weekend rates, this will result in a focus on the Sandwell site mortality

Cancellations and Theatre Utilisation :

- □ Performance has been challenging during the year, consistently below set targets. Impacted by winter pressures and resulting cancellations, bed capacity but also sickness.
- □ We had 592 late cancellations in the year representing 1.2% of our elective admissions vs the 0.8% target. Whilst improving in the latter months, unfortunately, March cancellations have been high at 1.7% vs the 0.8% target.

- Out of the 592 late cancellations, 223 represent avoidable cases (38%).
- Theatre utilisation remains below 85% at year-end; we have introduced new dashboards and consultant league tables to prompt improvements. This is all part of improvements for 2018-19.
- Job planning is a key driver for productivity improvements needed to support the 18/19 production plan, which should see theatre utilisation increase to required productivity levels. Job plans are being finalised.
- In terms of immediate highlights from the data on theatres, theatre scheduling and early finishes indicate single biggest opportunity (clearly coupled with job planning to support this throughput)

Data Completeness:

Open Referrals

- Unfortunately, rising still, but renewed effort is being put in place to close out recommendations already identified. IT constraints impacted the improvement on this matter.
- Other data quality matters and improvements are subject to a future 'red flag' report as well as Data Quality Committee at which there has been a request for improved group attendance (DQ leads from each group are starting to come in).

CQUINs :

2017-18

- The funding value full year 2017/18 is £8.8m for the trust.
- The Trust has done well to deliver so many, complex CQUINs and has done well to embed those into already existing initiatives.
- Q4 reporting to commissioners is due at the end of April2018.
- A potential loss value has been calculated at £850k, a 10% of the total annual funding value.
- The risk previously identified has now materialised across the following schemes:
  - Improvement of health & wellbeing of NHS staff - improvement of 5% against 2 out of 3 specific staff survey questions is unlikely (£452k)
  - Sepsis continuing to partially deliver (£170k)
  - Antibiotic usage unlikely to deliver 1% reduction year on year (£170k)
  - Secondary Care Dental : Audit of Day Case Activity (£55k)

2018-19

- The PMC/EG has been asked to endorse CQUIN leadership.
- Most CQUINs are 2-year schemes and there will be no additional ones to add (national nor local CCG ones)

Sandwell and West Birmingham Hospitals NHS Trust

Integrated Quality & Performance Report

Month Reported: March 2018

Reported as at: 25/04/2018

TRUST BOARD

Contents

March 2018

Infection Control

CDiff - compliant
• x3 C. Diff cases reported during the month of March
• This completes the financial year at x29 cases year to date against target of 30 cases

• The annual target set by the CCG for 17/18 has therefore been met.

MRSA - compliant
• Nil cases of MRSA Bacteraemia were reported in the full year.
• Therefore meeting the annual target set at zero.

MRSA Screening - compliant overall, but not in all groups/directorates
Year End Position :
• Non-elective patients screening 91.4%
• Elective patients screening 89.0%
• Both indicators are compliant with 80% target in-month and full year at Trust level

Elective screening whilst compliant with standard at trust level, it is not for Medicine & EC. The Group need to take forward with Infection Control lead to ensure improvement is visible.

MSSA - compliant
MSSA Bacteraemia (expressed per 100,000 bed days)
Year to date rate at 4.7 compared to target of 9.42.

Harm Free Care

Safety thermometer - not compliant
• 94.7% reported for March;
• 94.5% full year;
NHS Safety Thermometer target 95%, whilst recent months see positive improvement, we continued in the year to marginally fail standard.

• x112 [x78] falls reported in March with x1 [x0] fall resulting in serious injury, this is a large step up in numbers of falls based on long term average of 77 per month. Hot spots are reported in Leasowes and D47; deep-dives in progress
• x943 falls reported year to date against an annual trust target of 804 and x14 falls resulting in serious harm; Deputy Chief Nurse confirms that SWBH is comparing very well against peers
• In month, there were 49 falls within community, 60 in acute setting and 3 related to car park falls and outpatients area.
• Falls remain subject to ongoing CNO scrutiny and routine tracking of the Safety Plan on falls reduction; it is an integral part of ward dashboards.
• The IQPR from April will show falls against 1,000 OBDs as a secondary measure to absolute number of falls

• x6 [x8] avoidable, hospital acquired pressure sores reported in March of which there are 1x grade4, x2 grade 3, x4 grade 2
• x4 separate cases reported within the DN caseload.
• On a full year basis there were 143 pressure sores reported with 1xGrade4;
• CNO keep in view as part of Safety Plan

• x4 [x5] serious incidents reported in March;
• Routine collective review in place and reported to the Q&S Cttee.

• WHO Safer Surgery (Audit - brief and debrief - % lists where complete) as at March at 99.4% (99.1%) vs the 100% target. Improving last couple of months, but persistently some lists are missed. Clinician/list specific follow up by Group Director of Ops to secure 100% compliance. Improvement plan features as part of persistent reds management

• No never event was reported in March; x3 full year
• No medication error causing serious harm in March; x1 case in last 20 mnths

• x27 DOLS have been raised in March of which 27 were 7-day urgents;

VTE Assessments - compliant
• Compliance full year at 96.1% performing generally to target during the last 18 months, however, in March at 93.9% not compliant with 95% standard; Medical Director is progressing review and expects to be back on track from April
• 464 assessments were missed in March; being addressed through Safety Plan roll out to secure 100% compliance.

Obstetrics

C-section rate - compliant
• The overall Caesarean Section rate for March is 25.6% (28.9%) and 25.6% full year just above the 25% target, driven mainly clinical need in non-elective cases which climbed above average long term trend in a few periods
• Elective rates are 7.6% (comparing well to historical long term avg trend of 8%) and non-elective rates are 18% in the month (back in line with average historical performance)
• Performance considered at Q&S & Board and to be kept in view.

• Adjusted perinatal mortality rate (per 1000 births) for March 4.66 vs. threshold level of 8;
• The indicator represents an in-month position and which, together with the small numbers involved provides for sometimes large variations.
• The full year position is at 5.5 and within the tolerance rate of 8.0.

The level of births in March is at 429 up to February low levels; however, March level of births at 429 is behind births rates last year, same period (474)

• Post Partum Haemorrhage (>2000ml) 1X case reported in March against a target of 4, full year there are 20x cases and below a target of 40

• Puerperal Sepsis for February is within normalised range following new sepsis pathways being implemented; Audit is in progress as per CQC action plan.

• No maternal death was reported in March; full year we report x1 death in the last 18mnths (Aug17).
• However, the Trust was notified this month of a maternal death that happened just less than 12 months post natal, the death relates to 2016 (internal systems have been appropriately updated).

Breastfeeding - compliant
• Breastfeeding initiation performance reports quarterly; March quarterly count is at 76.43% compliant with the 74% target.

Mortality & Readmissions

Mortality - within confidence limits other than HSMR Sandwell
• The Trust overall RAMI for most recent 12-mth cumulative period is 109 (available data is as at December) reporting now in the IQPR a revised RAMI methodology, which needs to be monitored over the next few months to see the impact and comparison to historic approach - clinical effectiveness are monitoring.
• RAMI for weekday and weekend each at 103 and 128 respectively. MDO review and report to the Trust Board in April recommended an improvement plan for Sandwell site weekend mortality.
• SHMI measure which includes deaths 30-days after hospital discharge is at 108 for the month of October (latest available data).
• RAMI New Methodology effective from 1st Dec17: CHKS RAMI was developed over ten years ago, it has become more complex, and this along with other reasons, led to a review. The Clinical Effectiveness team will be monitoring changes in methodology and any impact resulting from this on the organisation or benchmark, they are aware of the methodology.
• HSMR identifying Sandwell as an outlier, which is being progressed via the Mortality and Quality Alerts Committee.

• Deaths in Low Risk Diagnosis Groups (RAMI) - month of December is 90. This indicator measures in-month expected versus actual deaths so subject to larger month on month variations.
• Crude in-month mortality rate for February is 1.6% [1.8%] slightly higher than 12mths avg trend due to Dec and Mar peaks; the rolling crude year to date mortality rate remains consistent at 1.3 and consistent with last year same period
• There were x142 [x178] deaths in our hospitals in the month of February; similar higher than last year same period which was at 139

Mortality Reviews within 42 Days - not compliant
• Mortality review rate in January at 44% and continually below target;
• Revised Learning from Deaths arrangements are being implemented, which will provide for routine 100% review.

• Readmissions (in-hospital) reported at 7.7% in February
• 7.3% rolling 12 mths. The equivalent, latest available peer group rate is at 7.9% (source: CHKS) .

Stroke Care & Cardiology

Patient Stay on Stroke Ward - compliant
March indicates that 94.2% of patients are spending >90% of their time on a stroke ward, compliant with the 90% operational threshold in the month;
full year compliance at 92.9% vs 90% target

Admission to Acute Stroke Ward - not compliant full year
• March admittance to an acute stroke unit within 4 hours is at 91.4% vs national standard of 80%; a recovery in month, but full year we achieved performance of 75.2% vs the 80% target.

Scans - compliant
• Pts receiving CT Scan within 24 hrs of presentation delivery in month at 100% [100%] meeting the 95% standard in month and at 97.7% full year
Pts receiving CT Scan within 1 hr of presentation at 69.7% meeting target of 50%, but volumes received at SWBH may be increased during the Walsall to Wolverhampton service transfer

Thrombolysis - compliant in month
Compliance at 100% in the month of March

Angioplasty - compliant
For March 100% compliance, on both, Primary Angioplasty Door to balloon time (<90 minutes) and 91.7% Call to balloon time (<150 minutes) at 94.7% and delivering consistently full year against 80% targets

RACP - compliant
RACP performance for March at 100% [100%] exceeding the 98% target for over 2 years

TIA Treatments - compliant
• TIA (High Risk) Treatment <24 Hours from receipt of referral delivery as at March at 66.7% against the target of 70%.
• TIA (Low Risk) Treatment <7 days from receipt of referral delivery at March is 87% against a target of 75%.
• Both indicators are consistently delivering over the required standard and have met targets again on a full year basis.

Cancer Care

Cancer standards - compliant
• Reporting always one month in arrears
• February and March delivery reported across all headline cancer targets; nationally the trust performs well on cancer access targets
• February 62 Days delivery at 87.4%
• March expected to delivery the 62 days target and secure a Q4 performance of 85.3% for this indicator; the Trust will have meet all quarterly and annual performance in 17/18
• Impact of prospective changes to oncology & gynae-oncology services on performance being assessed - estimated at c1-2% adverse & which may compromise delivery of standards

Patient Waiting times
• x8.5 patients waited longer than the 62 days at the end of February.
• 2 [x3] patients waited more than 104 days at the end of February
• The longest individual patient waiting time for treatment as at the end of February was 113 days

Neutropenic sepsis - not compliant
The breaches in month are being RCAed daily, historically we show breaches being generally only minutes above the required 1hr.
• (4/46 patients) - 8.7% of neutropenic sepsis March cases failed to receive treatment within prescribed period (less than 1hr). The breaches on average were no more than 6 minutes over the 1hr. Continuous actions are being progressed to further address remaining issues, progress is significant in terms of reduction of breaches so far this year and to previous years.
• Performance reporting continuous to monitor daily, weekly and monthly tabled at the OMC.

Inter-Provider Transfers - not compliant
• No tertiary referrals were met within 38 days by the Trust for the month of February; the persistent failure to meet this target requires attention and escalated to GDO for review & assurance. Cancer team track breaches and provide RCAs for each. Fines are being proposed for the failure to achieve this target.

Patient Experience - MSA & Complaints

MSA - compliant
• For March there were no MSA breaches reported.
• The trust continues to monitor all breaches.

Friends & Family
• Reporting of performance is undergoing a full review as part of 'persistent red' initiative. Performance improvement will be driven through this action plan.
• Scores and response rate remain low throughout the year, well below regional peers, mainly due to Trust using sub-optimal processes to recover responses, options are being considering including SMS/IVM.

Complaints
• The number of complaints received for the month of March is 97 [86] with 5.9 [2.5] formal complaints per 1000 bed days, showing an increase to previous rates, and higher to last year same period (3.9).
• 99% [100%] have been acknowledged within target timeframes (3 days)
• 25% [19%] in month responses have been reported beyond agreed target time; escalated to DG for remedy.

Patient Experience - Cancelled Operations

Cancelled Ops - not compliant
• 59 sitrep declared late (on day) cancelations were reported in March. Of these 14 (24%) were avoidable; avoidable cancellations being subject to improvement actions
• As a proportion of elective admissions, this represents 1.7% in March. Improvement plans are progressed to deliver target (0.8%); this is an ambitious target and depends on a number of factors such as bed availability which will be mitigated by the introduction of the 23hr day unit.

28 Day Breaches - not compliant
• There was 1x breach of the 28 days guarantee in March in Plastic Surgery
• Full year the trust reported x8 28 day breaches
• No urgent cancellations took place during the month of February

Theatre Utilisation - not compliant
• Theatre in-session utilisation is consistently below target of 85%; 71.6% in month, 72.6% performance on a full year basis.
• A second indicator has been added to the IQPR to measure 'overall session utilisation' (outside in-session timings, to sense-check productivity, albeit outside a regular session timing); this will serve as a reality check on whether performance outside the regular sessions delivers. This at March reports 79.6%. We will also start to report elective and non-elective utilisation splits.
• Intensive planned care focus aims to improve booking rates, scheduling and throughput through enhanced job planning and hence minute utilisation will improve as a result, but will always depend on level of cancellations and bed-capacity in the organisation.
• New theatre dashboards have been released to the management to allow improved visibility of performance;
• This information currently identifies 'early finishing' as a potential area of focus; from this we can interpret that we have a scheduling opportunity (too many minutes are un-used due to early finishes) without additional cases being put on the lists, as well as low throughput in certain specialities.

Emergency Care

ED 4hr standard - not compliant
• The Trust's performance against the 4-hour ED wait target in March was 79.9% [79.82%] against the 90% STF & 95% national target
• 3,582 [3,377] breaches were incurred in March
• Trolley waits >12 hrs were not incurred in March and 1x case only across the full year.
• The full year 17-18 performance is at 83.4%

ED quarterly performance trend for 17/18: Q1 at 83.31% ; Q2 at 87.11%; Q3 at 82.36% ; Q4 at 80.7%

WMAS Handovers - not compliant
• WMAS fineable 30 - 60 minutes delayed handovers at 196 [160] in March.
• x21 [x4] cases were > 60 minutes delayed handovers in March; whilst March is unusually high, the Trust performs very well in this category with only 71breaches year to date > 60 mins

• Handovers >60mins (against all conveyances) are therefore 0.47% (21 cases)in March against total WMAS conveyances which were 4,487 in the month. The target is only 0.02% .
• On a full year basis, against conveyances of 52, 483, therefore, handovers >60mins are at 0.14% against the 0.02% target which reflects a good position, as well as sustained very low number of cases during the year, considering the pressure on the system.

Fractured NOF - not compliant full year
• Fractured Neck of Femur Best Practice Tariff delivery for March is at 85% (72%) meeting the 85% target in the month.
• Full year based delivery is at 69.4% below the 85% target

Bed moves after 10pm not compliant:
• There were 75 reported bed moves in March in the period from 10pm-6am (excluding moves for clinical reasons).
• This indicator is being monitored closely over the next few months to ensure that all clinical moves are considered appropriately, this has yet to happen for the 75 reported moves here.

Referral To Treatment

RTT - Incomplete pathway - compliant
• RTT incomplete pathway for March at 92.01% against the national target of 92.0%;
• The over 18 weeks patients backlog is at 2,404 as at March
The trust total waiting list is c30,100 below previous levels of c32,000
• Whilst overall the performance has been kept up to the standard over the last 12 months, 4 specialities are performing below 92% standard on the incomplete pathway; winter pressures causing lack of bed capacity will have contributed to this, there are improvements in place on how to recover each service to the standards over the next few months.

52 Week Breaches - not compliant
There is 2x 52 week breaches in March ; 1x Gynae patient (also breaching in February) and 1x ENT patient on the incomplete pathway.

Acute diagnostic waits - not compliant
• Diagnostic (DM01) performance for March was below standard of 99% at 98.34%;
• 138 breaches were incurred mainly in Cardiac CT improvement plans will be in place to address this particular issue

Data Completeness

• The Trust's internal assessment of the completion of valid NHS Number Field within inpatient data sets compliant in mnth with 98.4.% below operational threshold of 99% ; YTD (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.
• Data Quality Committee has been re-instated and monthly meetings will take place to address a number of DQ issues including ethnicity coding

Open Referrals - not compliant
• Open Referrals, referring to patients in the system without a future waiting list activity, stand at 152,201 as at March showing a continuing, increasing trend as administration / IT processes persistently do not close down referrals/pathways as appropriate.
• Recommendations have been made to COO on short and long-term improvements. This has yet to be agreed and put into place.
• Low patient risk rated (green risk) amount to c15,000 (which are part of the 152,201 total), are subject to auto-closures since Jan2016 and follow a set protocol.
• The recommendations to COO include: key drivers for removing open referrals issues form the trust sustainably are :
1) IT solutions (developed solutions, but not implemented),
2) - the 'Follow Ups WL' to be complete (open referrals not part of it now) and
3) that referrals are closed automatically on discharge (a seamless process rather than user dependent which currently fails; the IT solutions under 1 include a fix to this)

Staff

PDR - not compliant
• Reporting at 81.9% as at March year end against the 95% target, subject to focussed improvement initiative.

Sickness & Return to Work - not compliant
• In-month sickness for March is at 4.17% (4.74%); the cumulative sickness rate is 4.48% [4.50%].
• The number of short term sickness in the month reported at 818 [932] cases; long term 226 [230] cases;
• Return to Work in month is up to 82.1% [85.7%] below the 100% target

Turnover rate - not compliant
• The Trust annualised turnover rate is at 14.2% [14.0%] in March increasing to previous months,
• The Trust Nursing turnover target has been confirmed at 10.7% and as at March reporting at 13.5%

Mandatory Training - not compliant fully, but showing significant improvement
• Mandatory Training at the end of March is at 91.5% overall against target of 95%;
• Health & Safety related training is just below the 95% target at 94.98% in March just below the target.

CQUINs & Local Quality Requirements 2017/18

CQUINs : Q4 SUBMISSION DUE END OF APRIL
• The funding value full year 2017/18 is £8.8m.
• The trust is preparing to report the final delivery results for Q4 at the end of April
• The risk around Q4 milestones has been estimated £850k and at this stage looks to materialise.
• The risk is across the following schemes:
1) Improvement of health & wellbeing of NHS staff - improvement of 5% against 2/3 specific survey questions has now been confirmed by the staff results as not delivered (£452k impact),
2) Sepsis continuing to partially deliver (£170k),
3) Antibiotic usage unlikely to deliver 1% reduction year on year (170),
4) Secondary Care Dental : Audit of Day Case Activity (£55k)
5) the eRS CQUIN will also need confirming with the CCG as eRS slots not fully open based on exclusions therefore exclusions need to be confirmed as 'acceptable', but there is no value at risk that can be estimated for this at this stage

Local Quality Requirements 2017/18 are monitored by CCG and the Trust is fineable for any breaches in accordance to contract. Local Quality Requirements 2017/18 are monitored by CCG and the Trust is fineable for any breaches in accordance to contract. The Trust has now got only a small number of formally agreed RAPs (recovery action plans) in place at this stage demonstrating a good management of performance issues and responsiveness during the year.

STF Criteria & NHSI Single Oversight Framework

Summary Scorecard - March (In-Month)

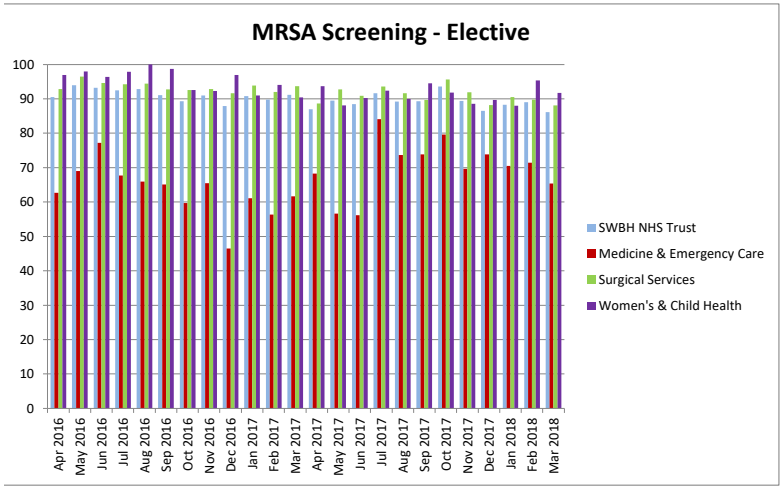
Summary Scorecard

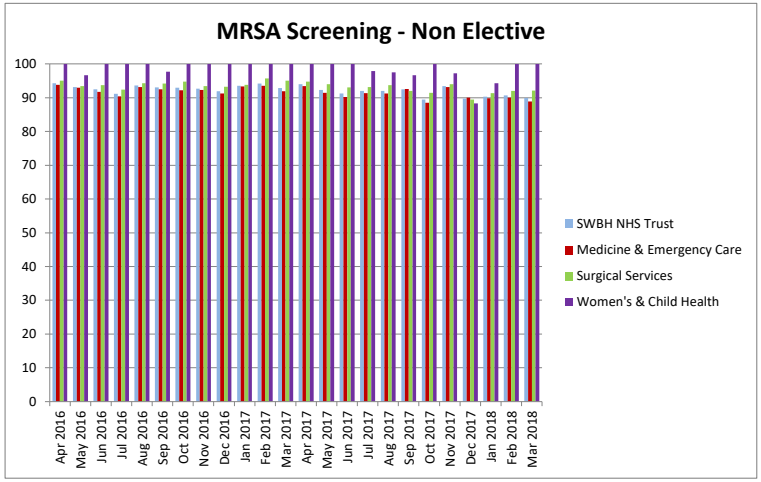
Section	Red Rated	Green Rated	None	Total
Infection Control	1	5	0	**6**
Harm Free Care	11	3	11	**25**
Obstetrics	2	7	5	**14**
Mortality and Readmissions	1	1	11	**13**
Stroke and Cardiology	2	9	0	**11**
Cancer	1	9	5	**15**
FFT. MSA, Complaints	11	4	9	**24**
Cancellations	6	3	0	**9**
Emergency Care & Patient Flow	6	9	5	**20**
RTT	7	1	6	**14**
Data Completeness	1	9	9	**19**
Workforce	9	1	10	**20**
Temporary Workforce	0	0	28	**28**
SQPR	10	0	8	**18**
Total	**68**	**61**	**107**	**236**

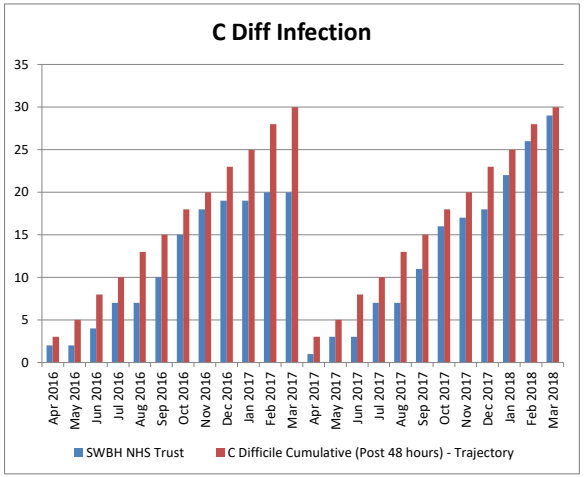
• Persistently red-rated performance (>12months) indicators (39 out of the above 68) are subject to performance improvement and monitoring; priorities for improvements have been re-confirmed at OMC as not all indicators carry the same level of significance. Indicators agreed to be 'resolved' are overseen by OMC.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Oct 2016) O N D J F M A M J J A S O N D J F M	Data Period	Group M	Group SS	Group W	Group P	Group I	Group PCCT	Group CO	Month	Year To Date	Trend
4			C. Difficile	<= No	30	2.5		Mar 2018	3	0	0			0		3	29	
4			MRSA Bacteraemia	<= No	0	0		Mar 2018	0	0	0			0		0	0	
4			MSSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9.42		Mar 2018								0.0	4.7	
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	94.9	94.9		Mar 2018								4.9	9.0	
3			MRSA Screening - Elective	=> %	80	80		Mar 2018	65.4	88.1	91.7			0		86.2	89.0	
3			MRSA Screening - Non Elective	=> %	80	80		Mar 2018	88.9	92.1	100			100		89.9	91.4	

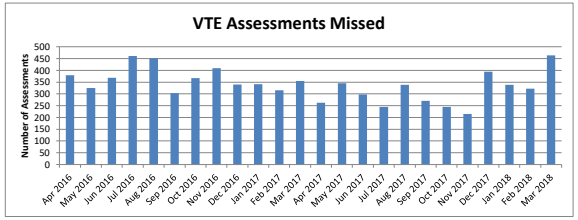


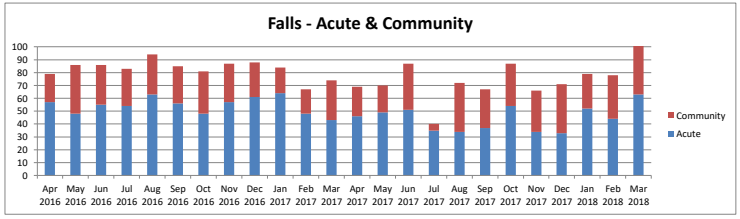


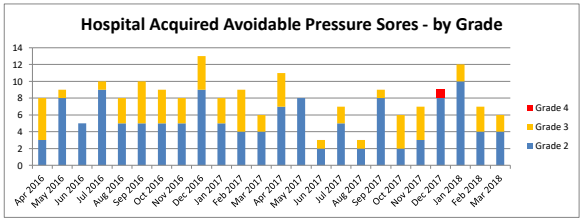


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	SS	W	P	I	PPCT	CO	Month	Year To Date	Trend
8		•d	Patient Safety Thermometer - Overall Harm Free Care	=> %	95	95																			Mar 2018								94.7	94.5	
8		•d	Patient Safety Thermometer - Catheters & UTIs	%			1.00	6.00	2.00	2.00	0.00	0.00	3.00	2.00	1.00	3.00	2.00	1.00	4.00	4.00	6.00	0.00	2.00	1.00	Mar 2018								0.08	0.21	
			Number of DOLS raised	No			-	25	22	15	14	23	15	14	6	27	22	20	48	31	19	36	30	27	Mar 2018	20	4	0	-	-	3		27	295	
			Number of DOLS which are 7 day urgent	No			-	25	22	14	14	23	15	14	6	27	22	20	48	31	19	36	30	27	Mar 2018	20	4	0	-	-	3		27	295	
			Number of delays with LA in assessing for standard DOLS application	No			-	6	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	-	-	0		0	3	
			Number DOLs rolled over from previous month	No			-	4	15	14	8	8	15	12	9	7	12	5	5	3	7	7	3	10	Mar 2018	6	0	0	-	-	4		10	95	
			Number patients discharged prior to LA assessment targets	No			-	6	6	2	11	6	3	11	7	7	9	9	11	7	2	4	8	3	Mar 2018	2	0	0	-	-	1		3	81	
			Number of DOLs applications the LA disagreed with	No			-	1	0	1	1	0	1	0	2	1	2	1	0	2	1	2	0	0	Mar 2018	0	0	0	-	-	0		0	12	
			Number patients cognitively improved regained capacity did not require LA assessment	No			-	5	2	1	0	0	3	1	1	13	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	-	-	0		0	18	
8			Falls	<= No	804	67	81	87	88	84	67	74	69	70	87	85	72	67	87	66	71	79	78	112	Mar 2018	45	15	0	0	0	49	3	112	943	
9			Falls with a serious injury	<= No	0	0	1	2	3	3	1	2	1	1	1	1	3	2	3	1	0	0	0	1	Mar 2018	0	1	0		0	0	0	1	14	
8			Grade 2,3 or 4 Pressure Ulcers (Hospital Aquired Avoidable)	<= No	0	0	9	8	13	8	9	6	11	8	3	7	3	9	6	7	9	12	7	6	Mar 2018	3	3	0			0		6	88	
			Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload Acquired)	<= No	0	0	0	2	5	6	8	6	5	8	4	7	4	3	6	4	4	2	4	4	Mar 2018						4		4	55	
3		•d•	Venous Thromboembolism (VTE) Assessments	=> %	95	95																			Mar 2018	88.8	97.2	96.5					93.9	96.1	
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	100	100																			Mar 2018	99.3	100.0	99.7		100.0			99.7	99.8	
3			WHO Safer Surgery - brief (% lists where complete)	=> %	100	100																			Mar 2018	100	100	97		100			99.6	99.4	
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	100																			Mar 2018	99	100	97		100			99.4	98.7	
9		•d•	Never Events	<= No	0	0	0	1	0	0	1	0	0	1	1	0	1	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	0	0		0	3	
9		•d	Medication Errors causing serious harm	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	Mar 2018	0	0	0	-	0	0		0	1	
9		•d•	Serious Incidents	<= No	0	0	6	5	10	5	6	5	4	4	3	1	8	5	4	6	4	3	5	4	Mar 2018	1	1	2	0	0	0	0	4	51	
9			Open Central Alert System (CAS) Alerts	<= No			14	10	8	6	5	4	8	9	27	3	3	8	10	6	5	7	6	5	Mar 2018								5	97	
9		•d	Open Central Alert System (CAS) Alerts beyond deadline date	No	0	0	2	1	2	0	1	0	0	0	1	1	1	0	0	1	1	2	2	2	Mar 2018								2	11	
			Safety Plan - Input Non-Compliant Days	<= No		<=3 Per Ward	NEW INDICATOR AWAITING POPULATION																		Jan-00								-	-	
			Safety Plan - Checks Compliant	%	98	98	NEW INDICATOR AWAITING POPULATION																		Jan-00								-	-	
			Safety Plan - Missed Checks	=> No		<=3 Per Ward	NEW INDICATOR AWAITING POPULATION																		Jan-00								-	-	

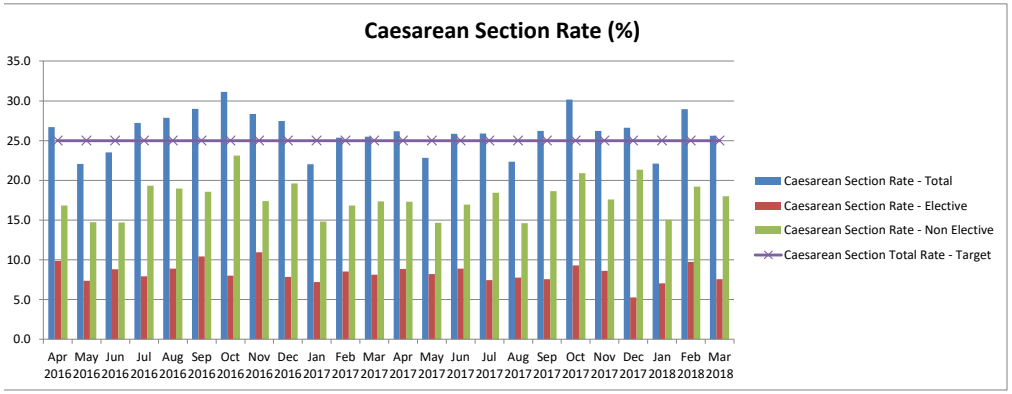


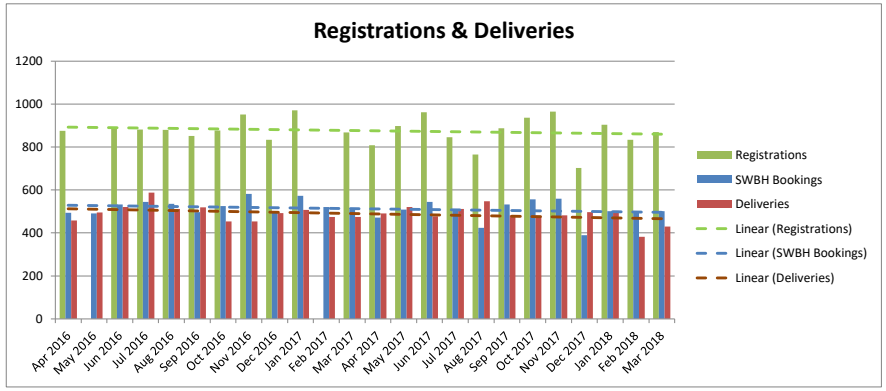




Patient Safety - Obstetrics

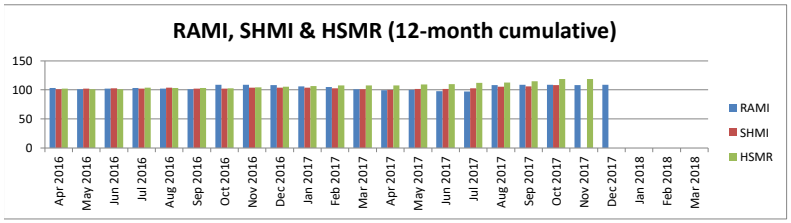
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory 2016-2017 Year	Trajectory 2016-2017 Month	Previous Months Trend (since Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Month	Year To Date	Trend
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			Mar 2018	25.6	25.6	
3		•	Caesarean Section Rate - Elective	<= %			8	11	8	7	9	8	9	8	9	7	8	8	9	9	5	7	10	8	Mar 2018	7.6	8.0	
3		•	Caesarean Section Rate - Non Elective	<= %			23	17	20	15	17	17	17	15	17	18	15	19	21	18	21	15	19	18	Mar 2018	18.0	17.7	
2		•d	Maternal Deaths	<= No	0	0																			Mar 2018	0	1	
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Mar 2018	1	20	
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																			Mar 2018	0.93	1.77	
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Mar 2018	4.66	5.50	
12	NEW		Stillbirth Rate (Corrected) (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	2.11	2.10	4.02	1.99	2.58	4.66	Mar 2018	4.66	2.89	
12	NEW		Neonatal Death Rate (Corrected) (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	4.22	2.10	0.00	0.00	2.58	0.00	Mar 2018	0.00	1.45	
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	85.0	85.0																			Mar 2018	92.2	79.4	
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																			Mar 2018	156.1	137.7	
2			Breast Feeding Initiation (Quarterly)	=> %	74.0	74.0	-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		Mar 2018	76.43	76.72	
2		•	Puerperal Sepsis and other puerperal infections (variation 1 - ICD10 O85 or O86) (%) -	<= %			2.9	2.8	3.5	2.9	1.9	2.6	4.4	2.5	2.5	1.8	0.8	0.9	0.5	0.8	0.6	0.9	1.1	1.0	Mar 2018	0.98	1.51	
2		•	Puerperal Sepsis and other puerperal infections (variation 2 - ICD10 O85 or O86 Not O864) (%)	<= %			1.8	1.9	1.7	2.5	1.6	2.3	3.0	1.6	1.6	1.0	0.6	0.6	0.5	0.5	0.6	0.7	0.4	0.7	Mar 2018	0.65	1.01	
2		•	Puerperal Sepsis and other puerperal infections (variation 3 - ICD10 O85) (%)	<= %			1.4	1.3	1.0	2.0	1.6	2.1	2.3	1.4	1.6	1.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	Mar 2018	0.00	0.57	

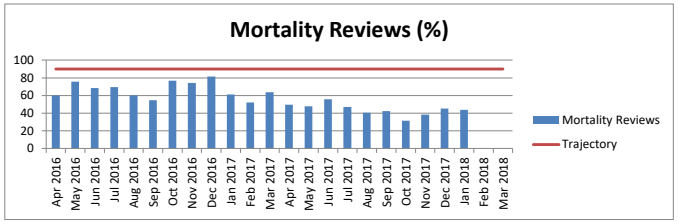


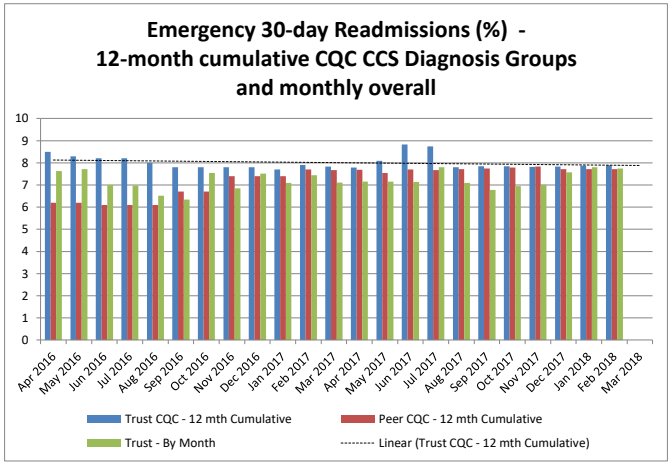


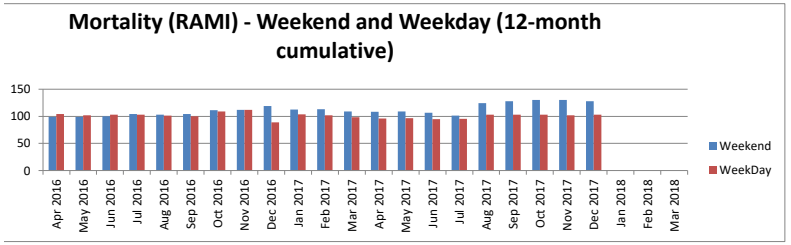
Clinical Effectiveness - Mortality & Readmissions

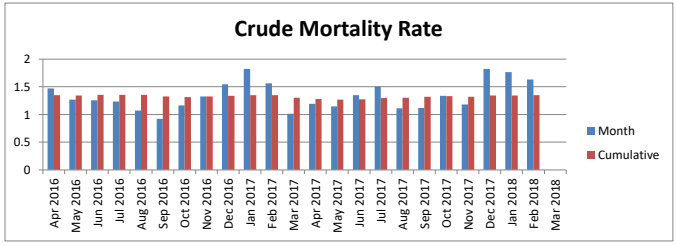
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	109	109	108	106	105	101	99	100	98	97	108	109	109	108	109	-	-	-	Dec 2017									938	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	109	112	89	104	102	98	96	97	95	95	103	103	103	102	103	-	-	-	Dec 2017									897	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	111	112	119	112	113	109	109	109	106	101	124	128	130	130	128	-	-	-	Dec 2017									1065	
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	102	104	104	104	103	101	100	102	102	103	106	106	108	-	-	-	-	-	Oct 2017									726	
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			103	105	106	107	108	108	107	109	110	112	113	115	118	119	-	-	-	-	Nov 2017									903.2	
5		C	Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	94	139	84	105	72	88	62	61	78	78	71	144	62	120	90	-	-	-	Dec 2017								90		
3			Mortality Reviews within 42 working days	=> %	90	90																	-	-	Jan 2018	44	44	100			0		44	44	
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.2	1.3	1.5	1.8	1.6	1.0	1.2	1.1	1.3	1.5	1.1	1.1	1.3	1.2	1.8	1.8	1.6	-	Feb 2018								1.63		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.3	1.3	1.3	1.3	1.4	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	-	Feb 2018									1.31	
			Deaths in the Trust	No			108	129	143	172	139	100	105	113	129	142	109	109	133	119	169	178	142	-	Feb 2018								142	1448	
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			7.5	6.8	7.5	7.1	7.4	7.1	7.2	7.2	7.1	7.8	7.1	6.8	7.0	7.0	7.6	7.8	7.7	-	Feb 2018								7.74		
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			8.0	7.3	7.1	7.2	7.2	7.1	7.1	7.0	7.1	7.1	7.2	7.2	7.2	7.2	7.2	7.2	7.3	-	Feb 2018									7.27	
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			7.8	7.8	7.8	7.7	7.9	7.8	7.8	8.1	8.8	8.7	7.8	7.8	7.8	7.8	7.8	7.9	7.9	-	Feb 2018	-	-	-			-			7.90	





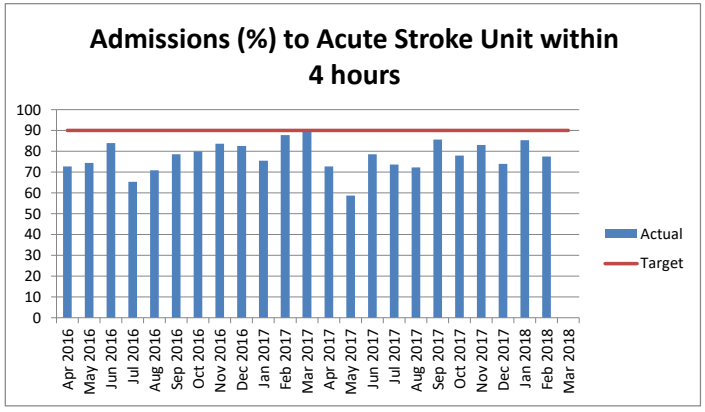


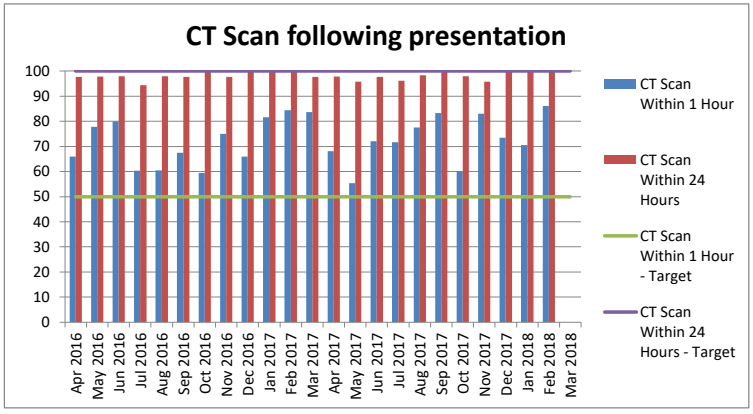


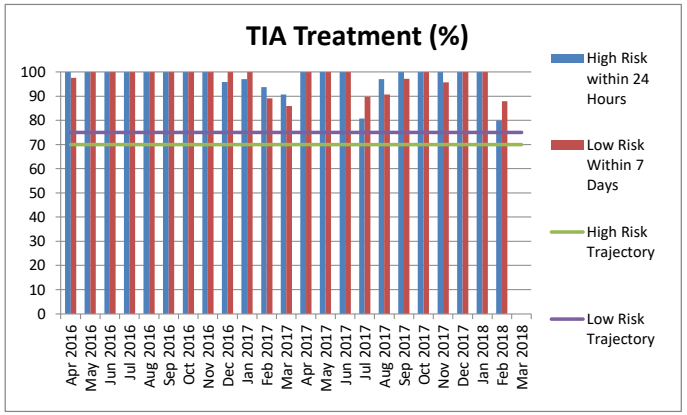


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Month	Year To Date	Trend
3			5WD: Pts spending >90% stay on Acute Stroke Unit	=> %	90.0	90.0																			Mar 2018	94.2	92.9	
3			5WD: Pts admitted to Acute Stroke Unit within 4 hrs	=> %	80.0	80.0																			Mar 2018	91.4	75.2	
3			5WD: Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0																	-		Mar 2018	69.7	72.0	
3			5WD: Pts receiving CT Scan within 24 hrs of presentation	=> %	95.0	95.0																			Mar 2018	100.0	97.9	
3			5WD: Stroke Admission to Thrombolysis Time (% within 60 mins)	=>	85.0	85.0																			Mar 2018	100.0	66.1	
3			5WD: TIA (High Risk) Treatment <24 Hours from receipt of referral	=>	70.0	70.0																			Mar 2018	66.7	94.9	
3			5WD: TIA (Low Risk) Treatment <7 days from receipt of referral	=>	75.0	75.0																			Mar 2018	88.9	95.6	
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0																			Mar 2018	100.0	100.0	
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0																			Mar 2018	91.7	93.9	
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0																			Mar 2018	94.7	95.9	
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0																			Mar 2018	100.0	100.0	



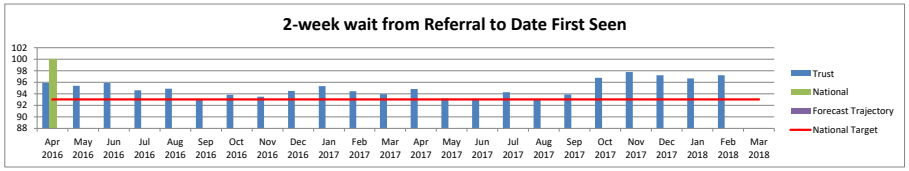


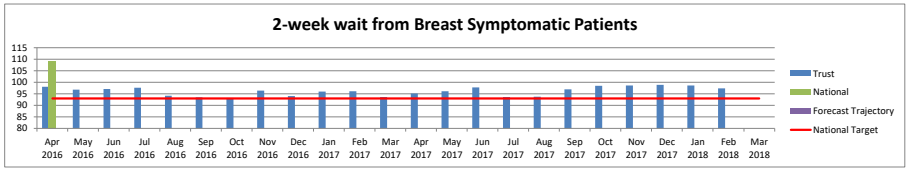


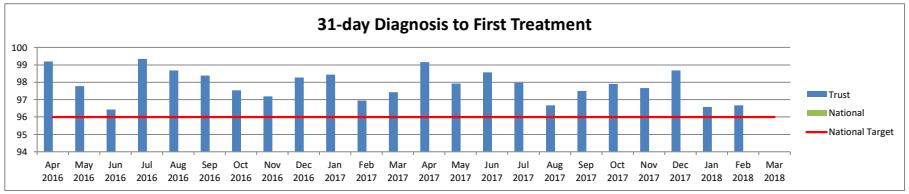
The stroke indicators in the IPR are based on 'patient arrivals' not 'patient discharged' as this monitors pathway performance rather than actual outcomes which may / may not change on discharge.
National SSNAP is based on 'patient discharge' which is more appropriate for outcomes based reporting.
Both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

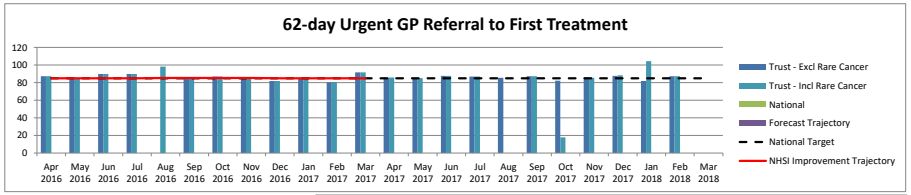
Clinical Effectiveness - Cancer Care

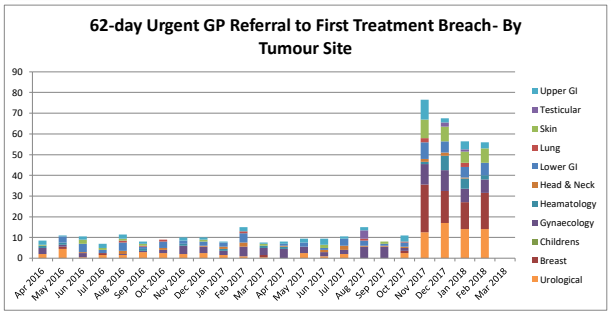
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
1			2 weeks	=> %	93.0	93.0																		-	Feb 2018	95.7	97.6	99.4			0.0		97.2	95.3	
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		-	Feb 2018		-						97.4	96.9	
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Feb 2018	100.0	98.5	88.9			0.0		96.7	97.7	
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0																		-	Feb 2018								94.4	97.2	
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																		-	Feb 2018								100.0	100.0	
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																		-	Feb 2018								-	0.0	
1			62 Day (urgent GP referral to treatment) Excluding Rare Cancer	=> %	85.0	85.0																		-	Feb 2018	92.3	90.4	65.0			0.0		87.4	85.8	
1			62 Day (urgent GP referral to treatment) Including Rare Cancer	=> %	85.0	85.0									.									-	Feb 2018	92.3	90.4	65.0			0.0		87.4	80.6	
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																		-	Feb 2018	0.0	100.0	100.0			0.0		100.0	96.8	
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																		-	Feb 2018	87.5	94.1	66.7			0.0		88.9	91.0	
1			Cancer - Patients Waiting over 62 days	No			10	11	10	8	15	8	8	10	10	11	11	9	11	12	9	13	9	-	Feb 2018	1.0	4.0	3.5			0.0		8.5	110.5	
1			Cancer - Patients Waiting over 104 days	No			2	1.5	2.5	1.5	4.0	5.0	5.0	2.0	1.0	1.5	5.0	1.0	4.0	2.0	3.0	3.0	2.0	-	Feb 2018	1.0	1.0	0.0			0.0		2.0	29.5	
1			Cancer - Longest Waiter in days	No			133	77	107	120	150	162	140	139	106	102	184	141	125	173	104	102	113	-	Feb 2018	113	112	99			0		113		
1			Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	=> No	0.0	0.0	12	12	19	17	8	6	11	6	4	10	3	7	8	7	7	3	9	4	Mar 2018	4	0	0			0		4	79	
			IPT Referrals - Within 38 Days Of GP Referral for 62 day cancer pathway	%			50	0	0	33	0	50	0	0	0	25	25	67	0	20	0	54	0	-	Feb 2018	-	-	-			-		0	22	

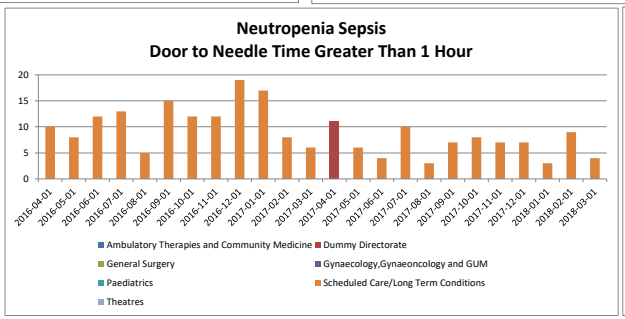


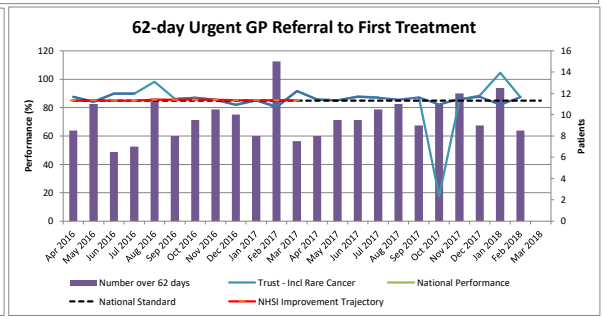






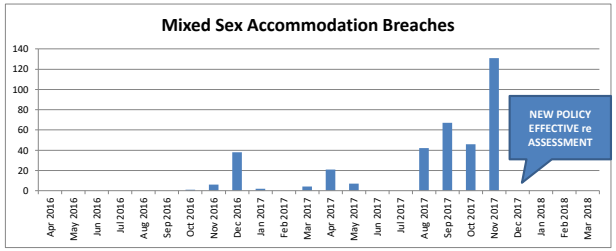


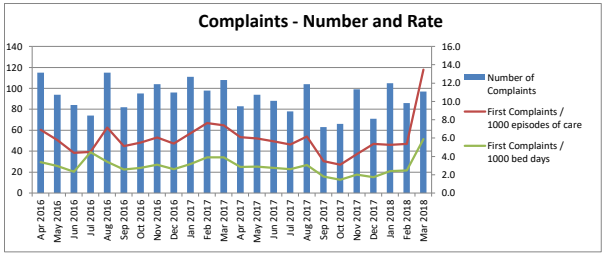


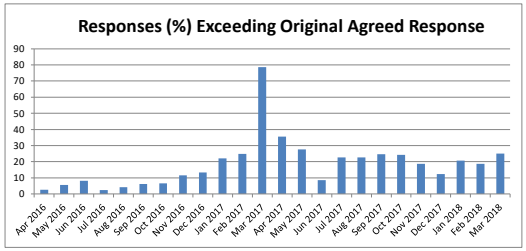


Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
8		b	FFT Response Rate - Adult and Children Inpatients (including day cases and community)	=> %	50.0	50.0	22	17	10	15	9.7	7.9	9.3	11	11	12	13	10	19.35	9.7	8.3	-	9.8	10.2	Mar 2018								10	11	
8		a	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95.0	95.0	88	94	97	97	95	96	95	92	92	83	83	83	81.84	85	89	-	88	88	Mar 2018								88		
8		b	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50.0	50.0	5.6	4.8	5.9	5.4	4.3	4.2	5.5	3.8	2.4	3.8	2.8	3.4	3.328	3.4	3.6	-	3.8	7.02	Mar 2018	7.02							7.0	3.8	
8		a	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95.0	95.0	73	75	73	77	76	73	75	71	73	72	75	73	73	58	-	-	75	74	Mar 2018	74							74		
8			FFT Response Rate: Type 3 WiU Emergency Department	=> %	50.0	50.0	0.5	0.3	1.2	0.6	0	0	0.1	0	-	0	-	-	-	-	8.8	-	5	####	Mar 2018	-							-	1.5	
8			FFT Score - Adult and Children Emergency Department (type 3 WiU)	=> No	95.0	95.0	64	100	100	65	0	0	0	0	0	0	0	-	-	-	16	-	0	0	Mar 2018	-							0		
8			FFT Score - Outpatients	=> No	95.0	95.0	88	89	90	88	88	90	90	89	88	91	89	89	90.63	92	90	-	92	90	Mar 2018								90		
8	NEW		FFT Score - Maternity Antenatal	=> No	95.0	95.0	86	90	86	97	11	95	88	90	75	90	50	90	92.5	76	75	-	0	100	Mar 2018								100		
8	NEW		FFT Score - Maternity Postnatal Ward	=> No	95.0	95.0	81	93	90	91	29	83	91	86	73	73	81	84	88.78	81	74	-	0	100	Mar 2018								100		
8	NEW		FFT Score - Maternity Community	=> No	95.0	95.0	100	100	50	0	0	80	100	100	0	0	50	0	0	0	0	-	0	0	Mar 2018								0		
8			FFT Score - Maternity Birth	=> No	95.0	95.0	71	88	90	88	23	92	82	83	69	76	58	48	83.34	74	100	-	94	100	Mar 2018								100		
8			FFT Response Rate - Maternity Birth	=> %	50.0	50.0	5.9	17	13	8.2	5.4	21	8.9	11	7	7.1	5.2	5.2	12.53	6.9	0.2	-	23	1.23	Mar 2018								1	8	
13		a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	1	6	38	2	0	4	21	7	0	0	42	67	46	131	0	0	0	0	Mar 2018	0	0	0		0	0		0	314	
9			No. of Complaints Received (formal and link)	No			95	104	96	111	98	108	83	94	88	78	104	63	66	99	71	105	86	97	Mar 2018	34	32	16	1	1	5	8	97	1034	
9			No. of Active Complaints in the System (formal and link)	No			152	148	157	176	177	194	205	184	185	184	167	154	136	148	161	187	181	183	Mar 2018	76	50	27	3	2	10	15	183		
9		a	No. of First Formal Complaints received / 1000 bed days	Rate1			2.8	3.1	2.6	3.2	3.9	3.9	2.9	2.9	2.8	2.6	3.1	1.8	1.4	2.0	1.7	2.4	2.5	5.9	Mar 2018	4.46	10	6.52			0		5.90	2.67	
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			5.5	6.1	5.4	6.5	7.6	7.4	6.1	6.0	5.6	5.3	6.2	3.5	3.1	4.2	5.4	5.3	5.3	13.5	Mar 2018	13.3	15.7	10.9			0		13.47	5.79	
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	=> %	100	100	99	100	100	99	98	94	100	100	100	100	100	98	100	90	92	99	100	99	Mar 2018	100	100	93.8	100	100	100	100	99	98	
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	<= %	0	0	6.6	11	13	22	25	79	36	28	8.6	23	23	25	24.17	19	12	21	19	25.1	Mar 2018	27	25	11.1	66.7	100	27.27	21.4	25	22	
9			No. of responses sent out	No			87	79	79	76	95	84	67	106	87	83	67	85	73	65	38	75	65	81	Mar 2018	28	25	10	0	2	5	11	81	892	
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jul 2016	N	N	N	N	N	N	N	No		
	NEW		Patient Harm - New Claims	No			NEW INDICATOR REPORTING FROM FEB18																11	6	Mar 2018	-	-	-	-	-	-	-	6	17	
	NEW		Patient Harm - Ongoing Claims	No			NEW INDICATOR REPORTING FROM FEB18																491	474	Mar 2018	-	-	-	-	-	-	-	474	965	
	NEW		Patient Harm - Closed Claims	No			NEW INDICATOR REPORTING FROM FEB18																26	0	Mar 2018	-	-	-	-	-	-	-	0	26	

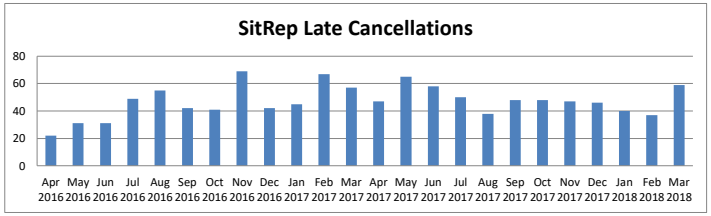


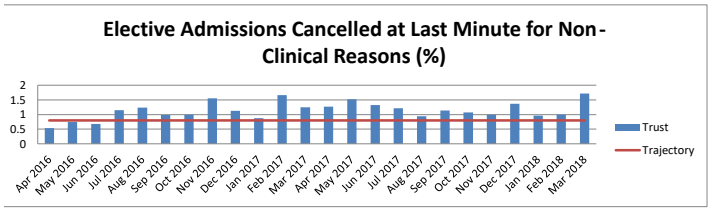


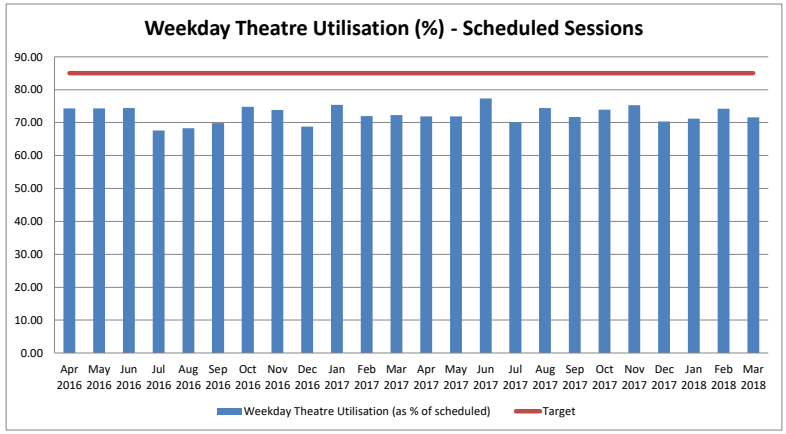


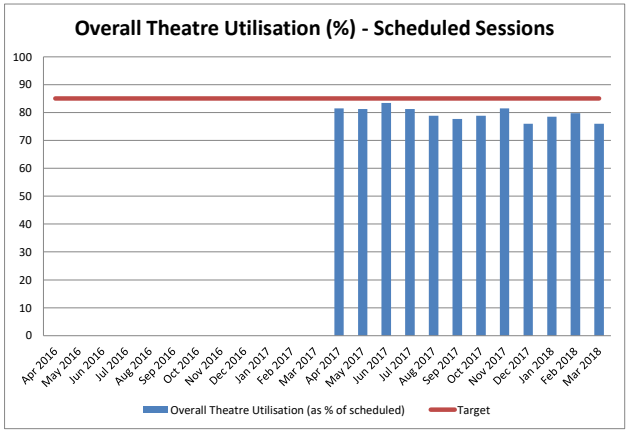
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
2			No. of Sitrep Declared Late Cancellations - Total	<= No	320	27	41	69	43	45	67	57	47	65	58	50	38	48	48	47	46	40	37	59	Mar 2018	7	41	5			6		59	592	
2			No. of Sitrep Declared Late Cancellations - Avoidable	No			17	28	19	13	19	17	24	27	20	21	12	31	11	14	13	17	10	14	Mar 2018	0	6	2			6		14	223	
2			No. of Sitrep Declared Late Cancellations - Unavoidable	No			22	41	18	29	48	37	23	37	37	29	26	17	31	33	33	23	28	45	Mar 2018	7	35	3			0		45	362	
2		•	Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	0.8	0.8	1.0	1.5	1.1	0.9	1.7	1.2	1.3	1.5	1.3	1.2	0.9	1.1	1.1	1.0	1.4	1.0	1.0	1.7	Mar 2018	0.91	2.08	2.04			1.21		1.7	1.2	
2		•e•	Number of 28 day breaches	<= No	0	0	1	0	3	6	0	0	1	0	0	0	2	0	0	0	0	2	0	1	Mar 2018	0	1	0			0		1	8	
2		•e	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	Mar 2018	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	Mar 2018	0.0	0.0	0.0			0.0		0	0	
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	<= No	0	0	1	3	4	0	3	0	3	1	3	1	1	0	1	1	1	4	3	2	Mar 2018	0	2	0			0		2	21	
			Multiple Hospital Cancellations experienced by same patient (all cancellations)	<= No	0	0	49	50	63	61	62	67	51	45	72	55	53	71	70	62	59	72	59	89	Mar 2018	10	76	3			-		89	758	
3			All Hospital Cancellations, with 7 or less days notice	<= No	0	0	234	273	272	269	284	257	219	230	250	245	213	243	294	244	272	302	212	276	Mar 2018	19	223	34			-		276	3000	
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	Mar 2018	0.0	73.5	70.3			52.8		71.6	72.6	
			Overall Theatre Utilisation (as % of scheduled)	<= %	85.0	85.0	-	-	-	-	-	-	•	•	•	•	•	•	•	•	•	•	•	•	Mar 2018	0.0	77.5	77.6			55.9		76.0	79.6	



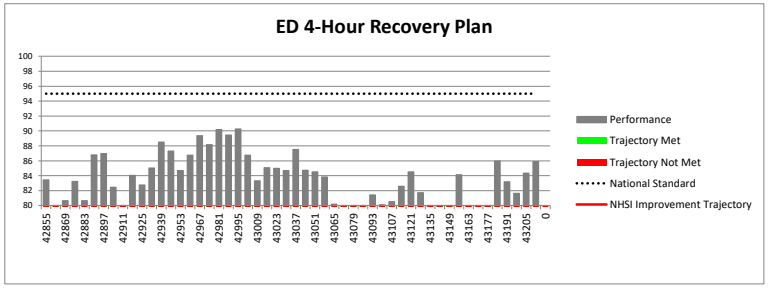


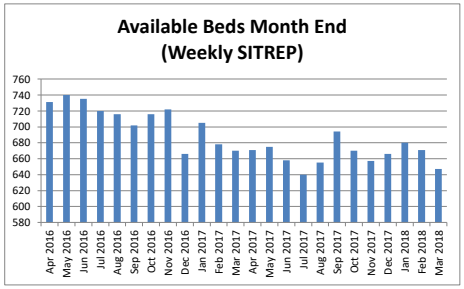


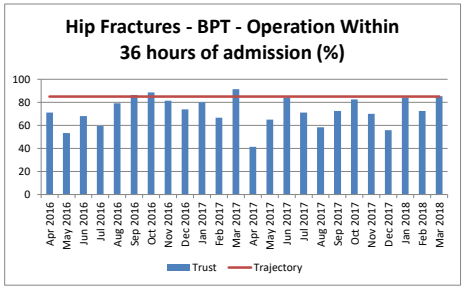


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend
2			Emergency Care 4-hour waits	=> %	95.00	95.00																			Mar 2018	75.4	81.9	97.5	79.90	83.39	
2			Emergency Care 4-hour breach (numbers)	No			2676	3237	3324	2821	3046	2875	2814	3549	3014	2686	2177	2150	2800	3168	3814	3249	3377	3582	Mar 2018	1971	1585	26	3582	36380	
2			Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			Mar 2018	0	0		0	1	
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			Mar 2018	13	14	25	13	14	
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Mar 2018	72	60	23	58	62	
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0														-					Mar 2018	4.94	5.49	6.05	5.28	7.68	
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Mar 2018	4.85	5.58	1.07	4.60	5.31	
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	112	162	193	162	129	107	110	159	242	111	127	90	143	207	208	163	160	196	Mar 2018	144	52		196	1916	
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	16	21	19	11	13	5	0	12	6	1	0	1	4	6	11	5	4	21	Mar 2018	18	3		21	71	
11			WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Mar 2018	0.82	0.13		0.47	0.14	
11			WMAS - Emergency Conveyances (total)	No			4233	4261	4622	4410	4034	4206	4137	4376	4254	4429	4278	4174	4557	4424	4725	4561	4081	4487	Mar 2018	2203	2284		4487	52483	
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																			Mar 2018	0.4	0.6		0.5	2.3	
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	<10 per site	<10 per site																			Mar 2018	6	5		11		
2			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	<= No	3.5% of available	3.5% of available	509	503	674	629	512	583	546	501	483	635	539	512	598	545	591	613	541	433	Mar 2018				433	6537	
			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities) as % of Available Beds	%	3.5	3.5	2.7	2.7	3.4	3.1	2.8	2.9	2.9	2.5	2.6	3.4	2.8	2.8	3.2	2.9	3.1	3.1	3.0	2.2	Mar 2018				2.23	2.88	
2			Delayed Transfers of Care (Acute) - Finable Bed Days (Birmingham LA only)	<= No	0	0	266	272	449	435	309	375	324	258	312	370	256	288	272	149	226	268	193	152	Mar 2018				152	3068	
2			Patient Bed Moves (10pm - 6am) (No.) -ALL	No			546	679	666	682	633	586	584	651	536	580	574	633	674	657	719	769	654	796	Mar 2018				796	7827	
2			Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units	No			219	273	251	249	228	221	229	234	205	245	216	233	231	268	291	282	215	278	Mar 2018				278	2927	
	New		Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units and Transfers for Clinical Reasons	No			38	59	45	32	43	46	44	33	37	29	23	43	39	54	72	65	48	75	Mar 2018				75	562	
			Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85.0	85.0																			Mar 2018				85	69.4	

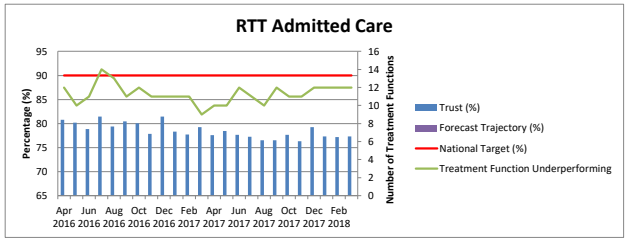


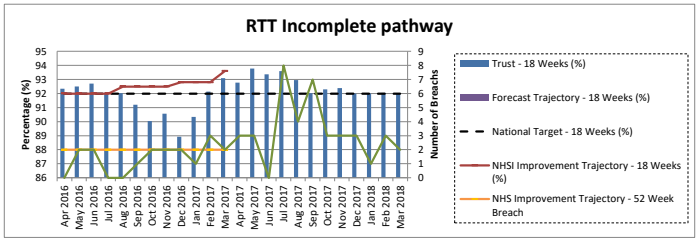


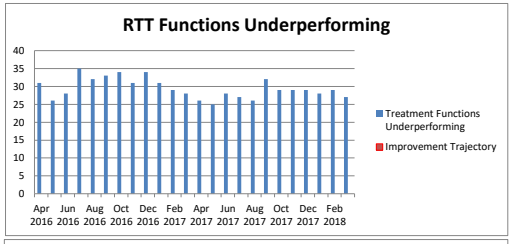


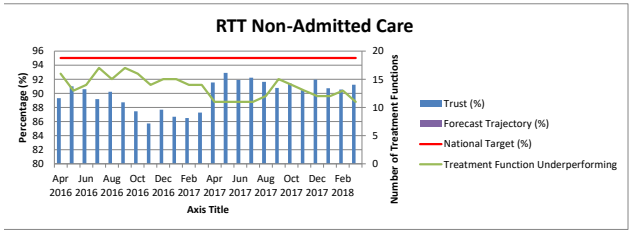
Referral To Treatment

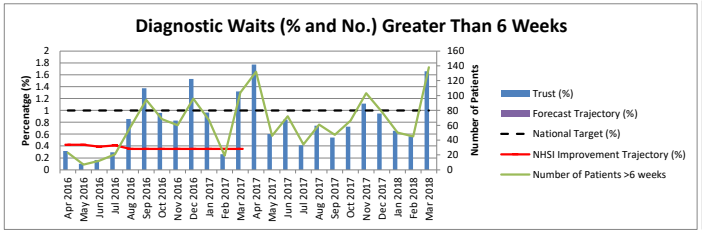
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
2			RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Mar 2018	91.3	70.4	89.2			88.9		77.31		
2			RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Mar 2018	80.0	91.3	96.8			85.8		91.21		
2			RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Mar 2018	89.9	90.7	93.7			94.9		92.01		
			RTT - Backlog	No			3728	3417	3908	3204	2578	2214	2327	2024	2188	2115	2304	2571	2451	2322	2410	2337	2356	2404	Mar 2018	509	1397	90			114		2404		
2			Patients Waiting >52 weeks	<= No	0	0	4	3	2	0	3	6	5	3	2	10	10	14	7	7	6	4	6	5	Mar 2018	0	4	1			0		5	87	
2			Patients Waiting >52 weeks (Incomplete)	<= No	0	0	2	2	2	1	3	2	3	3	0	8	4	7	3	3	3	1	3	2	Mar 2018	0	1	1			0		2	45	
2			Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	<= No	0	0	34	31	34	31	29	28	26	25	28	27	26	32	29	29	29	28	29	27	Mar 2018	6	15	1.0			3.0		27		
			Treatment Functions Underperforming (Incomplete)	<= No	0	0	6	6	8	5	4	5	5	4	5	5	4	5	4	5	5	4	4	4	Mar 2018	1	3	0			0		4		
2			Acute Diagnostic Waits in Excess of 6-weeks (End of Month Census)	<= %	1.0	1.0																			Mar 2018	0.5	2.7	0.0		1.8	0.0		1.66		
			Acute Diagnostic Waits in Excess of 6-weeks (In Month Waiters)	No			711	817	498	902	387	577	942	931	650	833	652	1336	914	1064	847	1672	531	373	Mar 2018	65	67	-		240	-		373		

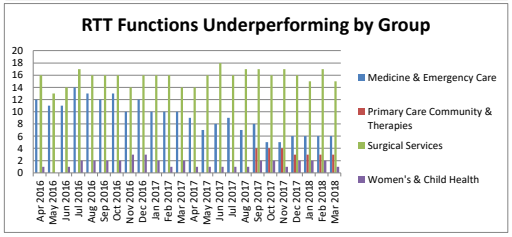


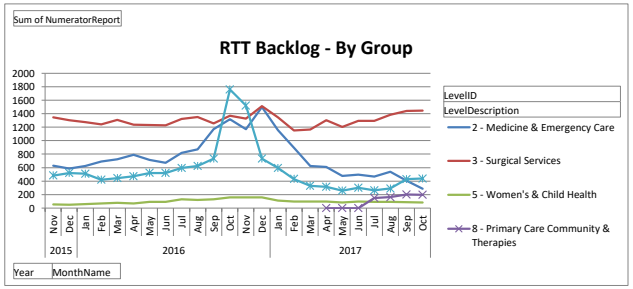


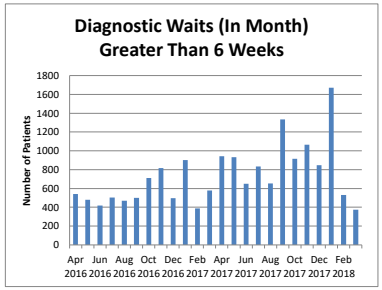


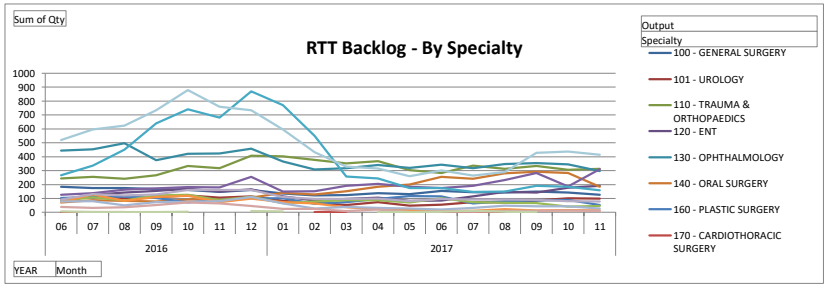






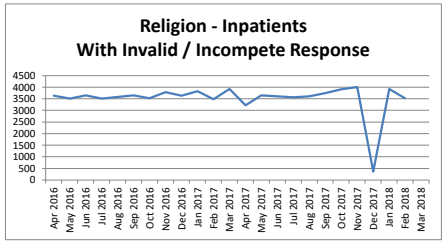


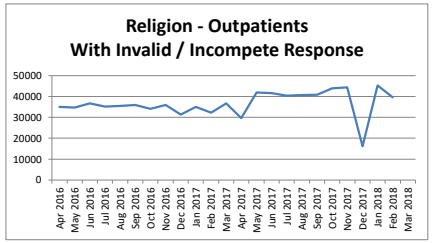


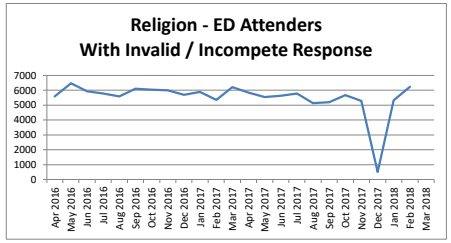


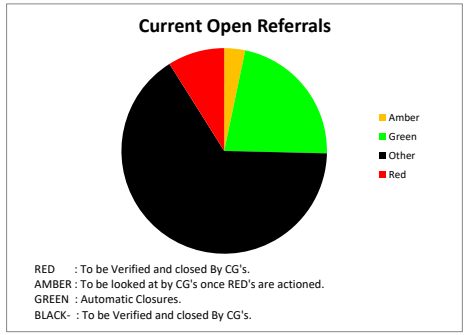
Data Completeness

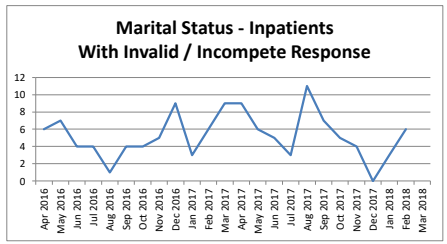
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
14			Data Completeness Community Services	=> %	50.0	50.0																			Mar 2018							61.2	61.2		
2			Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Feb 2018								99.4		
2			Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Feb 2018								99.1		
2			Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Feb 2018								99.3		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=> %	99.0	99.0	97.3	97.5	98.3	97.7	98.3	97.7	98.2	98.3	97.4	98.4	98.5	99.1	97.6	98.4	96.7	98.1	99.0	-	Feb 2018								99.0	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	99.6	99.6	99.5	99.5	99.4	99.5	99.4	99.5	99.5	99.6	99.6	99.6	99.5	99.6	99.6	-	Feb 2018								99.6	99.5	
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=> %	95.0	95.0	97.2	97.6	97.0	97.7	97.3	97.3	97.3	97.4	96.3	97.2	97.0	97.5	97.2	97.6	97.5	97.7	97.5	-	Feb 2018								97.5	97.3	
2			Ethnicity Coding - percentage of inpatients with recorded response	=> %	90.0	90.0																		-	Feb 2018								90.7	91.0	
			Ethnicity Coding - percentage of outpatients with recorded response	=> %	90.0	90.0																		-	Feb 2018								90.1	90.5	
			Protected Characteristic - Religion - INPATIENTS with recorded response	%			69.6	69.2	69.1	68.7	69.2	68.8	70.3	70.6	69.6	70.1	70.1	69.4	70.4	70.2	66.6	70.3	69.7	-	Feb 2018								69.7	70.1	
			Protected Characteristic - Religion - OUTPATIENTS with recorded response	%			58.1	57.5	56.9	57.0	57.2	56.9	56.7	52.9	53.2	53.1	53.5	54.5	53.8	53.5	63.7	52.8	52.7	-	Feb 2018								52.7	54.1	
			Protected Characteristic - Religion - ED patients with recorded response	%			64.3	64.1	64.7	64.1	64.7	64.2	64.7	67.2	65.3	66.2	66.7	67.0	66.1	67.3	65.2	67.2	67.2	-	Feb 2018								67.2	66.5	
			Protected Characteristic - Marital Status - INPATIENTS with recorded response	%			100.0	100.0	99.9	100.0	99.9	99.9	99.9	100.0	100.0	100.0	99.9	99.9	100.0	100.0	100.0	100.0	99.9	-	Feb 2018								99.9	100.0	
			Protected Characteristic - Marital Status - OUTPATIENTS with recorded response	%			40.4	39.9	35.8	40.8	41.3	41.5	41.3	41.1	41.9	41.4	41.0	40.9	40.4	39.8	41.4	39.4	39.0	-	Feb 2018								39.0	40.7	
			Protected Characteristic - Marital Status - ED patients with recorded response	%			40.9	41.5	40.8	40.5	41.3	41.1	39.8	42.7	42.0	42.2	40.2	40.6	40.7	41.6	38.6	40.1	39.6	-	Feb 2018								39.6	40.9	
2			Maternity - Percentage of invalid fields completed in SUS submission	<= %	15.0	15.0																		-	Feb 2018								6.8	6.8	
2			Open Referrals	No			219,866	222,444	225,175	226,846	230,675	235,998	239,934	245,160	250,072	254,761	258,800	262,603	270,519	274,113	277,674	281,624	285,192	289,164	Mar 2018	66,860	146,703	37,596	7,754	774	29,487		289,164		
			Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			87,537	92,360	95,712	99,043	102,885	108,584	111,242	115,133	118,367	123,475	126,271	129,941	134,026	138,043	141,009	144,564	149,221	152,201	Mar 2018	40,207	73,079	22,234	3,878	679	11,428		152201		

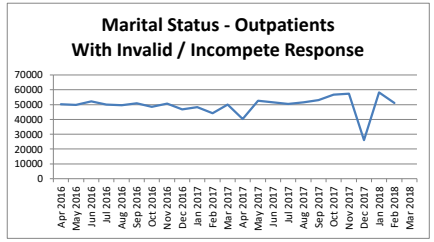


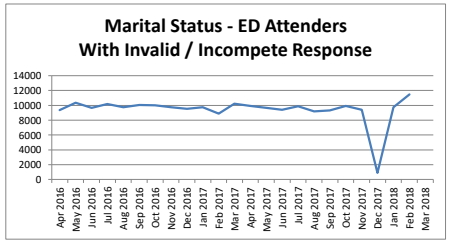






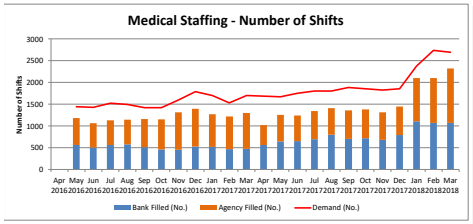


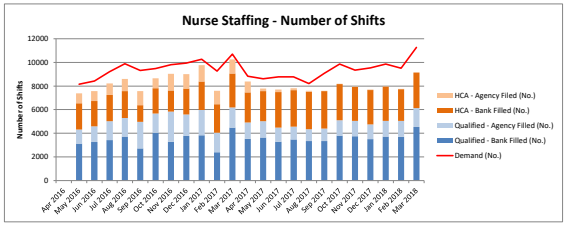




Temporary Workforce

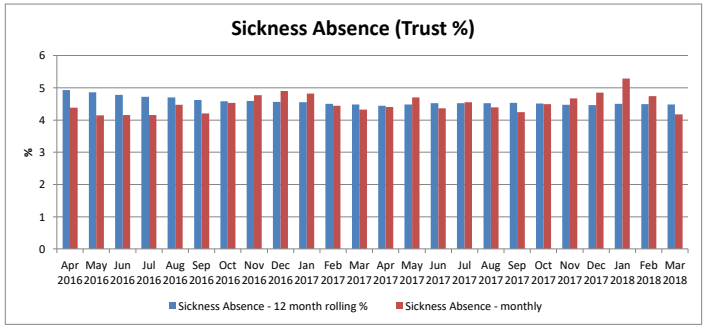
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
			Medical Staffing - Demand	No			1419	1596	1786	1699	1534	1703	1682	1669	1753	1805	1804	1887	1858	1823	1854	2381	2740	2696	Mar 2018	1910	563	181	0	30	12	0	2696	23952.0	
			Medical Staffing - Total Filled	%			81.25	82.46	77.94	74.93	79.4	76.1	60.4	75.07	70.62	74.52	78.27	71.86	74.33	71.91	78.05	88.37	76.79	86.09	Mar 2018	83.25	93.78	88.95	0	100	100	0	86	76.4	
			Medical Staffing - Bank Filled	%			40.07	34.42	37.79	40.93	44.12	36.65	55.51	51.48	52.58	51.75	56.52	51.77	52.06	52.02	54.66	52.52	50.76	46.19	Mar 2018	42.33	55.68	54.04	0	26.67	83.33	0	46	51.9	
			Medical Staffing - Agency Filled	%			59.93	65.58	62.21	59.07	71.44	63.35	44.49	48.52	47.42	48.25	43.48	48.23	47.94	47.98	45.34	47.48	49.24	53.81	Mar 2018	57.67	44.32	45.96	0	73.33	16.67	0	54	48.1	
			Medical Staffing - Filled Shifts - Snr Consultant	No			243	237	187	152	217	270	120	214	219	258	320	312	329	324	334	311	181	352	Mar 2018	227	88	5	0	30	2	0	352	3274.0	
			Medical Staffing - Filled Shifts - Jnr Doctor	No			951	1108	1196	1144	1001	1026	896	394	1019	1087	1092	1074	1052	987	1113	1793	855	1969	Mar 2018	1363	440	156	0	0	10	0	1969	13331.0	
			Nursing - Demand	No			9476	9802	9935	10261	9268	10708	8825	8616	8784	8760	8197	9080	9849	9335	9535	9866	9500	11272	Mar 2018	5323	2684	1609	18	112	1408	118	11272	111619	
			Nursing - Total Filled	%			91.18	92.03	90.68	92.75	95.55	95.8	95.29	90.22	87.78	89.1	92.59	83.87	83.29	85.1	80.62	80.64	81.48	81.2	Mar 2018	78.96	86.55	72.41	94.44	100	86.22	96.61	81	85.6	
			Nursing - Qualified - Bank Filled	%			46.77	36.3	41.77	40.3	27.07	43.52	42.07	46.67	42.61	44.43	44.12	43.91	46.36	47.21	45.52	46.72	47.66	49.7	Mar 2018	45.49	44.77	63.18	82.35	19.64	63.26	43.86	50	45.6	
			Nursing - Qualified - Agency Filled	%			18.76	28.38	20.17	22.55	18.71	16.76	16.32	17.77	15.48	13.94	13.03	13.92	15.87	16.39	16.29	16.67	17.59	17.5	Mar 2018	21.51	21.22	3.52	0	58.93	7.66	0	17	15.9	
			Nursing - HCA - Bank Filled	%			25.02	19.83	24.59	25.29	27.18	28.13	30.44	33.05	39.06	39.63	41.94	41.6	37.36	36.03	38.01	36.44	34.72	32.9	Mar 2018	33	34.01	33.3	17.65	21.43	29.08	56.14	33	36.7	
			Nursing - HCA - Agency Filled	%			9.444	15.49	13.48	14.48	12.91	11.59	10.74	2.509	2.84	1.999	0.909	0.46	0.402	0.378	0.182	0.176	0.026	0.0	Mar 2018	0	0	0	0	0	0	0	0	1.8	
			AHPs - Radiography - Demand (Shifts)	No			332	321	290	526	332	525	332	372	315	334	335	231	235	198	176	309	349	305	Mar 2018	0	0	0	0	305	0	0	305	3491	
			AHPs - Radiography - Filled (Shifts)	No			324	299	256	496	302	502	329	359	315	290	323	230	232	190	170	253	232	157	Mar 2018	0	0	0	0	157	0	0	157	3080	
			AHPs - Physiotherapy - Demand (Shifts)	No			38	190	186	276	478	356	180	242	257	104	99	100	108	88	75	33	113	35	Mar 2018	0	0	0	0	0	35	0	35	1434	
			AHPs - Physiotherapy - Filled (Shifts)	No			38	190	186	274	478	346	180	242	257	104	99	98	107	87	74	33	113	35	Mar 2018	0	0	0	0	0	35	0	35	1429	
			AHPs - Other - Demand (Shifts)	No			139	96	567	413	530	1009	459	527	471	511	536	482	532	460	451	519	385	500	Mar 2018	148	16	7	10	76	176	67	500	5833	
			AHPs - Other - Filled (Shifts)	No			95	200	567	412	527	885	457	527	471	508	534	476	520	445	440	502	371	497	Mar 2018	148	16	7	10	74	176	66	497	5748	
			Admin - Demand (Shifts)	No			2839	2479	2442	2381	4128	5135	4198	4228	4423	4054	4429	4091	4015	3928	3535	3778	3493	3607	Mar 2018	697	410	127	273	66	311	1723	3607	47779	
			Admin - Filled (Shifts)	No			2589	2452	2405	2348	4026	5079	4162	4184	4423	4031	4412	4025	3951	3838	3412	3707	3412	3496	Mar 2018	683	389	125	273	63	294	1669	3496	47053	
			Facilities - Demand (Shifts)	No			2185	1997	2172	2066	1971	2485	1795	2031	2101	1996	2182	2025	2059	2122	2008	2111	2226	2410	Mar 2018	10	49	1	0	14	4	2332	2410	25066	
			Facilities - Filled (Shifts)	No			2135	1969	2107	1992	1926	2425	1737	1999	2101	1966	2165	2006	2019	2098	1951	2054	2170	2384	Mar 2018	8	47	1	0	14	1	2313	2384	24650	
			Interpreters - Demand (Shifts)	No			5026	5508	4803	5159	4983	5634	4511	5139	5291	5101	4905	5116	5343	5699	4595	5354	4862	5079	Mar 2018	-	-	-	-	-	-	-	5079	60995.0	
			Interpreters - Total Filled	%			99.58	99.46	99.46	99.5	99.64	99.57	99.89	99.71	99.7	99.76	99.9	99.77	99.57	99.74	99.65	99.87	99.55	99.86	Mar 2018	-	-	-	-	-	-	-	100	99.8	
			Interpreters - Bank Filled	%			78.62	77.58	76.93	78.38	79.52	78.02	77.34	78.45	77.67	76.99	76.96	78.29	77.86	78.66	77.81	78.89	77.77	79.6	Mar 2018	-	-	-	-	-	-	-	80	78.0	
			Interpreters - Agency Filled	%			21.4	22.4	23.1	21.6	20.5	22.0	22.7	21.5	22.3	23.0	23.0	21.7	22.1	21.3	22.2	21.1	22.2	20.4	Mar 2018	-	-	-	-	-	-	-	20	22.0	
			Interpreters - Unfilled	%			0.4	0.5	0.5	0.5	0.4	0.4	0.1	0.3	0.3	0.2	0.1	0.2	0.4	0.3	0.3	0.1	0.5	0.1	Mar 2018	-	-	-	-	-	-	-	0	0.3	





Workforce

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
3			PDRs - 12 month rolling	=> %	95.0	95.0																			Mar 2018	56.4	65.1	75.9	86.8	57.3	76.9	69.2		81.9	
7			Medical Appraisal	=> %	95.0	95.0																			Mar 2018	73.6	79.8	82.7	85.7	86.7	122.7	100.0	82.2	81.4	
3			Sickness Absence (Rolling 12 Months)	<= %	2.50	2.50																			Mar 2018	4.8	4.7	4.4	3.7	3.8	4.1	4.6	4.48	4.5	
3			Sickness Absence (Monthly)	<= %	2.50	2.50																			Mar 2018	4.4	4.8	4.1	2.4	4.8	4.0	3.9	4.17	4.6	
3			Sickness Absence - Long Term (Monthly)	No			245	247	246	253	205	213	214	241	218	225	232	216	251	246	247	267	230	226	Mar 2018	40	48	35	6	11	32	2	226	2813	
3			Sickness Absence - Short Term (Monthly)	No			837	922	911	956	808	785	414	445	444	612	664	706	889	962	963	1021	932	818	Mar 2018	212	131	106	41	41	103	12	818	8870	
3			Return to Work Interviews following Sickness Absence (Cumulative)	=> %	100.0	100.0																			Mar 2018	67.5	91.8	81.9	89.6	84.2	85.9	82.1	81.5	79.7	
			Return to Work Interviews following Sickness Absence (In Month)	=> %	100.0	100.0	NEW INDICATOR REPORTING FROM Jan18																		Mar 2018	74.0	87.5	83.5	85.3	86.5	90.2	81.2	82.1	81.9	
3			Mandatory Training	=> %	95.0	95.0																			Mar 2018	86.6	90.6	90.7	95.1	91.3	95.5	94.4	91.5		
3			Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-		
3			Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0																			Mar 2018	90.8	0.0	93.5	98.2	93.5	0.0	98.6	94.98		
7			Employee Turnover (rolling 12 months)	<= %	10.0	10.0																			Mar 2018								14.2	12.8	
			Nursing Turnover	<= %	10.7	10.7	12.4	11.7	11.4	11.6	11.2	11.7	11.7	11.7	12.0	12.6	12.7	12.8	12.9	12.6	12.9	13.3	13.4	13.5	Mar 2018								13.5	12.7	
7			New Investigations in Month	No			3	0	3	4	3	9	14	1	3	4	4	2	7	4	5	4	3	4	Mar 2018	0	1	0	0	0	1	2	4		
7			Vacancy Time to Fill	Weeks			25	21	21	21	22	21	20	21	23	25	20	21	21	21	23	25	23	23	Mar 2018								23		
7			Professional Registration Lapses	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	0	0	0	0	0	
7			Qualified Nursing Variance (FIMS) (FTE)	No			313	293	305	268	246	257	256	276	281	289	287	269	252	244	265	248	243	261	Mar 2018								261		
15			Your Voice - Response Rate	No			-->	-->	-->	16.0	-->	-->	-->	-->	-->	18.8	-->	-->	-->	-->	-->	-->	-->	-->	Jul 2017	11.8	15.3	15.9	23.7	23.8	29	21.2	18.8		
15			Your Voice - Overall Score	No			-->	-->	-->	3.70	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.68	3.79	3.66	3.82	3.58	3.83	3.64	3.7		



Local Quality Indicators - 2017/2018

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Oct 2016) O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Comments	Month	Year To Date	Trend
			Safeguarding Adults Advanced Training	=> %	85	85	80	81	81	80	79	81	81	81	79	83	86	85	85	86	88	89	89	90	Mar 2018	Fully Recovered to Standard	89.668	85.33	
			Safeguarding Adults Basic Training	=> %	85	85	98	98	98	96	98	98	98	96	97	96	98	97	97	97	97	97	98	99	Mar 2018	Fully Recovered to Standard	98.67	97	
			Safeguarding Children Level 1 Training	=> %	85	85	98	98	98	97	98	98	98	97	98	96	98	98	98	98	98	98	98	99	Mar 2018	Fully Recovered to Standard	99.1	97.9	
			Safeguarding Children Level 2 Training	=> %	85	85	71	73	75	76	77	77	78	79	78	78	83	86	86	87	88	88	88	89	Mar 2018	Fully Recovered to Standard	89.5	84.1	
			Safeguarding Children Level 3 Training	=> %	85	85	73	75	78	78	81	84	85	88	89	88	87	85	85	90	90	90	90	91	Mar 2018	Fully Recovered to Standard	91.3	88.0	
			WHO Safer Surgery - Audit - brief and debrief (% lists where complete) - SQPR	=> %	100	100	98	97	95	97	99	99	98	98	98	99	99	99	99	98	100	99	99	99	Mar 2018	Progressed as Persistent Red Action Plan	99.4	98.7	
			Morning Discharges (00:00 to 12:00) - SQPR	=> %	35	35	16	17	17	20	17	16	16	15	17	17	15	16	15	15	18	17	17	16	Mar 2018	Progressed as Patient Journey Action Plan	16.3	16.1	
			ED Diagnosis Coding (Mental Health CQUIN) - SQPR	=> %	85	85	85	86	86	86	86	87	86	86	85	84	84	84	84	85	85	83	0	0	Mar 2018		0.0	69.1	
			CO Level >4ppm Referred For Smoking Cessation - SQPR	=> %	90	90	83	92	80	78	93	87	80	86	76	82	82	85	79	80	100	100	100	100	Mar 2018	Fully Recovered to Standard	100.0	86.8	
			BMI recorded by 12+6 weeks of pregnancy - SQPR	=> %	90	90	86	82	81	84	81	77	78	80	79	88	92	94	93	96	97	97	98	94	Mar 2018	Fully Recovered to Standard	94.3	90.2	
			CO Monitoring by 12+6 weeks of pregnancy - SQPR	=> %	90	90	76	76	75	73	78	79	76	75	75	74	71	74	80	76	79	76	77	76	Mar 2018	Recovery Action Plan progressing	76.5	75.6	
			Community Gynae - Referral to first outpatient appointment Within 4 weeks of referral	=> %	90	90	25	8	11	33	66	83	93	95	92	67	38	13	20	65	-	-	-	-	Nov 2017	Investigating ; likely to be impacted by routine patients (>4wks) being mixed in clinics to maximise capacity	65.5	65.0	
			Community Gynae - New to follow-up Ratio Less than 1 to 2	=> %	95	95	95	96	96	95	96	92	97	98	97	94	94	97	86	89	-	-	-	-	Nov 2017	Investigating ; likely to be impacted by routine patients (>4wks) being mixed in clinics to maximise capacity	89.2	94.6	
			Community Gynae - Onward Referral Rate	<= %	10	10	3	12	7	6	7	4	2	4	5	7	5	1	2	5	-	-	-	-	Nov 2017	Fully Recovered to Standard	5.2	4.2	
			Community Nursing - Falls Assessment For Appropriate Patients on home visiting caseload	=> %	100	100	42	77	69	60	62	58	69	-	57	58	57	54	55	52	60	67	78	91	Mar 2018	Recovery Action Plan progressing	90.6	61.6	
			Community Nursing - Pressure Ulcer Risk Assessment For New community patients at intial assessment	=> %	95	95	47	80	71	63	65	63	77	-	63	65	66	62	63	63	70	78	81	92	Mar 2018	Recovery Action Plan progressing	92.2	69.5	

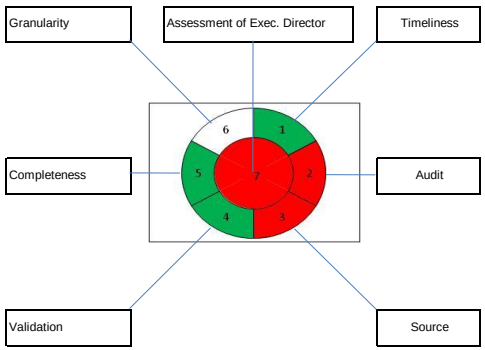
Legend

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
PCCT	Primary Care, Community & Therapies
CO	Corporate

Data Quality - Kitemark



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

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

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

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

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M		EC	AC	SC			
Patient Safety - Inf Control	C. Difficile	<= No	30	3																			Mar 2018	3	0	0	3	21	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Mar 2018	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective (%)	=> %	80	80																			Mar 2018	67	87	18	65.4		
Patient Safety - Inf Control	MRSA Screening - Non Elective (%)	=> %	80	80																			Mar 2018	89	92	80	88.9		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	19	20	14	14	16	9	7	5	12	13	9	19	15	9	19	16	20	Mar 2018	5	15	0	20	153	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	19	20	12	14	16	9	7	5	12	13	9	19	15	9	19	16	20	Mar 2018	5	15	0	20	153	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	4	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	1	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	3	14	12	8	8	11	6	6	4	8	3	2	1	3	2	1	6	Mar 2018	0	6	0	6	53	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	5	6	2	11	5	1	6	3	1	3	5	6	3	2	2	4	2	Mar 2018	0	2	0	2	38	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	1	0	1	1	0	0	0	2	1	2	0	0	1	1	1	0	0	Mar 2018	0	0	0	0	8	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	5	2	1	0	0	1	1	1	5	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	-	
Patient Safety - Harm Free Care	Falls	<= No	0	0	34	41	47	50	38	34	36	39	34	34	28	31	48	22	23	35	35	45	Mar 2018	5	40	0	45	410	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	2	3	3	1	2	1	1	0	0	1	1	3	0	0	0	0	0	Mar 2018	0	0	0	0	7	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	5	7	9	5	5	4	5	4	2	4	2	6	3	4	8	8	4	3	Mar 2018	1	2	0	3	53	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Mar 2018	87.5	85.7	95.4	88.8		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			Mar 2018	99.3	100.0	0.0	99.3		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Mar 2018	100	100	0	99.6		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Mar 2018	99	100	0	99.3		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Mar 2018	0	0	0	0	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	Mar 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Mar 2018	0	1	0	1	22	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98																	-	-	Jan 2018	41	49	39	44		

Medicine Group

Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			10.0	9.7	9.9	9.5	9.4	9.4	9.5	9.2	9.2	10.2	9.1	10.7	11.4	11.1	12.0	12.7	12.1	-	Feb 2018				**12.1**		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			10.0	9.3	9.4	9.4	9.4	9.4	9.4	9.3	9.3	9.4	9.4	9.6	9.7	9.8	10.0	10.2	10.4	-	Feb 2018					**9.7**	

Medicine Group

Section	Indicator		Trajectory Year	Trajectory Month	Previous Months Trend O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	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																		-	Feb 2018		89.6		89.6	92.7	
Clinical Effect - Stroke & Card	Pts admitted to Acute Stroke Unit within 4 hrs (%)	=> %	90.0	90.0																		-	Feb 2018		77.5		77.5	75.8	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																		-	Feb 2018		86.1		86.1	72.6	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.0																		-	Feb 2018		100.0		100.0	98.0	
Clinical Effect - Stroke & Card	Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																		-	Feb 2018		100.0		100.0	70.4	
Clinical Effect - Stroke & Card	Stroke Admissions - Swallowing assessments (<24h) (%)	=> %	98.0	98.0																			Mar 2018		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=> %	70.0	70.0																		-	Feb 2018		80.0		80.0	96.2	
Clinical Effect - Stroke & Card	TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=> %	75.0	75.0																		-	Feb 2018		87.9		87.9	96.4	
Clinical Effect - Stroke & Card	Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=> %	80.0	80.0																			Mar 2018		91.7		91.7	93.9	
Clinical Effect - Stroke & Card	Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			Mar 2018		94.7		94.7	95.9	
Clinical Effect - Stroke & Card	Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			Mar 2018		100.0		100.0	100.0	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Feb 2018			95.7	95.7		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Feb 2018			100.0	100.0		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Feb 2018			92.3	92.3		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			1	2.5	2	1.5	3	2.5	2	2	4.5	1	2.5	2	3.5	2.5	0.5	1.5	1	-	Feb 2018	-	-	1.00	1.00	23	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	0	1	1	1	1	1	0	1	0	0	0	2	2	0	0	1	-	Feb 2018	-	-	1.00	1.00	7	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			75	71	107	111	135	105	140	91	106	97	99	81	125	173	104	102	113	-	Feb 2018	-	-	113	113		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0.0	0.0	12	12	19	17	8	6	0	6	4	10	3	7	8	7	7	3	9	4	Mar 2018	-	-	4	4	68	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	6	30	2	0	4	21	7	0	0	3	61	46	129	0	0	0	0	Mar 2018	0	0	0	0	267	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			27	40	35	40	45	42	34	42	40	27	49	24	26	47	29	30	38	34	Mar 2018	13	20	1	34	420	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			56	63	62	66	61	75	79	79	91	83	82	74	59	75	67	73	78	76	Mar 2018	38	34	4	76		

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	
			Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M		EC	AC	SC			
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Mar 2018	-	4.38	-	0.91		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	1	0	0	0	2	0	0	0	0	0	0	0	Mar 2018	0.0	0.0	0.0	0	3	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	0	6	2	4	6	2	3	11	3	5	2	8	2	3	4	6	0	7	Mar 2018	0.0	7.0	0.0	7	54	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	57	44	29	51	37	41	28	35	63	31	62	41	#####	#####	#####	#####	#####	#####	Mar 2018	0.0	0.0	0.0	0.0		
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	Mar 2018	0.00	0.00	0.00	0.00	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95.0	95.0																			Mar 2018	75.4	81.9	Site S/C	78.8	82.4	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			1579	1750	1866	1776	1769	1721	1662	1742	1580	1483	1280	1257	1636	1714	2188	2257	0	2635	Mar 2018	2501	1	133	2635	19434	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0																			Mar 2018	0.0	0.0	Site S/C	0	1	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.0	15.0									-										Mar 2018	13.0	14.0	Site S/C	13	14	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60.0	60.0																			Mar 2018	72.0	60.0	Site S/C	65	61	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0														-					Mar 2018	4.9	5.5	Site S/C	5.2	8.0	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Mar 2018	4.9	5.6	Site S/C	5.2	5.7	
Emergency Care & Pt. Flow	WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	112	162	193	162	129	107	110	159	242	111	127	90	143	207	208	163	160	196	Mar 2018	144	52		196	1916	
Emergency Care & Pt. Flow	WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	16	21	19	11	13	5	0	12	6	1	0	1	4	6	11	5	4	21	Mar 2018	18	3		21	71	
Emergency Care & Pt. Flow	WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Mar 2018	0.82	0.13		0.47	0.14	
Emergency Care & Pt. Flow	WMAS - Emergency Conveyances (total)	No			4233	4261	4622	4410	4034	4206	4137	4376	4254	4429	4278	4174	4557	4424	4725	4561	4081	4487	Mar 2018	2203	2284		4487	52483	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			Mar 2018	0.0	92.5	88.9	91.3		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			Mar 2018	0.0	70.8	91.6	80.0		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			Mar 2018	0.0	86.2	96.8	89.9		
RTT	RTT - Backlog	<= No	0	0	1319	1168	1500	1154	897	622	610	479	497	467	538	407	288	398	504	480	497	509	Mar 2018	0	451	58	509		
RTT	Patients Waiting >52 weeks	<= No	0	0	1	2	1	0	0	1	1	2	1	7	4	1	0	0	0	0	1	0	Mar 2018	0	0	0	0		
RTT	Treatment Functions Underperforming	<= No	0	0	13	10	12	10	10	10	9	7	8	9	7	8	5	5	6	6	6	6	Mar 2018	0	4	2	6		

Medicine Group

RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Mar 2018	0	0.5	0.51	**0.50**	

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	
			Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M		EC	AC	SC			
Data Completeness	Open Referrals	No			74,142	75,046	75,926	75,925	76,880	78,278	78,984	79,971	81,548	83,160	84,417	85,453	62,769	63,236	64,194	65,058	65,868	66,860	Mar 2018	15,146	27,466	24,248	66860		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Req	No			27,787	30,150	31,585	32,319	33,572	35,739	36,247	36,822	37,760	39,488	40,216	40,844	35,242	36,135	37,044	37,620	39,394	40,207	Mar 2018	12,902	16,084	11,221	40207		
Workforce	WTE - Actual versus Plan	No			229	231	244	202	194	208	205	199	227	236	223	223	204	200	218	191	190	192	Mar 2018	101.8	85.69	0	192		
Workforce	PDRs - 12 month rolling (%)	=> %	95.0	95.0																			Mar 2018	49.16	61.19	0		74.1	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Mar 2018	59.46	83.33	0		77.2	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15																			Mar 2018	4.78	4.75	0.00	4.75	4.74	
Workforce	Sickness Absence - In month	<= No	3.15	3.15																			Mar 2018	4.34	4.38	0.00	4.35	5.13	
Workforce	Sickness Absence - Long Term - In month	No			45	40	39	39	33	40	53	59	48	45	54	49	51	49	63	64	46	40	Mar 2018	14	26	0	40	621	
Workforce	Sickness Absence - Short Term - In month	No			194	206	243	223	207	182	66	68	80	131	145	157	173	233	236	219	203	212	Mar 2018	94	118	0	212	1923	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100																			Mar 2018	59.0	73.8	0.0		68.75	
Workforce	Mandatory Training (%)	=> %	95.0	95.0																			Mar 2018	85.77	87.07	0		82.4	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	0	0	1	2	3	0	0	1	1	0	0	1	2	2	0	0	Mar 2018	0	0	0	0		
Workforce	Nurse Bank Fill Rate %	=> %	100	100	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016				85		
Workforce	Nurse Bank Shifts Not Filled (number)	<= No	0	0	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016				710		
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-	
Workforce	Your Voice - Response Rate (%)	No			-->	-->	-->	8	-->	-->	-->	-->	-->	11.8	-->	-->	-->	-->	-->	-->	-->	-->	Jul 2017	10.9	9.6	20.5	11.8		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	3.68	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.51	3.90	3.58	3.68		

Surgical Services Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate					Month	Year To Date	Trend
			Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M		GS	SS	TH	An	O			
Patient Safety - Inf Control	C. Difficile	<= No	7	1																			Mar 2018	0	0	0	0	0	0	6	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Mar 2018	0	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80	80																			Mar 2018	90.03	92.59	0	0	58.33	88.1		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80	80																			Mar 2018	90.91	94.76	0	86.67	91.67	92.1		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	4	0	0	0	2	1	3	0	12	7	6	15	12	9	7	9	4	Mar 2018	1	0	0	3	0	4	85	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	4	0	0	0	2	1	3	0	12	7	6	15	12	9	7	9	4	Mar 2018	1	0	0	3	0	4	85	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	0	0	0	0	0	1	4	0	3	1	2	1	1	0	0	0	0	Mar 2018	0	0	0	0	0	0	13	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	0	0	0	0	1	0	3	0	6	5	2	2	1	0	0	3	0	Mar 2018	0	0	0	0	0	0	22	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	0	0	0	0	0	1	0	0	0	0	0	0	1	0	1	0	0	Mar 2018	0	0	0	0	0	0	3	
Patient Safety - Harm Free Care	Falls	<= No	0	0	10	12	13	8	6	6	10	7	11	11	4	5	5	10	10	17	7	15	Mar 2018	7	3	3	1	1	15	112	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	Mar 2018	0	1	0	0	0	1	2	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	4	0	1	1	2	1	1	3	0	2	0	0	2	2	1	2	2	3	Mar 2018	1	2	0	0	0	3	18	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Mar 2018	97.22	95.56	0	98.44	97.62	97.2		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			Mar 2018	99.86	100	100	100	100	100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Mar 2018	0	0	100	0	100	100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Mar 2018	0	0	100	0	100	100.0		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	0	0	2	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Mar 2018	0	1	0	0	0	1	9	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98.0																	-	-	Jan 2018	29	100	0	0	0	44.4		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			6.0	5.1	5.9	6.0	6.3	5.7	6.2	6.5	6.3	7.3	6.9	6.0	6.0	5.4	6.1	6.1	7.1	-	Feb 2018						7.1		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.99	6.3	6.11	6	5.95	5.84	5.83	5.86	5.92	5.98	6.09	6.1	6.1	6.21	6.23	6.24	6.3	-	Feb 2018							6.1	

Surgical Services Group

Surgical Services Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate					Month	Year To Date	
			Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M		GS	SS	TH	An	O			
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Feb 2018	97.6	-	0.0	-	-	97.61		
Clinical Effect - Cancer	2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		-	Feb 2018	97.4	-	-	-	-	97.42		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Feb 2018	98.5	-	0.0	-	-	98.53		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Feb 2018	90.4	-	0.0	-	-	90.36		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			7	4	5	5	8	2	2	5	3	8	3	2	6	4	8	10	4	-	Feb 2018	-	-	-	-	-	4	52	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			2	2	2	0	2	1	1	1	0	2	2	0	2	0	3	3	1	-	Feb 2018	1	-	0	-	-	1	15	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			351	191	158	103	193	105	119	114	98	134	108	84	110	0	119	126	112	-	Feb 2018	112	-	0	-	-	112		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	-	0	-	-	0	0	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	1	0	8	0	0	0	0	0	0	0	39	6	0	2	0	0	0	0	Mar 2018	0	0	0	0	0	0	47	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			37	29	26	32	25	36	24	29	20	28	29	18	16	28	22	24	25	32	Mar 2018	11	6	2	1	12	32	295	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			51	39	45	62	63	66	78	61	51	57	50	38	40	36	47	47	52	50	Mar 2018	22	6	4	2	16	50		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Mar 2018	3.31	5.16	0	0.41	0.27	2.08		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	1	0	3	4	0	0	0	0	0	0	0	0	0	0	0	1	0	1	Mar 2018	0	1	0	0	0	1	2	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	29	57	31	35	49	45	32	49	38	41	28	37	35	35	24	20	29	41	Mar 2018	30	8	0	1	2	41	409	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	75.3	75.7	73	77.1	75.3	75.3	76.4	75.8	77.9	73.9	74.7	74.8	75.8	77.1	71.1	72.6	75	73.5	Mar 2018	73.6	70.5	0.0	96.8	71.7	73.52		
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	Mar 2018	0	0	0	0	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (%)	%	95.0	95.0	99.4	99.4	99.7	99.3	99.3	98.1	97.6	96.8	96.7	97.5	97.5	99.2	99.8	99.4	99.6	99.5	97.8	97.5	Mar 2018	-	-	-	-	97.54	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	<= No	0	0	92	76	109	70	68	112	137	109	93	106	69	73	84	80	89	66	0	179	Mar 2018	94	60	0	0	25	179	1085	
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	Mar 2018	-	-	-	-	0	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0	2.9	3.5	2.6	4.1	3.0	3.3	3.3	3.0	3.7	3.6	4.3	5.4	3.9	-	5.0	5.1	4.6	6.1	Mar 2018	-	-	-	-	6.05	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0	2.1	1.4	1.1	1.0	1.1	1.7	2.0	2.4	2.7	2.8	2.3	2.0	1.0	2.4	1.3	1.8	0.7	1.1	Mar 2018	-	-	-	-	1.07	-	-	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15	26	14	14	0	0	0	0	0	-	0	0	0	0	0	0	0	0	0	Mar 2018	-	-	-	-	25	0	0	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60	107	100	99	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2018	-	-	-	-	23	-	-	
Emergency Care & Pt. Flow	Hip Fractures BPT (Operation < 36 hours of admissions	=> %	85.0	85.0																			Mar 2018						85.2	69.4	

Surgical Services Group

Surgical Services Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate					Month	Year To Date	
			Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M		GS	SS	TH	An	O			
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																		Mar 2018	70.4	62.3	0.0	0.0	72.7	70.4		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																		Mar 2018	85.6	91.6	0.0	0.0	94.7	91.3		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																		Mar 2018	92.2	81.6	0.0	0.0	92.5	90.7		
RTT	RTT - Backlog	<= No	0	0	1369	1328	1514	1344	1153	1167	1304	1204	1293	1293	1385	1443	1447	1264	1271	1348	1370	1397	Mar 2018	538	421	0	0	438	1397		
RTT	Patients Waiting >52 weeks	<= No	0	0	2	0	1	0	2	2	4	1	1	1	5	9	4	7	5	2	0	4	Mar 2018	1	2	0	0	1	4		
RTT	Treatment Functions Underperforming	<= No	0	0	16	14	16	16	16	14	14	16	18	16	17	17	16	17	16	15	17	15	Mar 2018	8	5	0	0	2	15		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																		Mar 2018	2.7	0.0	0.0	0.0	0.0	2.7		
Data Completeness	Open Referrals	No			112,597	113,840	115,090	116,146	118,262	121,184	123,687	126,992	129,204	131,460	133,412	135,263	136,924	139,237	140,979	142,818	144,613	146,703	Mar 2018	50,318	16,213	0	5,861	74,311	146703		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requ	No			42,937	44,084	45,279	47,179	48,985	51,471	53,057	55,792	57,290	59,198	60,880	63,030	64,953	67,111	68,385	70,228	71,798	73,079	Mar 2018	27,792	8,543	0	3,920	32,824	73079		
Workforce	WTE - Actual versus Plan	No			146	140	151	185	157	166	168	172	176	196	181	180	172	169	158	150	155	161	Mar 2018	52.11	21.24	38.8	20.72	31.08	160.96		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																		Mar 2018	64.1	63.4	73.8	56.6	69.6		81.8	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																		Mar 2018	78.38	75.86	0	76.09	86.96		77.6	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15																		Mar 2018	4.5	5.9	6.4	4.5	2.2	4.7	4.7	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15																		Mar 2018	4.8	7.0	6.0	4.4	1.6	4.8	4.9	
Workforce	Sickness Absence - Long Term - In Month	No			52	50	53	52	33	32	30	41	38	51	50	47	49	47	34	47	42	48	Mar 2018	13.0	13.0	15.0	5.0	0.0	48.0	524.0	
Workforce	Sickness Absence - Short Term - In Month	No			181	173	181	166	149	138	61	50	55	96	96	119	159	170	172	151	160	131	Mar 2018	50.0	23.0	25.0	31.0	0.0	131.0	1420.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100																		Mar 2018	86.1	91.3	97.6	95.2	90.6	91.8	87.2	
Workforce	Mandatory Training	=> %	95.0	95.0																		Mar 2018	89.2	88.3	94.0	92.1	89.4		87.2	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-		-	
Workforce	New Investigations in Month	No			3	0	0	2	1	2	2	0	0	2	2	2	4	1	0	2	1	1	Mar 2018	1	0	0	0	0	1		
Workforce	Nurse Bank Fill Rate	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016						88.03	88	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016						238	238	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00						-	-	

Surgical Services Group

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

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M		G	M	P			
Patient Safety - Inf Control	C. Difficile	<= No	0	0																			Mar 2018	0	0	0	0	1	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Mar 2018	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.00	80.00																			Mar 2018	91.7			91.7		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80.00	80.00																			Mar 2018	0	100		100.0		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	1	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	1	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jan-00	0	0	0	0	0	
Patient Safety - Harm Free Care	Falls	<= No	0	0	3	1	1	2	1	1	0	3	1	0	0	0	1	1	0	0	0	0	Mar 2018	0	0	0	0	6	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	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	1	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	1	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Mar 2018	98.2	95.3		96.5		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			Mar 2018	99.4	100		99.7		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Mar 2018	96.3	100		96.6		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Mar 2018	96.3	100		96.6		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Mar 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Mar 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Mar 2018	0	2	0	2	8	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Directorate G	Directorate M	Directorate P	Month	Year To Date	
Patient Safety - Obstetrics	Caesarean Section Rate - Total	<= %	25.0	25.0																			Mar 2018		25.6		25.6	25.6	
Patient Safety - Obstetrics	Caesarean Section Rate - Elective	%			8	11	8	7	9	8	9	8	9	7	8	8	9	9	5	7	10	8	Mar 2018		7.58		7.6	8.0	
Patient Safety - Obstetrics	Caesarean Section Rate - Non Elective	%			23	17	20	15	17	17	17	15	17	18	15	19	21	18	21	15	19	18	Mar 2018		18		18.0	17.7	
Patient Safety - Obstetrics	Maternal Deaths	<= No	0	0																			Mar 2018		0		0	1	
Patient Safety - Obstetrics	Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Mar 2018		1		1	20	
Patient Safety - Obstetrics	Admissions to Neonatal Intensive Care	<= %	10.0	10.0																			Mar 2018		0.93		0.9	1.8	
Patient Safety - Obstetrics	Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Mar 2018		4.66		4.7		
Patient Safety - Obstetrics	Stillbirth (Corrected) Mortality Rate (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	1	1	2	1	1	2	Mar 2018		4.66		4.7		
Patient Safety - Obstetrics	Neonatal Death (Corrected) Mortality Rate (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	2	1	0	0	1	0	Mar 2018		0		0.0		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	85.0	85.0																			Mar 2018		92.2		92.2		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0																			Mar 2018		156		156.1		
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100.0	97.0						N/A	N/A	N/A			N/A	N/A					-	-	Jan 2018	100	0	0	100.0		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			5.4	5.9	5.0	4.0	5.4	4.7	4.6	4.5	4.8	4.3	3.7	4.3	4.3	5.5	4.8	5.0	4.4	-	Feb 2018				4.4		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			5.4	5.0	5.0	5.0	4.9	4.8	4.8	4.7	4.7	4.7	4.7	4.7	4.6	4.6	4.6	4.7	4.6	-	Feb 2018					4.7	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0		#DIV/0!																-	Feb 2018	99.4		100	99.4		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Feb 2018	88.9			88.9		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Feb 2018	65			65.0		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			1.5	4	3	2	4.5	3.5	4.5	3	2	2	5.5	5.5	1.5	6	1	1.5	3.5	-	Feb 2018	3.5	-	0	3.5	36	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	0	0	0.5	1.5	3.5	3	1	0	0	3	1	0	0	0	0	0	-	Feb 2018	0	-	0	0	8	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			76	98	98	120	150	162	126	139	95	102	184	141	90	0	86	74	99	-	Feb 2018	99	-	0	99		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	-	0	0	0	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	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	Mar 2018	0			0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			12	9	12	14	14	12	13	8	12	6	12	8	8	7	4	19	7	16	Mar 2018	5	8	3	16	120	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			23	16	21	24	24	22	19	12	15	14	14	17	15	13	19	29	23	27	Mar 2018	0	0	0	27		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Mar 2018	2.69		-	2.0		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0			0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	12	6	10	6	12	10	12	5	17	4	8	3	10	8	14	11	8	5	Mar 2018	5			5	105	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	79	79	71	80	83	81	83	82	82	80	79	77	73	79	75	73	80	70	Mar 2018	70.3	-		70.3		
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	Mar 2018	0	-	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			18	38	38	20	23	15	9	10	7	11	4	13	15	32	27	21	0	11	Mar 2018	10	0	1	11	160	
RTT	RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Mar 2018	89.2			89.2		
RTT	RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Mar 2018	96.8			96.8		
RTT	RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Mar 2018	93.7			93.7		
RTT	RTT - Backlog	<= No	0	0	161	161	160	111	96	96	98	81	97	91	91	90	81	77	56	47	50	90	Mar 2018	90			90		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	2	5	1	Mar 2018	1			1		
RTT	Treatment Functions Underperforming	<= No	0	0	2	3	3	2	1	2	1	1	1	1	1	2	2	1	2	2	2	1	Mar 2018	1			1		
RTT	Acute Diagnostic Waits in Excess of 6-weeks	<= %	0.1	0.1																			Mar 2018	0			0.0		

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Directorate G	M	P	Month	Year To Date	
Data Completeness	Open Referrals	No			26,671	27,018	27,523	27,970	28,605	29,483	30,091	30,838	31,759	32,486	33,158	33,869	34,430	34,844	35,501	36,199	36,730	37,586	Mar 2018	9,416	18,815	9,355	37586		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			11,421	12,342	12,816	13,222	13,822	14,698	15,253	15,849	16,571	17,454	17,950	18,689	19,315	19,739	20,322	20,867	21,365	22,234	Mar 2018	5,804	13,001	3,429	22234		
Workforce	WTE - Actual versus Plan	No			107	109	126	119	111	116	119	124	116	117	108	96.9	92	94.5	105	120	120	132	Mar 2018	20.9	70.6	40.3	132.3		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Mar 2018	69.7	72.6	81.2		82.9	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Mar 2018	85.2	87.5	76.5		83.7	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Mar 2018	3.32	5.06	3.92	4.4	4.4	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Mar 2018	1.55	3.82	5.22	4.1	4.5	
Workforce	Sickness Absence - Long Term - in month	No			43	43	30	30	23	29	27	36	28	31	30	29	34	30	30	38	35	35	Mar 2018	1	21	13	35.0	383.0	
Workforce	Sickness Absence - Short Term - in month	No			113	125	114	142	83	105	50	41	40	88	89	91	128	135	131	137	127	106	Mar 2018	10	61	35	106.0	1163.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Mar 2018	86	80.9	82.2	81.87	83.36	
Workforce	Mandatory Training	=> %	95.0	95.0																			Mar 2018	88.1	91.3	0		88.1	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	0	0	0	1	3	1	0	0	0	0	1	1	1	0	0	0	Mar 2018	0	0	0	0		
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016				98	98	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016				40	40	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	0	0																										
Workforce	Your Voice - Response Rate	No			-->	-->	-->	13	-->	-->	-->	-->	-->	16	-->	-->	-->	-->	-->	-->	-->	-->	Jul 2017	14.1	12.6	24.8	16		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	3.66	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.54	3.72	3.6	3.7		

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M		G	M	P			
WCH Group Only	HV (C1) - No. of mothers who receive a face to face AN contact with a HV at =>28 weeks of pregancy	No			119	131	109	126	-	-	157	250	268	-	-	-	-	-	-	-	-	-	Jun 2017		-		268	675	
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	85.3	84.6	95.7	90.5	88.3	-	83.9	80.8	87.2	88	87	81.6	92.5	88.9	90.7	88.9	81	-	Feb 2018		-		81	86.48	
WCH Group Only	HV (C3) - % of births that receive a face to face new birth visit by a HV >days	%			7.71	1117	3.23	7.22	9.56	4.81	13.5	16.9	9.89	10.5	9	11.4	7.99	6.48	7.91	6.5	9.35	-	Feb 2018		-		9.35	9.99	
WCH Group Only	HV (C4) - % of children who received a 12 months review by 12 months	=> %	95.0	95.0	90.1	93.9	94.6	95.6	97.2	96.2	89.6	92.2	94.6	93.8	89.8	91.7	95.9	95.1	93.7	93.2	93.6	-	Feb 2018		-		93.65	93	
WCH Group Only	HV (C5) - % of children who received a 12 months review by the time they were 15 months	%			98.8	98.4	98.5	99.3	1.29	95.8	92.1	89.2	88.7	80.3	97.8	89.1	0	96.7	97.2	97.1	97.3	-	Feb 2018		-		97.3	85.01	
WCH Group Only	HV (C6i) - % of children who received a 2 - 2.5 year review	=> %	95.0	95.0	91.5	95.4	94.1	93	92.1	90.1	86.1	80.5	88	86.8	81.3	89.2	92.7	93.8	93.1	93.4	92.8	-	Feb 2018		-		92.79	89.01	
WCH Group Only	HV (C6ii) - % of children who receive a 2 - 2.5 year review using ASQ 3	%			92.8	89.4	89.2	89.7	82.5	84.2	84.6	78.2	84.5	84.2	80.2	85.5	87.1	81	91.7	92.4	92	-	Feb 2018		-		92.04	85.77	
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	-	-	-	-	-	-	Sep 2017		-		1	1	
WCH Group Only	HV (C8) - % of children who receive a 6 - 8 week review	=> %	95.0	95.0	95	95.9	93.9	96.9	-	95.5	100	98.8	98.7	99.7	100	98.6	99.7	98.9	99.3	99	97.6	-	Feb 2018		-		97.55	99.12	
WCH Group Only	HV - % of infants for whom breast feeding status is recorded at 6 - 8 week check	=> %	100	100	94	93.6	87.9	98.6	-	86.1	99.4	100	98.7	99.1	98.8	99.3	99.2	97	98	97.3	98.3	-	Feb 2018		-		98.25	98.63	
WCH Group Only	HV - % of infants being breastfed at 6 - 8 weeks	%			40.7	37.6	43.5	43.5	-	42.2	37.6	43.5	37.8	42.9	35.6	42.2	37.9	23.3	18.4	20.1	38.5	-	Feb 2018		-		38.46	34.32	
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	-	-	-	-	-	-	-	-	-	-	-	-	-	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			313	132	306	377	-	357	365	390	361	401	403	329	386	388	343	342	290	-	Feb 2018		-		290	3998	
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	92.4	91.3	93.5	97.2	-	91.3	-	-	-	97.4	-	-	-	-	-	-	-	-	Jul 2017		97.5		97.45	97.45	
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			347	330	310	342	-	322	205	197	212	210	326	263	223	246	209	290	94	-	Feb 2018		-		94	2475	
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	89.4	86.6	86.5	88.6	-	97.9	-	-	-	98.4	-	-	-	-	-	-	-	-	Jul 2017		98.4		98.41	98.41	
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			347	339	323	343	-	-	26	20	19	28	317	24	21	27	20	26	305	-	Feb 2018		-		305	833	
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	83.6	86.7	82.4	89.8	-	-	-	-	-	97.8	-	-	-	-	-	-	-	-	Jul 2017		97.8		97.77	97.77	

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			41	34	31	63	-	-	125	171	151	134	193	125	135	141	102	174	64	-	Feb 2018		-		64	1515	
WCH Group Only	HV - all untested babies <1 year of age will be offered NBBS screening & results to HV.	Y/N			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00						

Pathology Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Directorate HA	HI	B	M	I	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Mar 2018	0	0	0	0	0	0	0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Feb 2018	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Feb 2018	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Feb 2018	-	-	-	-	-	-		
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			2	3	2	4	1	2	1	1	1	0	1	0	3	1	3	2	1	1	Mar 2018	1	0	0	0	0	1	15	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			3	3	1	3	4	4	3	2	2	3	3	3	4	2	3	4	2	3	Mar 2018	3	0	0	0	0	3		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2018	-	-	-	-	-	-	-	
Data Completeness	Open Referrals	No			5,995	6,051	6,140	6,284	6,387	6,495	6,601	6,770	6,960	7,039	7,180	7,354	7,427	7,455	7,473	7,588	7,676	7,754	Mar 2018	2,339	0	2,673	0	2,742	7,754		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			2,407	2,444	2,478	2,613	2,685	2,791	2,845	2,956	3,034	3,321	3,246	3,387	3,495	3,631	3,725	3,752	3,953	3,878	Mar 2018	1,309	0	1,343	0	1,226	3,878		
Workforce	WTE - Actual versus Plan	No			40	37	31	34.7	30.3	23.7	18.7	28.1	27.9	30.2	30.1	38.5	41.1	45.5	44.1	40	41.2	40.1	Mar 2018	10	2.9	9.9	8.2	2.4	40		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Mar 2018	73	92	85	86	100		86.4	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Mar 2018	60	88	100	100	100		77.62	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Mar 2018	3.3	1.5	4.5	3.8	2.2	3.66	3.61	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Mar 2018	1.9	1.3	3.7	1.7	3.7	2.44	3.61	
Workforce	Sickness Absence - Long Term - In Month	No			12	14	6	5	6	8	6	6	6	8	5	3	9	5	10	12	12	6	Mar 2018	0.0	1.0	3.0	1.0	0.0	6	88	
Workforce	Sickness Absence - Short Term - In Month	No			43	49	41	36	35	45	30	30	39	40	51	49	50	48	45	50	40	41	Mar 2018	9.0	1.0	15.0	7.0	9.0	41	513	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Mar 2018	91	100	85	96	96	89.6	86.9	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Mar 2018	96	95	92	96	97		91.6	
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	Mar 2018	0	0	0	0	0	0		
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016						265	265	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016						0	0	
Workforce	Your Voice - Response Rate	No			-->	-->	-->	22	-->	-->	-->	-->	-->	23.7	-->	-->	-->	-->	-->	-->	-->	-->	Jul 2017	15	31	20	36	33	24		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	3.82	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.5	3.3	3.9	4	3.9	3.82		

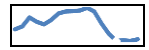
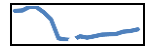
Imaging Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend
			Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M		DR	IR	NM	BS			
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Mar 2018	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Mar 2018	0	0	0	0	0	0	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	<= No	0	0	-	2.0	2.0	1.0	-	1.0	1.0	2.0	2.0	2.0	4.0	2.0	2.0	1.0	1.0	1.0	1.0	-	Feb 2018					4.2		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	=> %	0	0	13.0	15.0	17.0	17.0	15.0	16.0	15.0	16.0	16.0	17.0	18.0	19.0	21.0	20.0	19.0	19.0	20.0	-	Feb 2018						5.2	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																		-	Feb 2018			86.1		86.05	72.58	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.00																		-	Feb 2018			100		100	98.03	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Feb 2018	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Feb 2018	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Feb 2018	-	-	-	-	-		
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	Mar 2018	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			1	4	5	4	1	1	4	2	2	3	1	3	2	1	1	4	2	1	Mar 2018	1	0	0	0	1	26	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			1	4	9	3	2	2	1	3	4	5	2	4	3	3	1	4	4	2	Mar 2018	1	1	0	0	2		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2018	-	-	-	-	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			55	60	55	66	54	100	102	128	94	106	100	97	122	111	140	84	0	85	Mar 2018	85	0	0	0	85	1169	
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Mar 2018	1.81				1.81		
Data Completeness	Open Referrals	No			399	428	438	461	481	498	512	532	545	560	577	608	623	666	707	736	749	774	Mar 2018	774	0	0	0	774		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			346	373	386	403	421	438	454	474	482	506	531	553	570	596	621	645	659	679	Mar 2018	679	0	0	0	679		
Workforce	WTE - Actual versus Plan	No			41	40	38	32	31	32	35	39	36	35	30	25	20	24	28	24	32	30	Mar 2018	17	2.1	3.6	1.8	29.5		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Mar 2018	54	90.9	73.1	69.5		79.2	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Mar 2018	85.7	0	100	0		88.0	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Mar 2018	2.7	10.8	2.0	3.0	3.77	4.13	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Mar 2018	3.6	9.7	2.4	2.7	4.75	4.09	
Workforce	Sickness Absence - Long Term - in month	No			7	13	10	15	13	9	6	10	7	7	4	6	8	6	4	6	8	11	Mar 2018	5.0	1.0	0.0	0.0	11.00	83.00	
Workforce	Sickness Absence - Short Term - in month	No			29	41	40	53	36	32	29	22	24	22	22	34	31	39	36	41	38	41	Mar 2018	19.0	1.0	5.0	8.0	41.00	379.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Mar 2018	90.3	0	66.7	86.3	84.2	75.3	
Workforce	Mandatory Training	=> %	95.0	95.0																			Mar 2018	88.1	93.3	93.7	96		87.6	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	Mar 2018					0		
Workforce	Your Voice - Response Rate	No			-->	-->	-->	20	-->	-->	-->	-->	-->	24	-->	-->	-->	-->	-->	-->	-->	-->	Jul 2017	20	10	52	23	23.8		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	3.58	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.4	0	4.1	4.2	3.58		
Imaging Group Only	Unreported Tests / Scans	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								
Imaging Group Only	Outsourced Reporting	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								
Imaging Group Only	IRMA Instances	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								

Primary Care, Community & Therapies Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Directorate AT	IB	IC	Month	Year To Date	Trend
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.0	80.0																			Mar 2018	0	0	0	0		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	2	2	1	0	5	4	4	1	3	2	5	14	4	1	10	5	3	Mar 2018	0	3	0	3	56	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	2	2	2	0	5	4	4	1	3	2	5	14	4	1	10	5	3	Mar 2018	0	3	0	3	56	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	2	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	1	1	2	0	0	3	2	3	0	3	0	2	1	4	5	2	4	Mar 2018	0	4	0	4	29	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	1	0	0	0	0	2	2	4	0	1	2	3	3	0	2	1	1	Mar 2018	0	1	0	1	21	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	Mar 2018	0	0	0	0	1	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	Mar 2018	0	0	0	0	2	
Patient Safety - Harm Free Care	Falls	<= No	0	0	33	30	27	20	19	31	23	21	36	36	38	30	33	32	38	27	34	49	Mar 2018	3	43	3	49	397	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	1	2	1	0	1	0	0	0	0	Mar 2018	0	0	0	0	5	
Patient Safety - Harm Free Care	Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	0	1	3	2	2	1	5	1	1	1	0	3	1	1	0	2	1	0	Mar 2018	0	0	0	0	16	
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Mar 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Mar 2018	0	0	0	0	1	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Mar 2018	0	0	0	0	10	
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	Mar 2018	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			3	8	4	6	1	1	4	3	8	4	10	2	7	6	4	14	5	5	Mar 2018	5	0	0	5	72	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			5	5	6	6	6	6	9	10	12	9	11	8	8	8	9	14	11	10	Mar 2018	8	2	0	10		

Primary Care, Community & Therapies Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Directorate AT	IB	IC	Month	Year To Date	
Workforce	WTE - Actual versus Plan	No			104	109	122	115	112	118	128	130	131	132	136	130	112	97.9	86.7	87.8	86.8	89.5	Mar 2018	31.3	28.9	29.3	89.5		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Mar 2018	70.8	74.4	83.6		88.3	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Mar 2018	3.21	5.11	3.8	4.13	4.06	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Mar 2018	4.2	5.5	2.29	3.96	4.14	
Workforce	Sickness Absence - Long Term - in month	No			22	23	29	32	24	24	24	19	19	15	24	21	26	36	35	36	32	32	Mar 2018	9	-	-	32	319	
Workforce	Sickness Absence - Short Term - in month	No			74	104	101	102	93	82	57	60	57	78	84	76	121	128	135	146	133	103	Mar 2018	18	58	27	103	1178	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Mar 2018	82	88.4	84.7	85.94	80.93	
Workforce	Mandatory Training	=> %	95.0	95.0																			Mar 2018	0	95.5	0		90.8	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	1	0	0	0	0	0	1	0	0	0	1	0	0	0	0	1	Mar 2018				1		
Workforce	Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	87.87	87.87	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	87	87	
Workforce	Your Voice - Response Rate	No			-->	-->	-->	29	-->	-->	-->	-->	-->	29	-->	-->	-->	-->	-->	-->	-->	-->	Jul 2017	31.1	24.1	31.1	29		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	3.83	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.72	3.72	3.96	3.83		

Primary Care, Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M		AT	IB	IC			
Community & Therapies Group Only	DVT numbers	=> No	730	61	-	-	-	-	-	-	41	54	59	70	54	56	55	55	29	53	35	58	Mar 2018				58	619	
Community & Therapies Group Only	Adults Therapy DNA rate OP services	<= %	9	9	7.88	7.37	12.2	12.2	8.97	8.04	8.47	8.18	8.5	7.79	8.04	-	-	-	-	-	-	-	Aug 2017				8.0	8.2	
Community & Therapies Group Only	Therapy DNA rate Paediatric Therapy services	<= %	9	9	0	1.42	0.87	3.94	1.15	-	-	-	-	-	14.3	10.2	8.91	-	-	-	-	-	Oct 2017				8.9	10.1	
Community & Therapies Group Only	Therapy DNA rate S1 based OP Therapy services	<= %	9	9	10.8	10.3	10.6	11.3	10.7	10.1	11.1	10.9	10.3	9.98	11.1	10.7	11.5	11.5	14.9	14.7	11.5	14.3	Mar 2018				14.3	11.7	
Community & Therapies Group Only	STEIS	<= No	0	0	1	1	0	0	0	0	0	0	-	1	2	3	0	-	0	0	2	-	Feb 2018				2	8	
Community & Therapies Group Only	Green Stream Community Rehab response time for treatment (days)	<= No	15.0	15.0	19	17	19.2	15.4	14.3	15.5	15.5	16.7	18.3	18.5	19.4	15.5	14.7	12.4	15.3	13.2	19.6	21.5	Mar 2018				21.5	200.35	
Community & Therapies Group Only	DNA/No Access Visits	%			2	2	2	1	2	1	1	1	1	1	1	1	1	1	1	1	1	1	Mar 2018				0.69		
Community & Therapies Group Only	Baseline Observations for DN	=> %	100	100	36.8	53	57.3	55.8	59.2	56.3	66.8	58.2	51.8	56.3	56.1	52.4	52	61.7	59.2	70.4	76.4	87.5	Mar 2018				87.5	60.75	
Community & Therapies Group Only	Falls Assessments - DN Intial Assessments only	%			42	77	69	60	62	58	69	63	57	58	57	54	50	60	60	67	78	91	Mar 2018				90.63		
Community & Therapies Group Only	Pressure Ulcer Assessment - DN Intial Assessments only	%			47	80	71	63	65	63	77	68	63	65	66	62	59	72	70	78	81	92	Mar 2018				92.19		
Community & Therapies Group Only	MUST Assessments - DN Intial Assessments only	%			26	52	46	48	36	46	58	52	46	49	49	49	43	54	55	61	77	90	Mar 2018				90.23		
Community & Therapies Group Only	Dementia Assessments - DN Intial Assessments only	%			14	53	53	52	62	44	55	50	43	60	38	63	41	50	47	59	70	89	Mar 2018				88.63		
Community & Therapies Group Only	48 hour inputting rate - DN Service Only	%			94	93	93	69	93	94	92	90	93	92	93	93	94	96	94	95	94	96	Mar 2018				96.17		
Community & Therapies Group Only	Making Every Contact (MECC) - DN Intial Assessments only	%			177	251	369	308	382	460	488	467	453	428	420	369	556	398	337	424	365	461	Mar 2018				90.04	62.08	
Community & Therapies Group Only	Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload acquired)	No			0	2	5	6	8	6	5	8	4	7	4	3	6	4	4	2	4	4	Mar 2018				4	55	
Community & Therapies Group Only	Avoidable Grade 2 Pressure Ulcers (DN caseload acquired)	No			0	2	2	4	6	3	5	8	4	7	4	3	3	4	4	2	3	2	Mar 2018				2	49	
Community & Therapies Group Only	Avoidable Grade 3 Pressure Ulcers (DN caseload acquired)	No			0	0	3	2	2	2	0	0	0	0	0	0	1	0	0	0	1	2	Mar 2018				2	4	
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	2	0	0	0	0	0	Mar 2018				0	2	

Corporate Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate							Month	Year To Date	Trend
			Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M		SG	F	W	M	E	N	O			
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			13	11	12	11	11	14	3	9	5	10	2	8	4	9	8	12	8	8	Mar 2018	2	0	0	1	0	2	3	8	86	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			13	18	13	12	17	19	16	17	10	13	5	10	7	11	15	16	11	15	Mar 2018	3	0	0	1	1	6	4	15		
Workforce	WTE - Actual versus Plan	No			123	118	133	98.6	94.5	105	99.5	103	102	102	107	123	114	111	122	116	119	137	Mar 2018	9.38	-3.56	5.06	16.5	-0.13	57.1	52.9	137.3		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Mar 2018	73	64	54	82	62	70	69		83.4	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Mar 2018			95					100.0	61	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Mar 2018	2.91	2.62	2.93	3.79	4.92	5.82	4.07	4.62	4.67	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Mar 2018	3.10	3.14	0.85	4.94	3.23	4.99	3.13	3.93	4.47	
Workforce	Sickness Absence - Long Term - in month	No			64	64	79	0	1	0	2	1	2	2	2	2	1	2	1	1	2	2	Mar 2018	1.00	0.00	0.00	0.00	0.00	1.00	0.00	2.00	20.00	
Workforce	Sickness Absence - Short Term - in month	No			203	224	191	7	8	8	3	2	3	1	4	10	4	5	7	15	11	12	Mar 2018	9.00	0.00	0.00	0.00	0.00	3.00	0.00	12.00	77.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Mar 2018	90.1	64.5	73.5	76.3	82.7	84.4	84.3	82.1	80.8	
Workforce	Mandatory Training	=> %	95.0	95.0																			Mar 2018	0	95	0	98	96	92	96	94.4	91	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	
Workforce	New Investigations in Month	No			0	0	2	1	1	4	6	0	2	1	1	0	0	1	1	0	2	2	Mar 2018	0	0	1	0	0	1	0	2		
Workforce	Your Voice - Response Rate	No			-->	-->	-->	18	-->	-->	-->	-->	-->	21	-->	-->	-->	-->	-->	-->	-->	-->	Jul 2017	67.7	41.5	42.9	30.4	30.3	6.6	21.9	21.2		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	3.64	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.83	3.61	3.98	3.55	3.52	3.62	3.37	3.64		

Paper ref:	TB (05/18) 019

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Persistent Reds IQPR March2018		
Sponsoring Executive	Dave Baker, Director of Partnerships and Innovation		
Report Author	Yasmina Gainer, Head of Performance & Costing		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

Discussion Points:

Process: All of the red indicators have now been categorised between Resolve (bring back to core standard); Improve (agree and interim objective and timescale); or Tolerate - (ensuring that there is no deterioration). This allows us to put more effort into the resolve effort.

OMC has already received papers for improvement for many of the "resolve ones". The additional ones (4 main categories) will be picked up in the next OMC where an interim objective will be agreed for each of the improve areas (12) subsequently leading to plans and timescales for these. Once target performance and delivery dates are agreed the Performance team will build graphs showing trajectory against target and time.

Summary of performance up to March 2018 :

Resolve items have moved largely into the right direction through March.

Worthy of mention in March are: the Neutropenic Sepsis performance (91.3% with just 6 minutes being the step to success); Emergency Care Unplanned Reattendance rate that fell from 7.9% to 5.3% (just 0.3% to go); and PDRs that rose from ~73% to 82%.

Sickness remains stubborn and is perhaps worthy of trying some new ideas to make an impact along with a staged target.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	x	Public Health Plan		People Plan & Education Plan	x
Quality Plan	x	Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Monthly item

4. Recommendation(s)

The Trust Board is asked to:

a.	Recognise the additional detail around process including the support of OMC
b.	Recognise some significant improvement in some areas
c.	Have a short discussion around new ideas to tackle sickness

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s):					
Board Assurance Framework		Risk Number(s):					
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Persistent IQPR Reds – Supplement March 2018

Categorisation : Over recent months the persistent reds have been categorised as follows:

- Resolve (restore to standard)
- Improve (a reduced improvement target has been agreed to build up to required standard)
- Tolerate (a reduced standard has been agreed based on circumstances which justify the decision)
- TBC – has now been apportioned appropriately to the above categories

We can see from the table below that the focus has now shifted towards 'resolve' equal in numbers to 'improve' and the tolerate is low.

In respect of governance arrangements, at April OMC it has been decided that 'resolve' will continue to be presented to monthly OMCs and that the key priority is for those to be remedied in the first place.

The indicators in the 'improve' cohort are to be moved along in line with current arrangements and action plans with staged targets agreeds.

As at March the 39 individual Persistent Red indicators (some have been for simplicity been grouped below) **have been prioritised as per table below:**

Resolve	Improve	Tolerate
1. Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	1. Sickness Absence Monthly / Cumulative	1. Caesarean Section Rate - Total
2. WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	2. Sickness LTS/STC (cases)	2. Early Booking Assessment (<12 + 6 weeks)
3. Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	3. Mandatory Training	3. RTT - Admitted Care (18-weeks)
4. No. of Sitrep Declared Late Cancellations - a. Total	4. Nursing Turnover	4. RTT – Non - Admitted Care (18-weeks)
5. Weekday Theatre Utilisation (as % of scheduled)	5. Patient Bed Moves (10pm - 6am) (No.) - exc. ALL moves for clinical reasons	
6. Emergency Care Patient Impact - Unplanned Attendance Rate (%)	6. Hip Fractures - Best Practice Tariff - Operation < 36 hours of admission (%)	
7. Patients Waiting >52 weeks	7. Emergency Care 4-hour waits / breaches	
8. Treatment Functions Underperforming (Incomplete)	8. Mortality Reviews within 42 working days	
9. Open Referrals without Future Activity/ Waiting List	9. Patient Safety Thermometer - Overall Harm Free Care	
10. PDRs - 12 month rolling	10. Patient Safety Thermometer - Overall Harm Free Care	
11. Medical Appraisal	11. 12. FFT Response & Score rates	
12. Return to Work Interviews following Sickness Absence		

Month 12 (March18) performance for resolve and improve is as follows :

Resolve

We have not managed to resolve all of the indicators that we planned to by 31 March 2018, however there is evidence that these indicators are improving as we can see from the table for the last quarter. Further improvements to managing the process have been agreed at OMC.

	Indicator	Measure	2017-2018 Year	Treatment	Actual Performance Jan-18	Feb-18	Mar-18
Harm Free Care	WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	Resolve	98.6%	99.1%	99.4%
	Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	=> No	0	Resolve	93.0%	72.0%	91.3%
Cancelled Operations	Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	0.8	Resolve	1.0%	1.0%	1.7%
	No. of Sitrep Declared Late Cancellations - Total	<= No	320	Resolve	40	37	59
	Weekday Theatre Utilisation (as % of scheduled)	=> %	85	Resolve	71.2%	74.2%	71.6%
Access To Emergency Care & Patient Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5	Resolve	7.7%	7.9%	5.3%
Workforce	PDRs - 12 month rolling	=> %	95	Resolve	73.9%	72.8%	81.9%
	Medical Appraisal	=> %	95	Resolve	78.1%	79.3%	81.4%
	Return to Work Interviews following Sickness Absence	=> %	100	Resolve	80.0%	81.0%	79.7%
RTT	Patients Waiting >52 weeks	<= No	0	Resolve	1	3	2
	Treatment Functions Underperforming (Incomplete)	<= No	0	Resolve	4	4	4
Open Referrals	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No		Resolve	144,564	149,221	152,201

Appendix 1: Persistent Red Tracker March 2018

Persistent Red Recovery Plan

	Indicator	Measure	2017-2018 Year	Responsible Lead	Plan In Place Yes / No	Root Cause of Issue	Treatment	Actual Performance Jan-18	Feb-18	Mar-18	Current Position	What are we doing to recover / monitor the position?	Specific Actions
Obstetric	Caesarean Section Rate - Total	<= %	25	**Amanda Geary**	**Yes**	Clinical decision making in line with clinical presentation, clinical need, clinical guidelines (local and national) and patient choice.	**Tolerate**	22.0%	28.9%	25.6%	**Agreed to Tolerate**. • The performance against this target fluctuates on a monthly basis which is solely driven by patient need. •The performance is monitored across elective and non-elective patients; elective CS rate follows a long term average of 8.2% against which Feb is slightly increased to 9.7% (this is not deemed unusually high); non-elective long term average is at 17.8% against February actual of 19.2%. •Whilst both are up in the month, the year to date performance is at 25.6% close to the target of 25%. •Monthly variation is therefore tolerated within reasonable levels determined by clinical decision and intervention to yield safe outcome for mother and baby.	•Where CS rate exceeds 25% assurance is sought that appropriate guidelines have been followed, emergency CS are reviewed by MDT within 24 hours of case taking place •Good practice also highlighted with strong focus remaining on outcomes (i.e. reduction in perinatal mortality and morbidity). • Review in place to determine whether increase in locums impacts rate.	• Review in place to determine whether increase in locums impacts rate • Continue to monitor cases and embed learning as appropriate
	Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	85	**Amanda Geary**	**Yes**	External patient factors, primary care referral processes and other organisation's capped bookings impacts on timeliness of patient referral and receipt by Trust for processing and booking within 12+6 to meet 90% hence targets adjust to 85% in line with outcome of local review.	**Tolerate**	81%	78%	92%	**Agreed to Tolerate**. • Target threshold of 90% exceeds influence and SWBH control owing to external factors. •170 breaches in February result from : 'out of area' women presenting late, women transferring after to our care after 12+6, GPs referring late, only 5/170 are within SWBH control to influence and on that basis the trust would have delivered performance well above 90%. •A proposal to adjust the indicator target to a more realistic level of 85% **or** to tolerate under-performance due to those reasons is recommended **Outcome:** CCG accepted a proposal to change to 85% in March 2018.	•Any internal data quality/booking have been addressed and continue to be monitored. • The indicator count now excludes transfers past 12+6 weeks • If indicator performance is validated to be persistently outside of trust control, the trust will discuss CCG to either reduce the target or support improvement in areas outside of trust control. • The indicator is monitored monthly at patient level with a March stock take and audit to follow to ensure breaches are solely SWBH out of control.	• Monitor breaches to ensure outside of SWBH control and keep our own breaches to its current low levels •Continue to influence timely referrals from GPs and other trusts **Outcome:** Service to monitor late bookers in agreement with CCG and outliers to be presented to CQRM
Harm Free Care	Patient Safety Thermometer - Overall Harm Free Care	=> %	95	**Debbie Talbot**	**Yes**	failure to implement preventative strategies via person centred risk assessment and care planning	**Improve**	93.7%	95.1%	94.5%	**Improve:** stop the pressure' to focus on wards with high numbers of pressure ulcers - commencing with D16, email from medical director re VTE compliance , reinforce safety plan and accountability's	•extend 'stop the pressure' and use of safety cross	•study day for tissue viability(includes continence training_) - wards targeted for attendance
	Falls	<= No	804	**Debbie Talbot**	**Yes**	as above (no falls lead)	**Improve**	79	78	112	**Improve** : whilst performance is red against the current target, it is acknowledged that the trust performs well on falls against peers; '• targets to be revised and based on occupied bed days (8% target for community beds etc.), '•detailed review of incidents to determine trends , new dementia team to reduce falls from intentional wandering 20 hi lo beds ordered (10 disseminated to date); • DT to meet with C&T GDON re improvement plan	•replace non mechanical beds at Leasowes, staff training '• revise trust targets '•review against local and national benchmark	•falls lead to start ward based activity (awaiting confirmation of funding)
	WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	**David Carruthers**	**Yes**	1. Different processes have been needed to gather compliance data for non-ORMIS areas and for the Brief & Debrief elements in the ORMIS areas. 2. Data quality issues have been identified through clinical effectiveness department. 3. Missed brief/debriefs	**Resolve**	98.6%	99.1%	99.4%	**Re-confirm plans:** A further sample of data for November is currently being analysed.	•The majority of cases where a Debrief was not recorded as being undertaken were for consultants in Cardiology (16/31). •A specific audit examining the consent taking within cardiology has been included in the Trusts Clinical Audit Plan for 2017/19. The audit is planned to be completed in Q4 of this financial year.	•The fundamental challenge in collecting the data in one system is that the 3 sections requires to be collected at a patient level and the Team Brief and Team debrief collected at organisational (list) level. •To take this forward it is recommended that a small working group is convened, with representation from the Theatre management team, Communications, Medical Directors Office, Hospital Information Services and Clinical Effectiveness.
	Mortality Reviews within 42 working days	=> %	90	**David Carruthers**	**Yes**	1. Intermittent problems with mortality review system with consultants not received reviews to complete. 2. Sometimes the review is automatically routed to the wrong consultant e.g. surgery routed to medicine consultant. If this is not highlighted it won't get reviewed. 3. Some consultants are not completing their allocated mortality reviews. This could be due to clinical competing demands on time or non-engagement in the process. 4. There is no dedicated support for the administration of mortality reviews therefore reliant on ad hoc checks of compliance progress. 5. When consultants leave or CDs change if the system isn't updated then consultants who have left will be assigned rev iews and they will not be completed. 6. Sometimes the scanned notes are not available for the review to be completed.	**Improve**	38.0%	45.1%	44.0%	**Re-confirm plans in line with current position:** 1. Manual requests for reviews will be sent out once so we are sure all reviewers are receiving their allocated reviews.		•The mortality process is currently being reviewed as part of the Learning From Deaths framework. It is expected that the processes currently in place will change and therefore the manual processes in place will be for the interim period. •The new policy for Learning from Deaths will indicate the deaths that are required to be reviewed. • The KPI should be reviewed to reflect this change.
	Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	=> No	0	**Michelle Harris**	**Yes**	non compliance with designed process	**Resolve**	93.0%	72.0%	91.3%	**Resolve**: • February performance is lower than expected based on improvements made. •The 9 patients who breaches and had the antibiotic administered above the 1 hour, minutes after the 1h timeframe currently audited • The breaches are confined to ED out of hours	• Encourage chemo patients presenting in ED, with an unrelated presentation, to identify themselves as having Chemo or have no associated issues. • Also seeking advice in regard to antibiotic stewardship.	• Continue to RCA each breach and continually embed improved process
Cancelled Operations	Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	0.8	**Tina Robinson**	**Yes**	non compliance with policy and delay in improvement opportunities related to scheduling and theatre efficiency	**Resolve**	1.0%	1.0%	1.7%	**TBC**: • February performance just under target and consistent to January showing focus. •In February 37 patients breached, about 8 patients more than what would have delivered the target. • However, 27% of the cancellations have been avoidable (10/37) and hence without those, it would have been possible to achieve performance • This indicator performance is impacted to a large degree by staff sickness, bed availability (including critical care) all difficult to balance during a winter pressure period which are all factors that the surgical departments have been experiencing in this period	• Priority improvement areas Oral, ENT, Ophthalmology for scheduling and efficiency in theatres • Anticipating breaches in line with projected elective activity to ensure focus is maintained • Further training to staff in validation of cancellations to ensure accurate breaches are reported • Control the number of avoidable breaches	• Work through the avoidable breaches and embed learning and expectations for performance • Scheduling improvements for a number of specialities planned and delivered
	No. of Sitrep Declared Late Cancellations - Total	<= No	320		**Yes**	non compliance with policy and delay in improvement opportunities related to scheduling and theatre efficiency	**Resolve**	40	37	59	• Same as above	• Same as above	• Same as above
	Weekday Theatre Utilisation (as % of scheduled)	=> %	85	**Liam Kennedy**	**Yes**	In principle under utilised theatres will be removed for cost savings. There has been a delay in design and implementation of improvement programme to remove theatres in year at scale. In Q4 the programme will be modelled through to end of 2019 with a clear implementation plan.	**Resolve**	71.2%	74.2%	71.6%	**TBC:** • February performance for in-session utilisation at 74.2% • Improvements are driven by Theatre Improvement Programme • Benchmarking is indicating opportunities across most specialities including scheduling efficiency and other productivity	• Complete modelling and outline programme design • Connect trajectories for improvement in line with production plan	• Start implementation of utilisation programme '• Modelling needs to accommodate 2018-19 contract uplift in activity and have time and resource to deliver this change at scale '• Review benchmarking and implement an overall improvement plan using this to baseline performance
Access To Emergency Care & Patient Flow	Emergency Care 4-hour waits	=> %	95	**Rachel Barlow**	**Yes**	Delay in implementation of ED and Patient Flow improvement plans; increased demand over winter	**Improve**	82.5%	79.8%	79.9%	• **Improve:** Implement Patient Flow programme particularly admit pull and COW model	• Implement Patient Flow programme gaining benefit from admit pull and COW model and implementing on call rota	• Full implementation of improvement programmes
	Emergency Care 4-hour breach (numbers)	No	0	**Rachel Barlow**	**Yes**			3249	3377	3582	Correlated to the above indicator	Correlated to the above indicator	Correlated to the above indicator
	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5	**Michelle Harris**	**Yes**	underperformance analysed in 6 month audit which has informed improvement focus as follows: gynae pathway, GP direct bookings, catheter pathway to SAU, frequent attenders MDT	**Resolve**	7.7%	7.9%	5.3%	**Resolve:** • Audit completed in December and themes for improvement agreed. '• Performance on track in March18 against improvement trajectory	• Implement improvement approach	
	Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	<= No	0	**Caroline Rennalls**	**No**	IPR is reporting red performance due to the fact that there is no target set, when this is set the performance may switch to green and therefore will be removed from persistent red flagging	**Evaluate**				**Evaluate indicator**: • Meeting to discuss threshold vs performance & count to be re-scheduled. This will inform whether indicator needs to be on the persistent red report.		•Meeting to be re-schedule by Head of Capacity
	Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	0	**Caroline Rennalls**	**No**		**Evaluate**						
	Patient Bed Moves (10pm - 6am) (No.) - exc. ALL moves for clinical reasons	=> %		**Rachel Barlow**	**Yes**	This indicator has definition has been redefined. The bench mark data will be assessed. An initial goal of 25% reduction will be set and reviewed at end Q4.	**Improve**	65	48	75	**Improve**: • This indicator definition has been re-defined. It now counts all bed moves between 10pm-6am for non-clinical reasons. The count excludes all moves which are considered to be for clinical patient need. An initial goal of 25% reduction will be set and reviewed at end Q4.	• Realise benefits of admit pull and COW improvement in flow • redesign flow into community beds i.e. book in advance	• Continue to review at patient level each month and finalise the count if necessary • in Q4 reduce non-clinical bed moves by 25%) •in Q1 18-19 all non-clinical moves will be eliminated • Continue improvement work and evaluate progress to inform further trajectory •establish benchmark to inform trajectory
	Hip Fractures - Best Practice Tariff - Operation < 36 hours of admission (%)	=> %	85	**Tina Robinson**	**Yes**	Challenges in acuity and pathways management . Recent challenge with snow and large demand.	**Improve**	84.0%	72.0%	85.0%	**Improve:** • Performance continuous to fluctuate from month to month	• Implement agreed improvement plan	• Review of Trauma planning meeting for improvement in January • review of effectiveness of snow and bad weather response in imaging and theatre team planning
Workforce	PDRs - 12 month rolling	=> %	95	**Raffaela Goodby**	**Yes**	PDR completion fluctuates over the year to reach 95% by the end of March. During 2018/19 all PDR's will be completed during Apr-June	**Resolve**	73.9%	72.8%	81.9%	**Improve:** • Accredited manager training rolled out inclusive of Aspiring to Excellence Training for managers.		• Close down PDR's ready for new PDR year and objective setting in April to June
	Medical Appraisal	=> %	95	**David Carruthers**	**Yes**	Late medical appraisals.	**Resolve**	78.1%	79.3%	81.4%	**Improve:** • Revised escalation process implemented. • Information from PRePis now used to update IPR frontsheet for medical appraisal compliance. • All appraisees receive a reminder in the month before their appraisal is due.	1. Summary of doctors in escalation process to be distributed to GDs and GDOPs monthly. 2. Copies of escalation letters will be sent to appropriate HR Business Partners, Clinical Director and Specialty Lead.	
	Sickness Absence (Rolling 12 Months)	<= %	3.15	**Raffaela Goodby**	**Yes**	Sickness has remained consistent during September - Jan but overall 12 months rolling sickness has improved.	**Improve**	4.50%	4.50%	awaiting reporting	**Improve:** Launch of manager training on sickness absence & well being. Group review scrutiny on sickness, incl long term sickness cases. Review of hot spot areas in medicine by DON & HRBP	•Further manager training on sickness and well being. •WCH specific workshops for managing absence. •Focus on RTW interviews.	• Escalations to group directors through group reviews for LT sickness cases. • Review of sickness policy. • Training & Development
	Sickness Absence (Monthly)	<= %	3.15	**Raffaela Goodby**	**Yes**	In month sickness has remained high with short term sickness increasing in Q3 and Q4. Long term sickness has reduced over the past 12 months.	**Improve**	5.30%	4.74%	awaiting reporting	**Improve:** Launch of manager training on sickness absence & Well being. Group review scrutiny on sickness, incl long term sickness cases. Review of hot spot areas in medicine by DON & HRBP	•Further manager training on sickness and well being. •WCH specific workshops for managing absence. •Focus on RTW interviews.	• Escalations to group directors through group reviews for LT sickness cases. • Review of sickness policy. • Training & Development
	Sickness Absence - Long Term (Monthly)	No	0	**Raffaela Goodby**	**Yes**	In month sickness has remained high with long term sickness has reduced over the past 12 months.	**Improve**	267	230	awaiting reporting	as above	as above	as above
	Sickness Absence - Short Term (Monthly)	No	0	**Raffaela Goodby**	**Yes**	In month sickness has remained high with short term sickness increasing in Q3 and Q4.	**Improve**	1021	932	awaiting reporting	as above	as above	as above
	Return to Work Interviews following Sickness Absence	=> %	100	**Raffaela Goodby**	**Yes**	Return to work interviews had a rapid improvement at the end of 2016 then have remained stubbornly at 80% since then. Q4 will see a key focus on RTW interviews through the Accredited Manager Roll out and through the Director of OD focus	**Resolve**	80	81	79.7%	**Improve**: • performance longer term average at 79% rising to around 80% in last 6 months; • in order to implement an improvement trajectory of 10% in Q4 the director of People and OD is : writing to every line manager in January, who reports a RTW compliance rate of below 85%.	Accredited manager training contains focus on health and well being, including the importance of return to work interviews.	• Follow up and communications around importance of return to work interviews, through accredited manager communications and corporate communications
	Mandatory Training	=> %	95	**Raffaela Goodby**	**Yes**	Past 12 months transition year for mandatory training, including a lack of focus around safeguarding training and a performance notice from the CCG. This is in turnaround since August last year.	**Improve**	89.0%	89.1%	91.5%	**Improve:** • Performance in last few months have seen a sharp improvement measuring 90% in the last few days of March so far which is great success story • Safeguarding training improved across all levels of this training and now stable for a number of months • Launch of new corporate induction	• BLS Delivery as part of CQC Improvement plan will impact figures • Corporate Induction Changes embedded.	• BLS Delivery as part of CQC Improvement plan will impact figures• Safeguarding improvements will be embedded.
	Nursing Turnover	%	10.7	**Raffaela Goodby**	**Yes**	Target agreed at 10.7% as recommended to the Trust Board in March 2017	**Improve**	13.3%	13.4%	13.5%	**Develop and update plans :**		

Persistent Red Recovery Plan

	Indicator	Measure	2017-2018 Year	Responsible Lead	Plan In Place Yes / No	Root Cause of Issue	Treatment	Actual Performance Jan-18	Feb-18	Mar-18	Current Position	What are we doing to recover / monitor the position?	Specific Actions
Referral to Treatment (RTT)	RTT - Admitted Care (18-weeks)	=> %	90	Liam Kennedy	Yes	Trajectory to deliver in Q4 impacted by winter pressure and cancellation of elective activity	Tolerate	77.4%	77.2%	77.3%	**Tolerate** : • the performance on these pathways has been impacted by winter pressures and cancellations most recently • focus will be on 18-19 production plan will form a base for improvement trajectories to this pathway	• The focus will be on delivering the production plan and provide the required capacity to service it • consider seasonal implications and try to remove the effect by front-loading activity where possible	• Delivery of activity plan
	RTT - Non Admitted Care (18-weeks)	=> %	95	Liam Kennedy	Yes	Trajectory to deliver in Q4 impacted by winter pressure and cancellation of elective activity	Tolerate	90.7%	90.5%	91.2%	**Tolerate** : • the performance on these pathways has been impacted by winter pressures and cancellations most recently • focus will be on 18-19 production plan will form a base for improvement trajectories to this pathway	• The focus will be on delivering the production plan and provide the required capacity to service it • consider seasonal implications and try to remove the effect by front-loading activity where possible	• Delivery of activity plan
	Patients Waiting >52 weeks	<= No	0	Liam Kennedy	No	Year to date analysis completed to inform improvement activities. Training 56% completed successfully. Improvement trajectory TBC	Resolve	1	3	2	**TBC:** • The indicator performance is subject to historic lack of correct patient clock stop applications which is being addressed through a number of different and effective training programmes • Improvement plans are progressed and clear trajectories will be part of this • PDR focus on accurate RTT rule applications to be considered as a core PDR element	• Training delivery is being evaluated •PDR focus being considered	• Deliver full training programme for all relevant staff
	Treatment Functions Underperforming (Incomplete)	<= No	0	Liam Kennedy	Yes	Trajectory to deliver in Q4 impacted by winter pressure and cancellation of elective activity	Resolve	4	4	4	**Resolve** : • 4 specialities are under the 92% incomplete pathway standard at this stage, but some are close to the target • there are plans for recovery in progress which depend on ability to carry out activity as planned this is highly dependent on winter pressure and cancellations	• Delivery of activity plan	• Delivery of activity plan
Open Referrals	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No		Liam Kennedy	Yes	These are open referrals for which there is no future activity or waiting list in the system	Resolve	144,564	149,221	152,201	**TBC:** • an ongoing issue which is not specific to our Trust • sustainably improvement is possible but depends on IT development to enable open referrals to be managed better through the system and improve visibility of these patients/referrals	• Delivery of proposed improvement action plan which will delivery PAS improvements, waiting list management	•Agree next steps and support for backlog and agree with IT the development implementation
Friends and Family	FFT Response Rate - Adult and Children Inpatients (including day cases and community)	=> %	50	Elaine Newell	Yes	Initial targets may have been unrealistic: Q3 22% west midlands , Q4 26% national due to low scoring baseline , absence of senior nursing in clinical groups, lack of corporate nursing lead (due to absence for Q3) , inconsistent technical and telecomms support /sign in	Improve				**Improve**: • The performance currently for response and score rates is very poor. • The performance features unfavourable against our regional peer group who all apply SMS/IVM patient approach methods • Our trust is behind this which results in limited patient contact, this in turn driving low response rates and hence scores are limited to a small number of responses • An improvement plan has been put in place for a number of initiatives including a) disseminate and collect cards for defined areas, b) escalate need for IVM to Chief Nurse c) ensure wards have functioning IPAds and connectivity d) meet with volunteers on wards to gain support to undertake	• Chief Nurse to enable the agreed approach for SMS/ IVM and patient contacts to be widened via the external company that we use • dementia lead nurse to review wider patient experience including FFT and ensure views of vulnerable adults accessed, named technical support and telecomms to action IVM • Deputy Chief Nurse to agree on realitic targets and co-relation to patient discharges so that the indicator becomes more relevant	•Clarify realistic and appropriate targets • Progress full action plan in terms of data and patient contact methods
	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95		Yes		Improve						
	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50		Yes		Improve						
	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95		Yes		Improve						
	FFT Response Rate: Type 3 W/U Emergency Department	=> %	50		Yes		Improve						
	FFT Score - Outpatients	=> No	95		Yes		Improve						
	FFT Score - Maternity Birth	=> No	95		Yes		Improve						
	FFT Response Rate - Maternity Birth	=> %	50		Yes		Improve						

Persistent Red Recovery Plan

	Indicator	Measure	2017-2018 Year	Responsible Lead	Plan In Place Yes / No	Treatment	Actual Performance Jan-18	Feb-18	Mar-18
Obstetric	Caesarean Section Rate - Total	<= %	25	Amanda Geary	Yes	Tolerate	22.0%	28.9%	25.6%
	Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	85	Amanda Geary	Yes	Tolerate	81%	78%	92%
Harm Free Care	Patient Safety Thermometer - Overall Harm Free Care	=> %	95	Debbie Talbot	Yes	Improve	93.7%	95.1%	94.5%
	Falls	<= No	804	Debbie Talbot	Yes	Improve	79	78	112
	WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	David Carruthers	Yes	TBC	98.6%	99.1%	99.4%
	Mortality Reviews within 42 working days	=> %	90	David Carruthers	Yes	Improve	38.0%	45.1%	44.0%
	Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	=> No	0	Michelle Harris	Yes	Resolve	93.0%	72.0%	91.3%
Cancelled Operations	Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	0.8	Tina Robinson	Yes	TBC	1.0%	1.0%	1.7%
	No. of Sitrep Declared Late Cancellations - Total	<= No	320		Yes	TBC	40	37	59
	Weekday Theatre Utilisation (as % of scheduled)	=> %	85	Liam Kennedy	Yes	TBC	71.2%	74.2%	71.6%
Access To Emergency Care & Patient Flow	Emergency Care 4-hour waits	=> %	95	Rachel Barlow	Yes	Improve to consistently beyond 85%?	82.5%	79.8%	79.9%
	Emergency Care 4-hour breach (numbers)	No	0	Rachel Barlow	Yes		3249	3377	3582
	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5	Michelle Harris	Yes	Resolve	7.7%	7.9%	5.3%
	Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	<= No	0	Caroline Rennalls	No	Evaluate			
	Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	0	Caroline Rennalls	No	Evaluate			

Persistent Red Recovery Plan

	Indicator	Measure	2017-2018 Year	Responsible Lead	Plan In Place Yes / No	Treatment	Actual Performance Jan-18	Feb-18	Mar-18
	Patient Bed Moves (10pm - 6am) (No.) - exc. ALL moves for clinical reasons	=> %		Rachel Barlow	Yes	Improve	65	48	75
	Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85	Tina Robinson	Yes	Improve	84.0%	72.0%	85.0%
Workforce	PDRs - 12 month rolling	=> %	95	Raffaela Goodby	Yes	Improve	73.9%	72.8%	81.9%
	Medical Appraisal	=> %	95	David Carruthers	Yes	Improve	78.1%	79.3%	81.4%
	Sickness Absence (Rolling 12 Months)	<= %	3.15	Raffaela Goodby	Yes	Improve	4.50%	4.50%	awaiting reporting
	Sickness Absence (Monthly)	<= %	3.15	Raffaela Goodby	Yes	Improve	5.30%	4.74%	awaiting reporting
	Sickness Absence - Long Term (Monthly)	No	0	Raffaela Goodby	Yes	Improve	267	230	awaiting reporting
	Sickness Absence - Short Term (Monthly)	No	0	Raffaela Goodby	Yes	Improve	1021	932	awaiting reporting
	Return to Work Interviews following Sickness Absence	=> %	100	Raffaela Goodby	Yes	Improve	80	81	79.7%
	Mandatory Training	=> %	95	Raffaela Goodby	Yes	Improve	89.0%	89.1%	91.5%
	Nursing Turnover	%	10.7	Raffaela Goodby	Yes	Improve	13.3%	13.4%	13.5%
Referral to Treatment (RTT)	RTT - Admittted Care (18-weeks)	=> %	90	Liam Kennedy	Yes	Tolerate	77.4%	77.2%	77.3%
	RTT - Non Admittted Care (18-weeks)	=> %	95	Liam Kennedy	Yes	Tolerate	90.7%	90.5%	91.2%
	Patients Waiting >52 weeks	<= No	0	Liam Kennedy	No	TBC	1	3	2
	Treatment Functions Underperforming (Incomplete)	<= No	0	Liam Kennedy	Yes	Resolve	4	4	4
Open Referrals	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No		Liam Kennedy	Yes	TBC	144,564	149,221	152,201
Friends and Family	FFT Response Rate - Adult and Children Inpatients (including day cases and community)	=> %	50	Elaine Newell	Yes	Improve			
	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95		Yes	Improve			
	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50		Yes	Improve			
	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95		Yes	Improve			
	FFT Response Rate: Type 3 WiU Emergency Department	=> %	50		Yes	Improve			
	FFT Score - Outpatients	=> No	95		Yes	Improve			
	FFT Score - Maternity Birth	=> No	95		Yes	Improve			
	FFT Response Rate - Maternity Birth	=> %	50		Yes	Improve			

Paper ref:	TB (05/18) 020

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Financial Performance P12 2017/18		
Sponsoring Executive	Tony Waite, Director of Finance		
Report Author	Dinah McLannahan Deputy Director of Finance; Tim Reardon Associate Director of Finance (Compliance)		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

This report deals with the financial performance for the full financial year 2017.18.

- The trust has, subject to audit, met each & all of its three key financial targets – P&L Control Total [CT], External Financing Limit [EFL] and Capital Resource Limit [CRL]. This is a differential performance vis a vis peer organisations and is noteworthy when taken together with operational target performance and step change discipline in safety plan compliance.
- Specifically in respect of CT the draft accounts record an over-performance before STF of £5m and with consequent 'bonus' STF of £10.2m. This should be paid in July and provides additional rigour to the trust's cash position having regard to the 2018.19 financial plan and prospective decisions on capital investment in Q1 & Q2 of the new financial year.
- There are key matters of accounting judgement consequent to the demise of Carillion as our PFI partner and which have potential to impact on the final accounts. It is not anticipated that these matters shall impair CT compliance and the trust is in dialogue with NHSI to confirm that. These matters, which relate to the carrying value and recognition of the Midland Met PFI asset, are the subject of on-going consideration and which is being overseen by the Audit Committee.

2. Alignment to 2020 Vision *[indicate with an **'X'** which Plan this paper supports]*

Safety Plan		Public Health Plan		People Plan & Education Plan	**X**
Quality Plan		Research and Development		Estates Plan	
Financial Plan	**X**	Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Finance and Investment Committee (27th April)

4. Recommendation(s)

The Trust Board is asked to:

a. Note the contents of his report.

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s): 1603						
Board Assurance Framework		Risk Number(s): BAF 5 and BAF 6						
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed		
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed		

Finance Report

Period 12 2017/18
March 2018

Trust Board
3rd May 2018

Contents

Page Title

Finance Report

Summary & Recommendations

Period 12 2017/18

Statutory Financial Duties	Value	Outlook	Note
I&E control total surplus	£13.9m	√	1
Live within Capital Resource Limit	£23.0m	√	2
Live within External Finance Limit	£36.7m	√	3

1. **Actual surplus £13.9m formally reported.**
2. **CRL achieved in line with application and consistent with gross expenditure at £26m.**
3. **EFL based on £7.0m surplus will be adjusted to reflect improved I&E out-turn to ensure no overshoot.**

Outlook

- NHSI P12 key data return includes actual surplus £13.9m, this is pre-draft accounts and audit.
- In prior years draft accounts and final accounts have not varied materially, the main uncertainty is in relation to bonus STF available and the value of the prepayment for MMH costs.
- STF will be confirmed on 20th April and reflected in draft accounts. It is possible that a disclosure is made in relation to the prepayment.
- Operational exit run rate is being analysed in order to understand the impact on the scale of 2018.19 financial challenge.

P12 key issues & remedial actions

- The trust has met each of its three key financial targets.
- Headline surplus £6.3m being £5.0m ahead of control total due to N/R measures including profit on land sale,.
- STF of £7.574m assumed earned for year; bonus STF of £10.2m notified & in draft accounts but not in this report.
- The normalised underlying position used for 2018.19 planning purposes is confirmed at £26.2m [including oncology stranded costs]. This is consistent with the 'in year' underlying position set out in this report.
- Pay bill £26.3m (Month 11 £25.928m) remains stable but stubborn; Agency spend £1.468m (Month 11 £1.283m). Agency spend for the year £15.8m against a ceiling of £11.7m, but compares to spend of over £23m for 2016.17.
- Following notification of a revised forecast out-turn the CRL for the Trust was adjusted by NHSI. The CRL has also been adjusted for two further allocations; £336k in total for Informatics WiFi and Cyber security. The resultant gross expenditure plan stands at £26.3m so with a full year actual spend of £26.264m there is an underspend of £72k, and the Trust has therefore achieved its statutory duty in relation to CRL.
- Cash at 31st March was £9.7m being £9.4m ahead of the NHSI plan. The Trust has not needed to access any borrowing during 2017.18.

Recommendation

- Challenge and confirm the reported full year position.
- Note the consistency with the initial data set but possible changes pre-draft accounts.

Finance Report

Performance to date – I&E and cash

Period 12 2017/18

Financial Performance to Date

For the full year to the end of March 2018 the Trust is reporting:

- Ahead of plan excluding STF
- Headline I&E surplus of £13.9m, exceeds NHSI plan by £3.9m as a result of £16.3m land sale profit, offsetting STF A&E failure and operational performance.
- I&E deficit £26.4m before non-recurrent and technical support, being £22.8m adverse to plan.
- Capital spend of £26.3m being consistent with CRL duty;
- Cash at 30th March £9.7m being £9.4m more than plan.
- Use of resources rating at 3 P11 year to date.

I&E

Full year reported performance at £13.9m exceeds forecast by £6.8m. The main drivers of this are as follows:

- £3.2m CCG fine/penalty provision release
- £1.2m taper relief
- £1.1m additional GRNI release
- £1.0 additional winter money benefit

With the exception of GRNI these are cash backed, however they are all non-recurrent and so do not provide any mitigation for the 2018/19 financial year.

Income shortfalls on production plan continues in March and the pay run rate continued at previous levels. These are recurrent issues that will continue for 2018/19.

Savings

Achievement of savings schemes for 2017.18 was £15.9m. Recurrent vs non-recurrent split to be confirmed

Capital

Capital expenditure to date stands at £26.3m against a revised full year forecast of £26.3m. Previously forecast slippage and planned deferral enabled the Trust to reduce its CRL requirement in the 2017/18 financial year.

Based on this reported position the Trust has achieved its statutory duty in relation to CRL.

Cash

The cash position is £9.4m above plan at the year end. This is due to deferred capex spend and asset disposal proceeds offsetting the impact of the underlying position.

This balance also exceeds the revised forecast level and consequently the Trust has achieved its statutory duty in relation to EFL.

Based on this cash balance the Trust is not now expecting to require working capital support in May 2018. NHSI has been notified that support is likely to be required in June 2018.

Better Payments Practice Code

Performance in March improved when measured in volume and deteriorated marginally in terms of value. However, both continue to be below the target of 95%. It is expected that this target will not be achieved in FY 2018/19 given the forecast cash position.

Finance Report

I&E Performance – Full Year – As reported

Period 12 2017/18

Period 12	CP Plan £'000s	CP Actual £'000s	CP Variance £'000s	FY Plan £'000s	FY Actual £'000s	FY Variance £'000s
Patient Related Income	35,369	41,540	6,171	424,405	421,369	(3,036)
Other Income	13,492	8,757	(4,735)	59,706	63,344	3,638
Income total	**48,861**	**50,297**	**1,436**	**484,111**	**484,713**	**602**
Pay	(21,496)	(26,333)	(4,837)	(300,666)	(313,993)	(13,327)
Non-Pay	(1,991)	(12,239)	(10,248)	(139,407)	(149,868)	(10,461)
Expenditure total	**(23,487)**	**(38,572)**	**(15,085)**	**(440,073)**	**(463,861)**	**(23,788)**
EBITDA	**25,374**	**11,725**	**(13,649)**	**44,038**	**20,852**	**(23,186)**
Non-Operating Expenditure	(2,099)	(1,641)	458	(25,144)	(7,010)	18,134
Technical Adjustments	(9,155)	(21)	9,134	(8,961)	63	9,024
DH Surplus/(Deficit)	**14,120**	**10,063**	**(4,057)**	**9,933**	**13,905**	**3,972**
Add back STF	*(1,222)*	*(856)*	*367*	*(10,483)*	*(7,574)*	*2,909*
Adjusted position	***12,898***	***9,207***	***(3,691)***	***(550)***	***6,331***	***6,881***
Technical Support (inc. Taper Relief)	*(250)*	*(8,249)*	*(7,999)*	*(3,000)*	*(30,664)*	*(27,664)*
Winter monies	*0*	*(1,315)*	*(1,315)*	*0*	*(2,029)*	*(2,029)*
Underlying position	***12,648***	***(357)***	***(13,005)***	***(3,550)***	***(26,362)***	***(22,812)***

The trust reported a headline surplus for the full year of £13.9m being £4m ahead of plan having taken account of the STF failure related to A&E 4hr waiting times performance. This surplus is driven by non-recurrent and non-operational support. £16.3m relates to the land sale. In addition the position has also utilised the benefit of £26m of contingency and support of which £15.4m was not in the original plan. (see Appendix 1).

The table shows performance against the **NHSI planned** levels of income, pay and non-pay spend. Internal plans have flexed budgets between these headings but maintain the year to date phasing of the bottom line surplus / deficit.

The underlying deficit for the full year is recorded as £26.4m. This is the underlying position for the 2017/18 financial year without technical support. In the planning assumptions for 2018/19 the normalised position was forecast at £22.7m, which has been reconfirmed at Month 11. The underlying and normalised positions use different methodologies to be arrived at. The underlying position did, however, inform the normalised position for planning purposes and so work is underway to assess the impact on the normalised position as this has been used for planning purposes going forward.

NB: The year end process involves an extended close and so P12 actuals are those extracted as of 17th April 2018. These correlate to the key data return submitted to NHSI on the 17th April. The main movements will be in relation to impairments and PDC which are not expected to change the DH surplus. The resulting draft accounts will be subject to audit and not final until the close of May 2018.

Finance Report

I&E Performance – Revised Plan Delivery

Period 12 2017/18

	Actual												
	Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Total Expected**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Patient Related Income	31,894	34,323	35,389	35,057	34,557	33,409	35,491	35,975	34,633	35,450	34,248	34,982	415,408
Other Income	4,445	3,996	4,184	4,853	3,529	4,091	4,078	4,132	4,132	4,101	4,121	4,121	49,785
Pay	(26,452)	(26,375)	(26,431)	(26,188)	(26,218)	(25,511)	(26,247)	(25,506)	(25,643)	(25,480)	(25,366)	(25,555)	(310,973)
Non Pay	(9,871)	(12,495)	(12,903)	(13,057)	(12,849)	(12,083)	(13,083)	(12,791)	(12,732)	(12,711)	(12,662)	(12,557)	(149,795)
Non Operational Costs	(2,064)	(2,098)	(2,037)	(2,079)	14,235	(2,038)	(2,049)	(2,049)	(2,049)	(2,049)	(2,049)	(2,049)	(8,372)
Grand Total	**(2,048)**	**(2,650)**	**(1,799)**	**(1,414)**	**13,254**	**(2,131)**	**(1,809)**	**(238)**	**(1,658)**	**(689)**	**(1,708)**	**(1,058)**	**(3,948)**
Actual							(2,197)	136	(1,663)	470	(1,122)	10063	
Variance - Month							(388)	374	(5)	1,159	586	11,121	
Variance - Cumulative							(388)	(13)	(18)	1,141	1,726	12,847	

Notes

- The Trusts reported financial performance benefits from high levels of non-recurrent support. As a result the fact that the reported position in period 12 and for the full year exceeds both forecast and plan does not represent any underlying improvement. Analysis of the position is underway but it is expected that the underlying position for 17/18 and also the normalised for 2018/19 will have deteriorated compared to both the forecast and business plan.

Finance Report

I&E Performance – Forecast and remediation plans - Pay

Period 12 2017/18

	Actual													
	Apr-17 £000's	May-17 £000's	Jun-17 £000's	Jul-17 £000's	Aug-17 £000's	Sep-17 £000's	Oct-17 £000's	Nov-17 £000's	Dec-17 £000's	Jan-18 £000's	Feb-18 £000's	Mar-18 £000's	Total Expected £000's	Apr-18
Pay P06 forecast	(26,452)	(26,375)	(26,431)	(26,188)	(26,218)	(25,511)	(26,267)	(26,086)	(26,243)	(26,080)	(25,966)	(26,155)	(313,973)	(26,155)
Required Improvement	0	0	0	0	0	0	0	600	600	600	600	600	3,000	0
Target for Pay	**(26,452)**	**(26,375)**	**(26,431)**	**(26,188)**	**(26,218)**	**(25,511)**	**(26,267)**	**(25,486)**	**(25,643)**	**(25,480)**	**(25,366)**	**(25,555)**	**(310,973)**	**(26,155)**
ACTUALS against forecast							**(26,416)**	**(25,515)**	**(26,330)**	**(26,295)**	**(25,928)**	**(26,333)**		
Variance - actuals to forecast							**(149)**	**(29)**	**(687)**	**(815)**	**(562)**	**(778)**		

April 2018 target run rate	**(24,076)**

Gap to close	**(2,079)**

Notes

- For month 12 the underlying pay position remained above £26m and was therefore consistent with prior months and higher than required.
- Since the revised plan, the only other month with a technical improvement was October (£871k). This shows that the pay bill remains challenging to reduce.
- Despite this, work is ongoing to reduce the pay bill and identify recurrent cost reduction plans for 2018.19.

Finance Report

Pay bill & Workforce

Period 12 2017/18

Pay and Workforce	Current Period	Previous Period	Change between periods	%	Plan YTD	Actual YTD	Variance YTD
Pay - total spend	£26,333k	£25,928k	£406k	2%	£300,666k	£313,993k	£13,327k
Pay - substantive	£21,459k	£21,857k	-£398k	-2%	£260,891k	£264,220k	£3,329k
Pay - agency spend	£1,468k	£1,283k	£185k	14%	£13,482k	£15,821k	£2,339k
Pay - bank (inc. locum) spend	£3,406k	£2,787k	£619k	22%	£26,293k	£33,951k	£7,658k
WTE - total	7,008	6,982	25	0%	6,701	7,008	307
WTE - substantive	6,077	6,092	-14	0%	5,960	6,077	117
WTE - agency	174	166	8	5%	160	174	15
WTE - bank (inc. locum)	756	725	31	4%	581	756	175
Memo: locum spend	£1,152k	£939k	£213k	23%	£507k	£9,664k	£9,157k
Memo: locum WTE	70	67	3	5%	4	70	66

NHSI locum spend target	£6,307k

Paybill & Workforce

- Total workforce at the end of March of 7,008 WTE [being 307 higher than plan] and including 174 WTE of agency staff.
- Total pay costs (including agency workers) were £26.3m in March against a P6 forecast of £26.1m. NHSI plan pay spend for March was £21.5m. This number reflected the Month 12 assumption that the gap of £13m in the plan would be met, lowering the plan.
- Significant reduction in temporary pay costs required to be consistent with FY 2018/19 plan assumptions. Focus on reduction in capacity and improved roster management, leading to reduced temporary staffing spend.
- The Trust did not comply with national agency framework guidance for agency suppliers in March. Shifts procured outside of this are subject to COO approval and is driven by strict commitment to maintaining safe staffing.
- The Trust's agency cap for 2017/18 is £11,672k and at the end of P12 the Trust had spent £15,821k on agency.
- This performance, at £15.8m for agency spend, represents an £8m reduction compared to 2016/17. Nursing and HCA agency spend is down and HCA vacancies are approaching zero. These results reflect the combined sustained efforts of the Deputy Director of HR and the Trust bank office .

Finance Report

I&E Performance – Forecast and remediation plans – Income & Non Pay

Period 12 2017/18

FORECAST	Actual													
	Apr-17 £000's	May-17 £000's	Jun-17 £000's	Jul-17 £000's	Aug-17 £000's	Sep-17 £000's	Oct-17 £000's	Nov-17 £000's	Dec-17 £000's	Jan-18 £000's	Feb-18 £000's	Mar-18 £000's	Total Expected £000's	Apr-18 £000's
Non Pay original £8m deficit forecast	(9,871)	(12,495)	(12,903)	(13,057)	(12,849)	(12,083)	(13,043)	(13,051)	(12,955)	(12,931)	(12,882)	(12,777)	(150,898)	(12,777)
Required improvement	0	0	0	0	0	0	220	220	220	220	220	220	1,320	
Revised non-pay	**(9,871)**	**(12,495)**	**(12,903)**	**(13,057)**	**(12,849)**	**(12,083)**	**(12,823)**	**(12,831)**	**(12,735)**	**(12,711)**	**(12,662)**	**(12,557)**	**(149,578)**	**(12,777)**
ACTUAL against Forecast							**(13,224)**	**(13,033)**	**(12,328)**	**(12,694)**	**(13,092)**	**(12,239)**		
Revised Plan Target non-pay Trajectory							**(401)**	**(202)**	**407**	**17**	**(430)**	**318**		**(11,300)**

Gap to close - current M13 view versus required	**(1,477)**

Notes

- Non-pay spend in P12 reflects the impact of GRNI release, the P12 underlying level is therefore consistent with previous months.

	Apr-17 £'000	May-17 £'000	Jun-17 £'000	Jul-17 £'000	Aug-17 £'000	Sep-17 £'000	Oct-17 £'000	Nov-17 £'000	Dec-17 £'000	Jan-18 £'000	Feb-18 £'000	Mar-18 £'000	Total £'000
Income: NHS Trusts	124	104	142	140	121	141	122	122	122	122	122	122	1,508
Income: Other NHS Bodies	229	156	37	172	82	167	140	140	140	140	140	140	1,684
Other Non Protected Income	132	(38)	115	102	72	(7)	66	66	66	66	66	66	775
Private Patients Income	8	50	118	261	365	269	184	184	184	184	184	184	2,173
SLAs: Main Healthcare Contracts	31,401	34,051	34,976	34,381	33,916	32,838	34,978	35,462	34,120	34,938	33,735	34,469	409,266
Grand Total	**31,894**	**34,323**	**35,389**	**35,057**	**34,557**	**33,409**	**35,491**	**35,975**	**34,633**	**35,451**	**34,248**	**34,982**	**415,406**
Actuals against forecast							35,241	36,306	34,421	35,873	33,359	41,540	
Variance to forecast							(250)	331	(212)	422	(889)	6,558	

Notes

- Income in P12 includes invoicing for over performance as well as release of a provision for fines and penalties. These adjustments therefore reflect full year performance and any year end agreement made with the CCG. Any impact they have on run rate will be a fraction of the increase in income from February to March.

Finance Report

Income Analysis

Period 12 2017/18

Performance Against SLA by Patient Type	Activity					Finance			
	Annual Plan	Planned	Actual	Variance		Annual Plan £000	Planned £000	Actual £000	Variance £000
A&E	226,873	226,873	218,261	-8,612		£24,194	£24,194	£24,978	£784
Emergencies	45,400	45,400	46,530	1,130		£85,899	£85,899	£92,954	£7,054
Emergency Short Stay	10,217	10,217	7,432	-2,785		£7,536	£7,536	£5,599	-£1,937
Excess bed days	10,495	10,495	13,703	3,208		£2,906	£2,906	£3,586	£680
Urgent Care						**£120,535**	**£120,535**	**£127,116**	**£6,581**
OP New	169,764	169,764	187,398	17,634		£25,597	£25,597	£27,394	£1,797
OP Procedures	61,597	61,597	72,176	10,579		£10,487	£10,487	£11,838	£1,352
OP Review	387,088	387,088	341,876	-45,212		£27,394	£27,394	£24,909	-£2,485
OP Telephone	12,965	12,965	15,447	2,482		£298	£298	£322	£23
DC	39,887	39,887	35,622	-4,265		£32,844	£32,844	£28,536	-£4,308
EL	6,408	6,408	6,235	-174		£16,430	£16,430	£14,873	-£1,557
Planned Care - production plan						**£113,049**	**£113,049**	**£107,872**	**-£5,177**
Planned care outside production plan	28,884	28,884	36,950	8,066		£4,683	4,683	£5,136	£454
Maternity	20,284	20,284	19,384	-900		£19,193	£19,193	£18,516	-£677
Renal dialysis	565	565	695	130		£68	£68	£83	£15
Community	619,003	619,003	642,128	23,125		£36,658	£36,658	£37,020	£362
Cot days	12,932	12,932	14,876	1,944		£6,782	£6,782	£6,820	£38
Other contract lines	3,630,049	3,630,049	4,113,522	483,473		£95,766	£95,766	£99,138	£3,373
Unbundled activity	72,583	72,583	72,056	-527		£8,512	£8,512	£8,723	£211
Other						**£171,662**	**£171,662**	**£175,437**	**£3,775**
Sub-Total: Main SLA income (excl fines)						**£405,246**	**£405,246**	**£410,425**	**£5,179**
Year to date refresh of prior months' data						£0	£0	£0	£0
Income adjustment - pass through drugs						£334	£334	£0	-£334
Fines and penalties						-£600	-£600	£0	£600
Cancer Drugs Fund						£2,636	£2,636	£964	-£1,672
Pass Through Drugs Accrual						£412	£412	£0	-£412
NHSE Oncology top up						£231	£231	£0	-£231
UHB Oncology						£924	£924	£0	-£924
National Poisons						£734	£734	£819	£85
SLA income -interpreting						£255	£255	£336	£82
SLA income -Neurophys / Maternity etc						£1,735	£1,735	£1,589	-£146
Mental Health Trust SLA						£29	£29	£30	£1
Individual funding requests						£0	£0	£23	£23
Private patients						£236	£236	£165	-£71
Overseas patients						£768	£768	£1,752	£983
Overseas patients Non EEA						£0	£0	£860	£860
Prescription Charges Income						£39	£39	£46	£7
Injury cost recovery						£1,249	£1,249	£593	-£655
NHSI Plan phasing adjustment						£7	£7	£0	-£7
Other adjustments						£1,062	£1,062	£3,765	£2,703
GRAND TOTAL patient related income						**£415,298**	**£415,298**	**£421,369**	**£6,071**

Notes

- This table shows the Trust's full year patient related income including SLA income performance by point of delivery as measured against the contract price & activity schedule.
- Planned care within the production plan is behind by £6.2m for the year.
- The 2017/18 deal with the CCG has offset the impact of this on out-turn. However this failure represents a risk to the 2018/19 plan.

Finance Report

Capital

Period 12 2017/18

Programme	Year to Date NHSI Revision £'000s	Year to Date Actual £'000s	Year to Date Gap £'000s	*Orders Placed £'000s*	Full Year NHSI Plan £'000s	Full Year Forecast £'000s	Full Year Variance £'000s
Estates	14,340	14,422	82	*6,522*	20,624	14,340	6,284
Information	8,666	8,314	(352)	*397*	10,572	8,330	2,242
Medical equipment / Imaging	2,266	2,249	(17)	*141*	5,006	2,266	2,740
Contingency	0	0	0	*0*	0	0	0
Sub-Total	**25,272**	**24,986**	**(287)**	*7,059*	**36,202**	**24,936**	**11,266**
Technical schemes	988	1,114	126	*0*	10,386	986	9,400
Donated assets	76	164	88	*0*	84	78	6
Total Programme	**26,336**	**26,264**	**(72)**	*7,059*	**46,672**	**26,000**	**20,672**

Notes

- In January 2018, the Trust re-forecast its Capital expenditure at £26m, against an original plan of £46.672m.
- The CRL was then adjusted for two further allocations; £336k in total for Informatics WiFi and Cyber security. The resultant gross expenditure plan stands at £26.3m so with a YTD actual spend of £26.264m there is an underspend of £72k.
- The Trust has therefore achieved its statutory duty in relation to CRL.

Finance Report

SOFP

Period 12 2017/18

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

	Balance as at 31st March 2017	Balance as at 31st March 2018	NHSI Planned Balance as at 31st March 2018	Variance to plan as at 31st March 2018	Forecast 31st March 2018
	£000	£000	£000	£000	£000
Non Current Assets					
Property, Plant and Equipment	207,434	215,978	242,166	(26,188)	220,917
Intangible Assets	166	698	239	459	239
Trade and Other Receivables	43,017	62,941	92,045	(29,104)	69,710
Current Assets					
Inventories	5,268	4,769	4,177	592	4,177
Trade and Other Receivables	25,151	40,249	20,946	19,303	25,946
Cash and Cash Equivalents	23,902	9,689	309	9,380	4,500
Current Liabilities					
Trade and Other Payables	(68,516)	(62,458)	(38,646)	(23,812)	(63,249)
Provisions	(1,138)	(1,855)	(1,196)	(659)	(1,196)
Borrowings	(903)	(1,306)	(3,353)	2,047	(2,187)
DH Capital Loan	0	0	0	0	0
Non Current Liabilities					
Provisions	(3,404)	(3,454)	(3,012)	(442)	(3,012)
Borrowings	(33,954)	(32,646)	(50,077)	17,431	(31,767)
DH Capital Loan	0	0	0	0	0
	197,023	**232,605**	**263,598**	**(30,993)**	**224,078**
Financed By					
Taxpayers Equity					
Public Dividend Capital	205,362	226,891	252,540	(25,649)	232,055
Retained Earnings reserve	(24,972)	(11,129)	(5,822)	(5,307)	(24,857)
Revaluation Reserve	7,575	7,785	7,822	(37)	7,822
Other Reserves	9,058	9,058	9,058	0	9,058
	197,023	**232,605**	**263,598**	**(30,993)**	**224,078**

Notes

- The table is a summarised SOFP for the Trust including the actual and planned positions at the end of the 2017/18 financial year.
- The cash impact of the land sale, reduced capital expenditure and working capital management have offset the cash impact of the underlying position. This has resulted in a cash balance at the 31st March of £9.7m.
- The position in this statement is consistent with the key data return to NHSI on 17th April. The ledger remains open and so this will not reflect the draft accounts submission of the 24th April. The main difference will be related to impairments and it will not impact cash.
- The draft accounts will then be subject to audit and any audit adjustments may lead to changes.

Finance Report

SOCF

Period 12 2017/18

ACTUAL/FORECAST	April Actual £000s	May Actual £000s	June Actual £000s	July Actual £000s	August Actual £000s	September Actual £000s	October Actual £000s	November Actual £000s	December Actual £000s	January Actual £000s	February Actual £000s	March Actual £000s
Receipts												
SLAs: SWB CCG	22,627	22,930	22,303	22,269	22,216	22,327	22,372	22,556	23,376	15,569	22,409	24,939
Associates	6,278	6,675	6,356	6,393	6,500	6,418	6,509	6,176	6,277	14,601	6,684	7,439
Other NHS	1,980	750	646	1,151	1,204	856	487	925	1,476	916	729	1,717
Specialised Services	3,583	3,374	3,838	6,668	4,327	3,373	3,536	3,787	3,364	3,161	3,689	8,858
STF Funding and Taper Relief	0	0	0	0	0	1,337	0	0	8,467	0	0	0
Over Performance	0	0	0	0	0	0	0	0	0	0	0	0
Education & Training - HEE	353	0	4,353	0	4,352	0	0	0	4,689	3	0	4,670
Public Dividend Capital	5,050	5,138	0	5,500	0	0	0	0	3,290	2,215	210	126
Loans	0	0	0	0	0	0	0	0	0	0	0	0
Other Receipts	1,769	4,237	2,759	2,770	3,138	2,661	2,413	2,737	1,459	3,679	2,800	4,313
Land Sale Receipt					18,800							
Total Receipts	41,641	43,105	40,255	44,751	60,538	36,973	35,318	36,181	52,397	40,145	36,521	52,062
Payments												
Payroll	13,431	13,789	14,017	13,567	14,042	14,023	13,877	13,627	14,290	14,074	13,953	14,254
Tax, NI and Pensions	9,910	10,133	10,202	10,047	10,062	9,867	9,789	10,232	10,197	10,223	10,092	10,047
Non Pay - NHS	2,342	2,929	2,230	1,911	2,628	1,093	3,606	1,844	1,588	1,960	2,200	2,200
Non Pay - Trade	3,100	12,869	13,105	10631	14,311	11,662	12,608	9,666	9,257	13,663	9,142	19,571
Non Pay - Capital	11,368	4,422	1,720	1,645	1,179	3,155	2,244	2,600	1,656	771	1,329	0
MMH PFI	3,397	2,055	2,552	2,022	1,587	735	630	2,549	2,075	2,778	0	0
PDC Dividend	0	2	0	0	3	3,447	0	2	0	1	0	2,963
Repayment of Loans & Interest	0	0	0	0	0	0	0	0	0	0	0	0
BTC Unitary Charge	440	440	440	440	440	440	440	440	440	440	440	440
NHS Litigation Authority	1,092	1,092	1,092	1,092	1,092	1,092	1,092	1,092	1,092	1,092	0	0
Other Payments	514	710	186	133	464	285	117	138	173	880	921	603
Total Payments	45,595	48,442	45,544	41,487	45,809	45,799	44,402	42,190	40,768	45,882	38,077	50,079
Cash Brought Forward	23,873	19,919	14,582	9,292	12,556	27,285	18,459	9,375	3,366	14,995	9,258	7,701
Net Receipts/(Payments)	(3,954)	(5,337)	(5,290)	3,264	14,729	(8,826)	(9,084)	(6,009)	11,628	(5,737)	(1,556)	1,983
Cash Carried Forward	19,919	14,582	9,292	12,556	27,285	18,459	9,375	3,366	14,995	9,258	7,701	9,684

Notes

- This cash flow summarises the cash movements during 2017/18.
- It indicates that the Trust exited the year with a £9.7m cash balance.
- This exceeded the forecast level of £4.5m. This was the level consistent with the revised EFL.
- On the basis of this performance the Trust has not exceeded its EFL.

Finance Report

Use of Resources Rating

Period 12 2017/18

Finance and use of resources rating	Expected Sign	03PLANYTD Plan 28/02/2018 YTD Number	03ACTYTD Actual 28/02/2018 YTD Number	03VARYTD Variance 28/02/2018 YTD Number	03PLANCY Plan 31/03/2018 Year ending Number	03FOTCY Forecast 31/03/2018 Year ending Number	03VARCY Variance 31/03/2018 Year ending Number	Maincode Subcode
Capital service cover rating	+	2	4		1	3		PRR0160
Liquidity rating	+	4	4		4	4		PRR0170
I&E margin rating	+	3	2		1	1		PRR0180
I&E margin: distance from financial plan	+		1			2		PRR0190
Agency rating	+	2	3		2	3		PRR0200

Overall finance and use of resources risk rating	Expected Sign	03PLANYTD Plan 28/02/2018 YTD Number	03ACTYTD Actual 28/02/2018 YTD Number	03VARYTD Variance 28/02/2018 YTD Number	03PLANCY Plan 31/03/2018 Year ending Number	03FOTCY Forecast 31/03/2018 Year ending Number	03VARCY Variance 31/03/2018 Year ending Number	Maincode Subcode
Overall rating unrounded	+		2.80			2.60		PRR0202
If unrounded score ends in 0.5	+		0.00			0.00		PRR0204
Risk ratings before overrides	+		3			3		PRR0206
Risk ratings overrides:								
Any ratings in table 6 with a score of 4 override - if any 4s "trigger" will show here	Text		Trigger			Trigger		PRR0208
Any ratings in table 6 with a score of 4 override - maximum score override of 3 if any rating in table 6 scored as a 4	+		3			3		PRR0210
Control total override - Control total accepted	+		YES			YES		PRR0212
Control total override - Planned or Forecast deficit	Text		No			No		PRR0214
Control total override - Maximum score (0 = N/A)	+		0			0		PRR0216
Is Trust under financial special measures	Text		No			No		PRR0218
Risk ratings after overrides	+		3			3		PRR0220

Notes

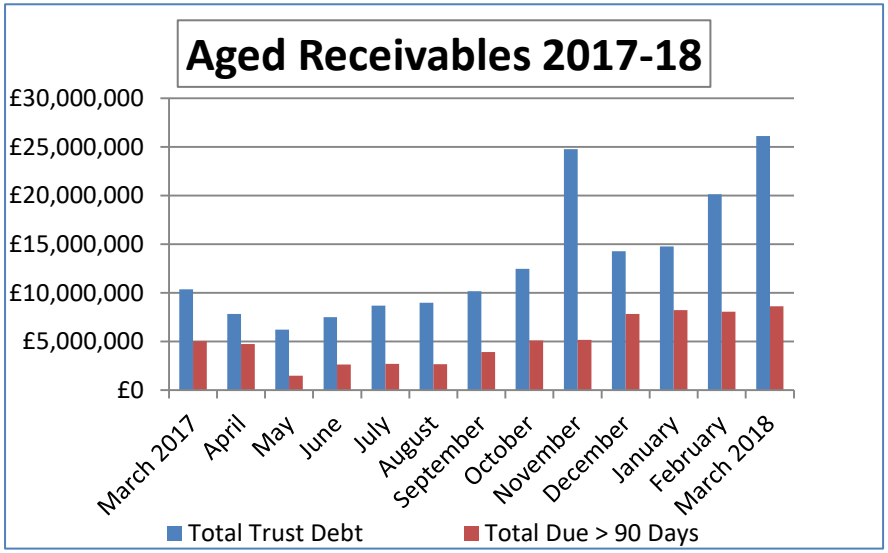
- The Trust's latest* use of resources rating year to date is 3 (amber) with a number of metrics showing 1 or 2 as previously reported. This is related to the profit generated on land which has been reported since the land sale transaction. However, not all metrics are affected:
- Capital service cover is calculated using margin before profit on sale and so is unaffected and consequently remains red;
- Agency spend remains more than plan resulting in a score of 3.

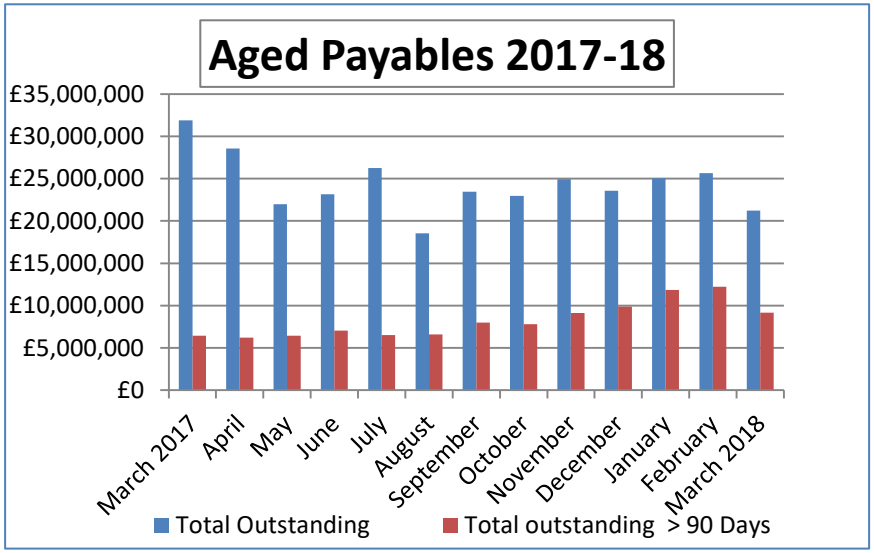
*This is P11 and is consistent with P10. P12 is not yet available.

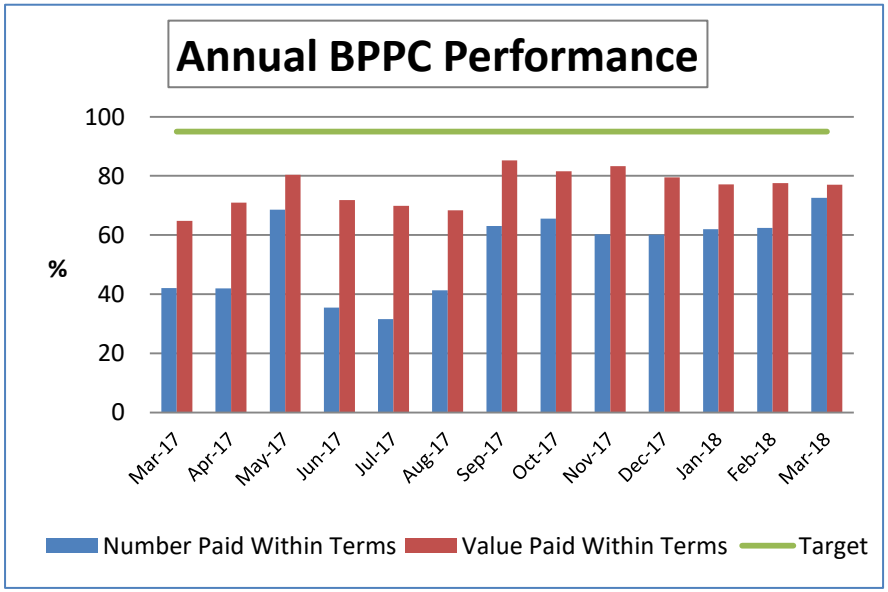
Finance Report

Aged Receivables, Aged Payables, BPPC and Cash Forecast

Period 12 2017/18







Note

- The March debt increased compared to February. The biggest driver of this was an NHSE SLA payment of £3m. This should have been paid within the month of March but wasn't received until the beginning of April. Since this was paid it does not represent a concern for aging or bad debts. March is also the month when invoices for over performance on NHS SLAs are raised. These will therefore have been reflected in the receivables balance at the end of March but not paid within that month.
- The overall Payables position has reduced since February. This is related to the implementation of the new system. The finance team made efforts to reduce the number of transactions that would be transferred over to the new ledger. The overall level of over 90 days liability has also reduced by 17% as old NHS invoices were paid.
- 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.

Appendices

Finance Report

Appendix 1 - Technical support

Period 12 2017/18

Contingency & flexibility utilised in delivering actual FY performance

	P12 Month	P12 FY
Unplanned contingency & flexibility	**£k**	**£k**
GRNI accrual released from balance sheet	1,032	1,840
Relase of pay accrual for Medical staffing		480
Accrual for winter pressures income	1,315	2,029
Release EDF Invoice accrual		177
Release Sandwell MBC Invoice accrual		79
Release invoices under £1k accrual		278
Relase of pay accrual for Admin, Nursing and Scientific staff groups		391
EPR accrual released from balance sheet		743
Taper relief - timing - income excess over costs accrued	3,767	4,000
Other contingency & flexibilities utilised		175
Release Commissioning provision	3,200	3,200
Profit on sale		16,300
	9,314	29,693
Planned contingency & flexibility		
Taper relief - income used to fund planned capex	250	3,000
Other contingency & flexibilities utilised	0	0
	250	3,000
Contingency & flexibility required to deliver FY reported position	**9,564**	**32,693**

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

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

The commissioning provision is classed as technical support although it was created in the 2017/18 financial year.

Notes

This details the non-operational support that has been utilised to achieve the reported full year positions*1. Also shown is the support required to maintain alignment with pre-STF plan *2.

Finance Report

Appendix 2 - Group I&E Performance

Period 12 2017/18

Period 12	Current Period			Run rate change	Year to Date		
	Plan	Actual	Variance	since P11	Plan	Actual	Variance
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Medicine & Emergency Care	1,911	1,137	(774)	191	20,918	16,312	(4,606)
Surgical Services	1,514	1,130	(384)	798	18,427	9,398	(9,029)
Women's & Child Health	1,957	1,725	(231)	191	23,359	19,400	(3,959)
Primary Care, Community and Therapies	1,024	661	(362)	325	10,297	6,513	(3,784)
Pathology	382	347	(35)	(83)	4,333	4,140	(193)
Imaging	324	371	47	158	3,581	2,626	(955)
Clinical Groups	**7,113**	**5,371**	**(1,741)**	**1,579**	**80,915**	**58,389**	**(22,526)**
Strategy and Governance	(1,285)	(1,268)	17	(53)	(15,632)	(14,995)	637
Performance & Insight	(108)	(122)	(14)		(1,298)	(1,258)	39
Finance	(440)	(411)	29	(43)	(4,382)	(4,377)	4
Medical Director	(1,056)	(708)	348	119	(10,440)	(9,865)	575
Operations	(1,122)	(1,034)	88	253	(13,720)	(13,406)	314
Workforce & Organisation Development	(481)	(494)	(13)	10	(5,979)	(6,014)	(35)
Estates & New Hospital Project	(1,158)	(1,320)	(162)	(199)	(12,707)	(13,192)	(484)
Corporate Nursing & Facilities	(1,367)	(1,848)	(481)	(140)	(17,284)	(19,305)	(2,021)
Corporate Directorates	**(7,018)**	**(7,205)**	**(187)**	**(53)**	**(81,442)**	**(82,412)**	**(970)**
Central	735	2,564	1,829	652	1,289	15,605	14,316
Income	1,408	8,432	7,024	6,519	16,017	22,260	6,243
Reserves	11,871	921	(10,950)	880	(7,055)	0	7,055
Technical Adjustments	17	(21)	(38)	(40)	208	63	(145)
DH Surplus/(Deficit)	**14,126**	**10,063**	**(4,063)**	**9,537**	**9,932**	**13,904**	**3,973**

Notes

- While the bottom line Trust full year variance year is favourable (vs budget) due to non-recurrent, non-operational support, the underlying Group variance of £22.5m adverse is highlighted as being offset by central items and release of reserves.
- Achievement of the control total has required significant use of non-recurrent measures, recognition of non-recurrent income, and further non-commitment of reserves.

Finance Report

Appendix 2 - Group I&E Variances

Period 12 2017/18

Period 12	Year to Date Variances													
	Main SLA excl P/T £'000s	Pass Thru SLA Inc £'000s	CDF and FP10s £'000s	Other PRI £'000s	STF £'000s	Other Income £'000s	Pay Substantive £'000s	Pay Bank £'000s	Pay Agency £'000s	Pay Other £'000s	Non Pay Pass Thru £'000s	Non Pay Other £'000s	Non Opex £'000s	TOTAL £'000s
Medicine & Emergency Care	8,269	2,334	0	(1,483)		(244)	7,993	(9,455)	(8,668)	(744)	(2,334)	(274)	0	(4,606)
Surgical Services	(6,580)	(96)	(96)	570		397	6,183	(4,340)	(2,492)	(1,283)	191	(1,484)	0	(9,029)
Women's & Child Health	(1,212)	153	0	(397)		(122)	4,779	(2,212)	(952)	(2,936)	(153)	(907)	0	(3,959)
Primary Care, Community and Therapie	1,124	1,361	(1,672)	(1,017)		5	4,419	(2,904)	(1,549)	(3,017)	311	(845)	0	(3,784)
Pathology	119	0	0	(105)		573	1,556	(321)	0	(1,524)	(0)	(492)	0	(193)
Imaging	(390)	0	0	95		(175)	983	(718)	(479)	31	0	(303)	0	(955)
Clinical Groups	**1,329**	**3,753**	**(1,768)**	**(2,337)**	**0**	**434**	**25,914**	**(19,949)**	**(14,139)**	**(9,473)**	**(1,985)**	**(4,305)**	**0**	**(22,526)**
Strategy and Governance	0	0	0	1,851		548	(67)	(150)	(134)	30	0	(1,441)	0	637
Performance & Insight	0	0	0	0		0	171	(8)	(108)	0	0	(15)	0	39
Finance	0	0	0	0		55	349	(175)	(136)	(14)	0	(75)	0	4
Medical Director	0	0	0	81		(268)	1,303	(471)	(2)	0	0	(68)	0	575
Operations	0	85	(367)	371		486	1,916	(635)	(503)	5	282	(1,325)	0	314
Workforce & Organisation Developmer	0	0	0	0		634	(228)	(205)	(12)	78	0	(303)	0	(35)
Estates & New Hospital Project	0	0	0	0		190	148	(48)	(51)	0	0	(723)	0	(484)
Corporate Nursing & Facilities	4	0	0	(6)		138	2,121	(2,005)	(99)	(1,102)	0	(1,072)	(0)	(2,021)
Corporate Directorates	**4**	**85**	**(367)**	**2,296**	**0**	**1,782**	**5,714**	**(3,697)**	**(1,045)**	**(1,003)**	**282**	**(5,022)**	**(0)**	**(970)**
Central	7	0	0	(259)	(2,909)	573	498	175	424	0	0	(2,350)	18,158	14,316
Income	(5,406)		0	8,733		2,842	94	0	0	0	0	(0)	(21)	6,243
Reserves	0	0	0	0		(8,910)	0	0	0	3,666	0	12,298	0	7,055
Technical Adjustments	0	0	0	0		0	0	0	0	0	0	0	(145)	(145)
DH Surplus/(Deficit)	**(4,066)**	**3,838**	**(2,135)**	**8,434**	**(2,909)**	**(3,279)**	**32,221**	**(23,472)**	**(14,760)**	**(6,809)**	**(1,703)**	**621**	**17,992**	**3,973**

Notes

- This shows the Group variances from their internal control totals in more detail. The net impact of STF failure and profit on sale driving the bottom line variance is seen in Central.

- The significant reliance on bank and agency staff is shown. Work streams to tackle pay include rostering, waiting list initiative and recruitment practices. The favourable variance seen in Central pay is a non-recurrent adjustment. Other pay relates to unidentified CIPs in Groups and the benefit of the reserve held for incremental drift. The pass through variance including cancer drugs fund and FP10 prescribing is net nil with Group overspends on other non-pay and the release of non-pay reserves benefitting the position.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC MEETING MINUTES

Venue: Conference Room, The Education Centre, Sandwell General Hospital

Date: 5th April 2018, 0930h – 1245h

Members Present:

Mr R Samuda, Chair	(RS)	**In Attendance:**	
Ms O Dutton, Vice Chair	(OD)	Mr M Reynolds, Chief Informatics Officer	(MR)
Cllr W Zaffar, Non-Executive Director	(WZ)	Mr D Baker, Director of Partnership and Innovations	(DB)
Mrs M Perry, Non-Executive Director	(MP)	Mrs C Rickards, Trust Convenor	(CR)
Mr H Kang, Non-Executive Director	(HK)	Mrs R Wilkin, Director of Communications	(RW)
Mr T Lewis, Chief Executive	(TL)	Miss Clare Dooley, Head of Corporate Governance	(CD)
Mr T Waite, Finance Director	(TW)	Mr J Pollitt, Assistant Director Strategic Development for item 13	(JP)
Dr D Carruthers, Medical Director	(DC)	Mr C Archer, Assistant Director Strategic Development, for item 13	(CA)
Ms R Barlow, Chief Operating Officer	(RB)		
Ms E Newell, Chief Nurse	(EN)	**Board Support**	
Miss K Dhami, Director of Governance	(KD)	Miss R Fuller, Executive Assistant	(RF)

Minutes	**Reference**
1. Welcome, apologies and declaration of interests	**Verbal**

Apologies were received from Professor Thomas and Mr Hoare.

Mr Samuda took the opportunity to thank Mrs Newell, Chief Nurse, who will be retiring from the NHS at the end of the month. He thanked her for her contribution to the Trust and the NHS and paid tribute to her contribution in the Trust being shortlisted by the Health Service Journal on Culture Change and also her work with clinical colleagues on the implementing the Trust Safety Plan.

Mrs Newell's successor, Mrs Paula Gardner, will join the Trust Board at the May 2018 meeting.

Declaration of Interests

No declarations of interests were received by Trust Board members.

2. Patient Story	**Presentation**

Mrs Newell introduced Nicole, a visually impaired patient and her assistance dog 'Misty' to the Trust Board. This patient story takes place in conjunction of the relaunch of the Trust Dog Assistance Policy, and Nicole has been invited to give her experiences of Trust services/care. Mrs Newell advised that Nicole would also be making some educational videos for the Trust, following this Board meeting.

Nicole informed the Board that she and Misty have been together for approximately 6 years, and having an assistance dog has improved her life significantly, by giving her more independence and helping her with communication, which has broken down some barriers unlike using a cane, which made people more distant to approach her.

Nicole explained that the majority of staff at the Trust accepted her and Misty, but a small number of staff seemed unsure of the 'rules' about assistance dogs present in the Trust.

Nicole noted that when Mistry is working she wears a harness issued by the guide dog association. During this time it is best not to approach or interact with her, but never be afraid to ask the owner if you want to stroke an assistance dog.

Nicole described an experience she had encountered during a visit to A&E. A doctor would not enter the treatment room and spoke to her from the doorway. There was no reason given about why the doctor did not want to come into the treatment room, and an assumption was made that it may have been a fear/phobia or due to cultural reasons. Also, Nicole was asked for the dog to leave the room while her consultation took place, which would not have been possible as Nicole would not have assistance to help her. Nicole explained all guide dogs are well trained and there temperament is not to become aggressive.

Nicole regularly attends clinics and staff know her and Mistry well, so there are usually no issues, but unfortunately when attending new places staff can be unsure how to treat her with her assistance dog.

Cllr Zaffar reflected this positive approach and raising the profile of assistance dogs. However, there have been issues with assistance dogs in the Muslim community. He stated there should be no faith restrictions for staff not to have assistance dogs in consulting rooms. Cllr Zaffar also offered his assistance in bringing this issue to the attention of Muslim colleagues.

Mr Samuda thanked Nicole and Misty for attending the Trust Board and sharing her experiences.

3. Actions from Patient Stories (April 21017 – March 2018)	**SWBTB (04/18) 001**

Mrs Newell informed the Board how the organisation gets the most out of learning from past patient stores. Many achievements have been recorded, not only from Board agreements, but from wider impacts the stories had in the organisation. Miss Dhami reminded the Board that stories are available for Quality Improvement Half Day (QIHD) sessions and on Connect (the Trust intranet). It was noted that staff are encouraged to make their own videos for learning purposes.

The following updates were highlighted, following queries from the Board:

- Breast feeding and fridges unable to store breast milk - the Infant Feeding Team have visited wards, attended meetings with managers and addressed the issue at senior nurse forums. Staff should now be confident that it is appropriate to store breast milk in ward fridges. Mrs Newell challenged this may be queried by inspectors at future inspection (CQC) visits.

The following stories were also discussed, which had been presented over the previous 12 month period:

- Parents visiting sick children on wards - the visiting policy has been revised to make it simpler for relatives and visitors to visit sick patients. This includes children who can visit, if over 2 years of age. An issue was noted in relation to a parent not able to use a staff toilet when with a sick child. It was confirmed this issue would be resolved once Midland Met Hospital is opened, as toilets will have no staff/visitor distinction.

- A Nigerian asylum seeker feared she would need to pay for medical treatment, and in general, treatment of overseas patients, which has been subject to national media interest for the NHS. Miss Dhami confirmed that a particular story regarding treatment of an asylum seeker was an error by the Trust, but the overseas policy is in place, and is used when treating all overseas visitors.

The Board discussed what further could be done to make patient stories visible. It was agreed that they are available on Connect, there may be an opportunity to play the stories (videos) on screens in the restaurant, and Heartbeat (the Trust newsletter) could feature a summary of the patient story presented to the Trust Board each month.

4. Questions from members of the public	**Verbal**

The following questions were recorded:

A request for an update on Midland Metropolitan Hospital construction. Mr Lewis reported interim works he had been discussing, to re-open the site in March, did not commence. However, as stated in the media today, early indications are that this will take place in April. Mr Lewis provided assurance, from the Prime Minister's recent statement to Parliament, that the hospital will be completed, noting the time delay in mobilisation is frustrating, particularly as there is a building contractor ready to commence works.

Appointment System - Mr Hodgetts, from Healthwatch, queried the short notice he and other patients were receiving to attend hospital appointments and the disappointment of arriving for some appointments to find it has been cancelled. Mr Hodgetts also queried why patients are receiving letters to book an appointment only to call and find all appointments have already been fully booked and a further letter would be provided once more appointments are released. Ms Barlow apologised for the inefficient service he and other patients are receiving and asked to speak to Mr Hodgetts outside of the meeting to ascertain further details of the experiences so she could address, and action. Mr Lewis stated a 3 week notice period should be given for appointments in the outpatient department , theatres and diagnostics, which are reportable in the Integrated Quality and Performance Report. It was noted work is ongoing to ensure visibility of this issue is covered in the Integrated Quality and Performance Report and Ms Barlow agreed to share some "real time" data that was presented at the Quality and Safety Committee as part of that visibility.

Public Trust Board - Miss Dhami advised the Board that to increase the accessibility of the public trust board meetings, the meeting we are progressing options to live stream over the next 6-12 months and from next month the meetings would be recorded.

ACTION:

- Ms Barlow to contact Mr Hodgetts to discuss experience of appointment bookings.
- Mr Baker to review the data reported in the IQPR to include </> 3 week notice

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

Mr Samuda informed the Board that new coversheets to reports are in use from this meeting. This was to draw attention to where the focus to the executive debate and provide more granularity to discussions.

Mr Samuda noted his comments to the delay on the Midland Metropolitan Hospital and stressed a lot of management time is currently being spent on managing the delay and it is essential to push hard to keep the focus high amongst all parties concerned. Mr Samuda paid tribute to the huge effort from key members of the team who are striving to get the new hospital back on track.

Mr Samuda reported on the Members Leaders Group (MLG), for governors, and gave a regular dialogue to members. It has been agreed that this group will be widened attendance/membership with patient interest groups to ensure the Trust is engaging with all in delivering the services.

Finally, Mr Samuda informed the Board of the staff pay 3 year pay award that is currently being consulted upon, which we understand will be nationally funded.

5a. Update People & OD Committee meeting held on 19th March 2018 and receive minutes from People and OD Committee meeting held on 26th January 2018	**SWBTB (04/18) 002 & 003**

Mr Kang highlighted the following from the meeting:

- Workforce planning. There is a knock on effect, due to the delay of Midland Met, on community roles and an interim model may be enacted. The temporary pay bill has been reduced, which will be further reviewed going into the next quarter.

- Junior Doctors. The junior doctor guardian reported to the committee that junior doctors felt unsupported with the new rota system as no involved in the system update. It was stated the appointment of the Education Medical Director would assist in addressing concerns and bring issues to the attention of the Trust Board.

The minutes of the meeting held on the 16th November were noted.

6b. Update Major Projects Authority 23rd March & Major Projects Authority minutes 16th February 2018	**SWBTB (04/18) 004 & 005**

Mr Samuda highlighted the following from the meeting:

- IT Infrastructure – clarification was provided on the risk rating assessment methodology for the escalation/de-escalation of risks. The focus of the meeting discussed the action plan to reduce the 2 red risks to amber in quarter 1. Mr Lewis corrected the note and confirmed all risks are to be cleared by the end of April. The amber risks were evaluated by the Committee and it was agreed they would be addressed in Q1.

- IT EPR – the Committee discussed the two dress rehearsal dates, with a smaller scale exercise taking place in April, and the full dress rehearsal in June. The level of clinical engagement was discussed and further arrangements for clinical sponsors is being finalised.

The minutes of the meeting on the 16th February were noted.

6c. Update Quality and Safety Committee – 23rd February 2018 & Quality and Safety Committee minutes 26th January 2018	**SWBTB (04/18) 006 & 007**

Ms Dutton highlighted the following from the meeting:

- Purple Point - the launch of this service commenced at the end February 2018 and the issues logged were noted as 50:50 compliments, and complaints.
- In-house Inspection Teams - feedback from the latest round is positive and more inspections will follow over the next few weeks.
- CQC Improvement Plan - progress Report. 2 of the actions will not meet the deadline of end March 2018, as require external assistance.
- Gynaecology/Oncology wards -the Committee discussed the mitigating risk of having reduced quality of service delivery to patients, due to staffing shortages. Once a solution is found, a set of actions will be put in place.
- Sepsis. - a briefing note was provided on the current national initiatives and the management of sepsis at the Trust across A&E and on wards.
- Neonatal Peer Review Report and Trust Response - a review by NHS England Quality Surveillance Team was positive but staffing issues were noted as a concern. It was noted the department is level 3 but staff at level 2/2.5

Mrs Newell reported an incident of unavoidable a death from CDiff - a TTR will be convened, and a report will be presented to the Committee.

The end of shift evaluation/approval system, being implemented for bank and agency staff to enable payment is taking place, however, it was noted that this is not an electronic process. The paper system is being used until an electronic method is in place. Mrs Newell reported that some of the elements can be completed pre-shift and the nurse then has a discussion on competences/feedback at the end of the shift.

Mrs Goodby informed the Board that a similar process will take place for non-nursing staff. Mr Lewis confirmed doctors will also have this check in place within the next month. Mrs Goodby confirmed it will be 100% compliant and Dr Carruthers confirmed doctors know who they need to report to and have a conversation on shift regarding competences, this will also ensure that the supervisory doctor is aware of any issues in training, so a doctor is not asked to undertake a competency they are not able/required to perform.

Dr Carruthers continued to inform the Board that some of the evidence can be obtained pre-shift and the discussion with the team is on the role they have been asked to complete. Mr Lewis stated this requirement was a safety requirement to ensure all clinical staff working in the Trust are able to undertake the role they are aligned to.

Mr Kang asked if the Trust's own bank staff also complete similar competency checks and Mrs Newell confirmed bank staff complete mandatory and competency based programmes prior to commencing work at the Trust.

The minutes of the meeting held on the 23rd February 2018 were noted.

6d. Update Finance & Investment Committee – 23rd March 2018 & Finance & Investment Committee minutes 23rd February 2018	**SWBTB (04/18) 008 & 009**

Mr Hoare chaired the meeting in the absence of Mr Samuda, however, following Mr Hoare's apologies for this Trust Board meeting, Mrs Perry highlighted the following:

- Financial Performance P11 - the control total and STF recovery are within plan and performance will be kept under close scrutiny towards year-end, in relation to potential capital decisions for the Board, as these are dependent on the financial positon and the commitments in Q1.

- New Finance System - no issues to escalate were noted following the launch of the system, but a full report would be presented to the Digital Committee in due course.

The minutes of the meeting held on the 23rd February 2018 were noted.

7. Chief Executive's Report	**SWBTB (04/18) 010**

Mr Lewis highlighted from his report:

Staff pay award - National consultation has commenced and, if successful, the award should commence in July, backdated to April 2018. The cost of the pay increase is centrally funded and adjustments will be made to budgets.

Specialised Commissioned Services - this is a material funding risk to the Trust, which is reflected on the Trust Risk Register. The Trust still continue to provide tertiary cancer services despite giving notice to terminate the service. The Trust is hoping to reach a final settlement with Specialised Commissioning in the near future.

GP Booking System - Mr Lewis stated the Trust is one of a small number of Trusts nationally that have the ability to book an appointment with a GP from A&E. Since its inception, in December 2017, take up of numbers has been modest. However, work is commencing to make booking a GP appointment normal clinical practice. Work will take place with the A&E teams, potentially as part of triage, if the recommendation is to book an appointment with the GP and A&E staff will do this so the patient leaves with an appointment. It was noted this system assists patients as they do not have to call the GP practice personally.

Mr Lewis informed Cllr Zaffar, following his query on ensuring the right urgent care treatment is provided, that productive discussions are taking place with Parsonage Street Walk-in Centre, by Sandwell Hospital and Summerfield Urgent Care Centre, by City Hospital.

Mrs Dutton asked for clarification on the discussion at the Clinical Leadership Executive on extended patient stay. Mr Lewis commented the discussion takes place on decision making sequence to ensure EDD is fixed and not altered by another team when reviewing patient care, unless clinical escalation increases patient stay. The conversation on behaviours, and ensuring staff have empowerment to decide length of stay in hospital, is not appropriate for recovering patients as there is clinical evidence supporting that long stays in hospital can be to the detriment of the patient. It was noted the currently length of stay for many patients was 10 days, and it is within our gift to manage the pathways so length of stay can be reduced substantially. The Trust "Consistency of Care" work is also focusing on adherence to EDD sequencing, emphasising nursing teams and doctors support EDD through meaningful conversations.

Midland Metropolitan Hospital: Risk Assessment (tabled paper) - Mr Lewis brought to the attention of the Board 2 new risks on the Trust Risk Register, namely:

- Potential late delivery of the hospital to 2020 (this item will be discussed in detail at the Private Trust Board meeting today).

- Continuing with The Hospital Company, which may jeopardise workforce, fiscal funding and leadership bandwidth.

Mr Lewis continued to add that Mrs Perry had highlighted risks at a previous Board meeting, which the tabled document addresses. However, for the May meeting a precis list under safeguarding will compiled.

Mr Lewis recommended that the Board accept into the Trust Risk Register the two risks tabled.

The Board accepted the recommendation.

AGREEMENT:

- Risk numbers 3020 and 3021 be included on the Trust Risk Register.

8. Trust Risk Register	**SWBTB (04/18) 011**

The following updates were provided on the Trust Risk Register

- Results Acknowledgement - Dr Carruthers informed the Board on two issues in acknowledging results in pathology and radiology. The pathology blood tests policy has been revised and a Quality Improvement Half Day (QIHD) will take place to ensure this is embedded within the Trust. The policy reflects timely review of tests and the QIHD will involve all clinical leads (medical and nursing). The red flagged and standard x-ray radiology reports will now require electronic acknowledgement to resolve the issue. The outstanding issue of the system not forwarding results named to alternative professional following departure from the Trust of the previously named lead, will be reviewed and the Board will be provided with an update at the June 2018 Trust Board meeting.

- Risk number 2955 was presented to the Clinical Leadership Executive but was rejected for escalation to the Board following investment into the CESR project for middle grade doctors.

ACTION:

- The Board to be provided with an update on issues of how to resolve tests/results sent to a named doctor now left the Trust, ensuring these tests are acknowledged by an appropriate staff member.

9. Integrated Quality & Performance Report	**SWBTB (04/18) 012**

Mr Lewis informed the Board of an ownership change in performance management from Tony Waite, Director of Finance to Dave Baker, Director of Partnerships and Innovation. The report forms a view of the year ahead and focuses on the calibre of actions and resolving any areas of concern. Mr Baker advised the Board of the key points for consideration namely:

- The CDiff for the year just missed the deadline to delivery, however the improvement is considered as success.

- Increased effort is focused on delivering the IPR on working day 6 of each month to enable directorate teams to have as much time as possible to focus on improvement and make appropriate changes.

- Work has been undertaken on theatre cancellations aligned to the trade-off between delivering the production plan and reducing theatre cancellations/alignment to correct bed numbers. The process is now stronger and there is an expectation that theatre cancellation rates will improve over future months.

9.1 Persistent Reds	**SWBTB (04/18) 013**

Mr Baker reported neutropenic sepsis is almost at the 100% target (currently at 91%) with cases only missing the deadline by minutes. The patient safety thermometer performance has achieved the target in February and mandatory training has improved significantly since the previous Trust Board meeting.

Mr Kang asked how many minutes was the neutropenic sepsis target missed by. Ms Barlow stated 4 breaches were reported, all of which were less than 6 minutes, and this is being further reviewed by the Risk Management Committee.

Clarity was sought on the measurement when reporting theatre cancellations/utilisations, as the paper referred to week day to week end. Following a brief discussion Mr Baker assured the board that a dashboard was available which looked at all sessions noting when theatres commenced and concluded. Mr Baker agreed to use the term "elective" and "non-elective" for ease of understanding when producing future reports.

Mrs Goodby reported, as part of the CQC report, improvement was required on basic life skills as compliance is poor and she was pleased to report this target has increased from 40% to 91% and will increase throughout April 2018 showing better transparency and clearance when CQC return to review this.

9.2 Financial Performance – P11 2017/18	**SWBTB (04/18) 014**

Mr Waite reported cash balances are ahead of plan at £4.5m and any borrowing replacement is now expected in 2018/19. The capital spend is expected to be brought in-line following minor movements in spend relating to IT (hardware) prices.

Over performance has secured the STF, which represents real cash and underpins the capital investment programme. This reflects a judgement to be made by Mr Waite that non-recurrent opportunities sufficiently exceed residual risks.

It was noted costs incurred in respect of advisors working on the Midland Met Hospital is being supported by NHS Improvement until the end of March 2018.

10. Amenable Mortality and Learning from Deaths Trajectory	**SWBTB (04/18) 015**

Dr Carruthers advised the Board how mortality data is monitored by several different measures and changes in recording, such as palliative care, and the number of co-morbidities, can affect the number of expected deaths and adversely influence the Trust's position.

Mr Kang queried if City or Sandwell have a higher mortality rate. Dr Carruthers stated the data used is comparative to local population, but recording of diseases can alter data and he would review coding of diseases.

For clarity, it was noted the Trust's Stroke Unit was based at Sandwell.

Mrs Dutton noted the weekend death rate was higher and queried if intelligence to underpin this position is known. Dr Carruthers agreed to review this further but noted some patients, particularly end of life patients, were admitted into hospital during the week with expected death to be at weekend. However, following comments from Mr Lewis, weekend mortality should be compared year on year to ascertain to position (potential pattern) further.

Following discussion the data confirms that the Trust is not unsafe, but action to reduce reported expected deaths to compare with neighbouring Trusts will take place, through improved coding and clinical care to meet the ambition to improve mortality figures.

Mr Lewis and Mr Samuda indicated that the next report should detail a route to a better than expected SHMI result and Dr Carruthers reflected the difficulty of precision but agreed that a clear aim would concentrate minds and effort.

ACTION:

- Action Plan/report to be presented to the May Trust Board meeting showing interventions to reduce amenable mortality.

11. Bed Base Risk Mitigation	**SWBTB (04/18) 016**

Ms Barlow informed the Board there are still a high number of unfunded beds in the organisation following 25 beds closed in the last 3 weeks and she will review the trigger points to enable pre-emptive measures to be taken, as this is one of the biggest financial risks to the Trust. Ms Barlow provided assurance to the Board that there was no safety implications but experience for patients requires improvement.

The Board discussed the implications of open unfunded beds on the financial position and discussed the opportunities to reduce length of bed days. These would be explored further through QIHDs and at a Consistency of Care Medicine Learning into Action event next week. Ms Dutton noted the refreshed look was welcomed and mobilising the top leadership team with the clinicians was the right approach to take.

Mr Samuda asked for clarity on risks if beds and closed and Ms Barlow commented the risk would be migrated to the ambulance service, as there would be safety issues in the A&E department to transfer patients to wards and regionally our neighbouring Trusts would be under additional pressures. Mrs Newell commented she had attended clinical ward rounds noting change is related to the opportunity to reduce length of stay so beds could be released. The number of beds to close in specialities was noted (from the paper). It was noted that work in ambulatory care has grown and there is scope to increase further, providing speciality cover at the front door i.e. respiratory teams working in A&E and other specialities to enable admittance avoidance.

Mr Lewis expressed concern and noted the financial risk to the Trust is approximately £4m – £5m, Q1 this is approximately £1m - £2m, therefore the challenge to close beds is imperative to improve the financial position. Also, individuals need to take ownership that reducing bed days is a collective task not an action for the leadership team.

The recommendation is to close beds but ensure a quality impact assessment is completed on the risk of closing 45 during April, then reducing to 31 and then down to zero. Mrs Newell stressed there would need to be an appropriate mechanism in place to measure quality and safety and was confident the necessary beds could be removed from gastro and respiratory but hard decisions would need to be taken.

Mrs Newell continued, along with Ms Barlow, on the cultural shift required across clinical teams to enable more timely (safe) discharge processes and the Trust-wide communications needed to assist this message.

Mrs Perry suggested that the Board mandate delivery of the trajectory set out by Ms Barlow – in effect a blend of two of the options offered by the paper. This was accepted by the Board and the financial and staffing plan for the Trust will reflect that approach.

12. Decreasing Sickness Absence & Improving Employee Mental Wellbeing	**SWBTB (04/18) 017**

Mrs Goodby gave the Board an update on initiatives proposed from the January 2018 meeting. She stated sickness absence has reduced to 5.6%, which is not within the target of 2.5%. There are a number of interventions to support and signpost staff to wellbeing activities however, uptake from hard to reach staff (not on email) is poor. The suggestion to offer projects during work time may improve uptake. These initiatives were discussed and challenged at the JCNC meeting and along with feedback from managers a more assertive approach Is required to increase the number of staff supported.

Mr Lewis queried how the paper responded to the Board's decision to mandate stress assessments in certain roles. Mrs Goodby indicated that it did move away from that approach because it appeared contractually complex. Mr Lewis suggested a wider executive discussion on appetite to address those concerns. Mrs Goodby noted that, as presently, managers provide support, encouragement and evidence base when asking employees to seek services.

Mr Kang commented on stress levels of staff queried manager support in relation to these sickness absences. Mrs Goodby stated there are some managers who lack confidence or awareness required to help in managing sickness related to mental wellbeing of staff. It was also noted in the sickness policy the onus was on the individual to take steps to get back to work, therefore this would be explored further through working with the JCNC to engage staff.

Mrs Rickards commented to reduce staff becoming absent and having continuous bouts of sickness should be the focus of managers, against policy, and in some cases, review the working environment to find causes of staff absence.

Ms Barlow asked about the financial impact of wellbeing interventions, as managing the finances is one priority. Mrs Goodby responded the mental health issues of staff is suggested to be underreported but having these interventions should enable long term savings (by reducing sickness absence). It was also stated there would be a Learning Into Action event (in Q2) to look for solutions to reduce absence and would involve colleagues from high performing and low performing areas. Mrs Goodby confirmed the People and OD Committee will also receive a report on MSK, which is another area of high sickness absence.

Following a discussion it was recommended that terms and conditions for new employees be reviewed to ensure any absence intervention would be mandatory rather than an optional choice.

Mr Samuda summarised the significant challenge to reducing sickness absence rates to a target level has been an issue for a long period of time and this must be a focus for improvement. The Trust has some cultural weaknesses and the current range of services offered does support staff wellbeing but in order to ensure the pay CIPs is delivered a report was requested about work which will make the difference in reducing sickness levels.

ACTION:

- Mrs Goodby to explore changing new employee terms of conditions to mandate attendance to wellbeing services.
- A firm plan to reduce sickness levels to be presented to the May Trust Board meeting.

13. City site development Options	**SWBTB (04/18) 018**

Mr Lewis introduced Mr Jim Pollitt and Mr Chris Archer, Associate Directors of Strategic Development and Mr Alan Kenny, Director of Estates and New Hospital to the meeting to contribute to the discussion on the City development once Midland Met Hospital has opened and services are transferred.

As part of the development, a new name for the City site would be explored, before approaching the local authority with our plans. Homes England will need to be approached, due to the delay of Midland Met, that the expected handover of the site by December 2019 would not take place. However, additional land may become available in due course that could be offered to them.

Mr Pollitt highlighted the plans for the City site including the building of a multi-storey car park and the possible opportunities of having a GP practice, pharmacy and care home amongst other commercial space on the site. There would also be the opportunity of providing retail outlets, which supports the growing community, and to service the workforce of the Trust and local area. Mr Pollitt continued to inform the Board that he has met with City Council planners on the Big City Plan and he received position support on the developments.

Cllr Zaffar welcomed the developments of the City site and highlighted how the landscape of Birmingham would be changing in the next 10 years including 30,000 – 40,000 new residents into the City of Birmingham, and on the City campus there is land to facilitate those services that would be required.

Mr Waite gave a briefing on the strategic case on the car park development and noted the wider economic benefits on this opportunity. Mr Lewis reiterated a car park would not blithe the landscape, as on the City site it would be no higher than the current BTC building, and the Trust would have overall control on the car park tariff. For the commercial developments there was a need to move at pace to be 'first in line' on opportunities going forward. For the non-commercial developments a GP and pharmacy would benefit the Trust and residents and this, along with the car park would be the initial developments to progress.

Mrs Dutton asked if the timescale on building the car park by 2019 was achievable. Mr Pollitt reassured the Board that the car park would be built as part of the national framework and the timescales are feasible for the car park to be built. Mr Archer explained that the majority of the due diligence work on the contractors has already taken place under framework, but that would be rerun and the Private Trust Board would receive those conclusions.

Mr Samuda confirmed that the executive team should progress the car parking initiative and work on a pharmacy and GP option, with further disposal of the City site featuring again for discussion at future Board meetings.

14. Financial Plan 2018-20 update	**SWBTB (04/18) 019**

Mr Waite reiterated the challenge for the Trust would be cash to afford the forward investment programme and there is a likelihood that revenue borrowing would need to be secured during the year. The financial control total for 2018/19 is challenging but achievable. There currently is a gap of £14m on the £42m and a list of opportunities is being worked up to address this.

The deadline to accept the control total is the 30th April 2018. Mr Lewis suggested that FIC study the matter in more detail against a set of condition precedents, which he would circulate for comment to all Board members over the following seven days. That list might include:

- Contracting income, specifically with NHSE
- Commercialisation detail to halve the gap
- The plans on sickness and beds needing to be progressed and results secured
-

It was agreed to ask FIC to make the submission and acceptance decision on behalf of the full Board.

15. Band 2 – 6 Nursing Career Escalator Programme	**SWBTB (04/18) 020**

Mrs Newell reported due to the recent pay award the uniqueness of the financial package for this programme has diminished. However, alternative proposals on the bonus incentive scheme have been discussed with lawyers, the Directors of Finance and at the People & OD Committee and reassurance is provided that this does not contravene standing financial instructions. The ability to offer a nurse £2,000 one-off payment as a bonus (payable in 2 segments) would be unique to this Trust. Mr Kang queried assurance for the Trust to ensure a nurse does not leave after the year and Mrs Newell confirmed a payback solution would be caveated, excluding exemptions such as maternity and unplanned sickness etc. Mr Waite queried this may have an affect allocation of budgets and possibly CIP, which he would discuss further with Mrs Newell outside of the meeting.

Mrs Newell recommended the Board approve/endorse the recommendation and confirmed that KPIs would be drawn up for regular monitoring via the People & OD Committee to stock take, after the first year of inception. The first cohort would commence in August/September 2018 after PDRs have been finalised.

Mr Lewis asked for a report in 3 months on whether there are any other professional areas this model could be used. Mrs Goodby stated there were other areas where key vacancies existed and she would provide the update, working in co-ordination with the Chief Nurse. Mrs Newell continued to state that due to the cessation of bursary payments for nurse training this programme has been devised to address the careers for band 2 – 6 nursing staff, but added caution before scoping other areas, as this would need to be proven as a success prior to any other role out.

16. Minutes of last meeting and action log (1st March 2018)	**SWBTB (04/18) 021/22**

Mrs Dutton had requested a quality impact assessment to be completed on the closure of the Halcyon Birth Centre, which was omitted from the minutes. Notwithstanding this amendment the minutes were agreed as a true reflection of the meeting.

Action Log – An update was provided for the following actions:

1st March 2018
1 – Question from the Public. No resolution at this time but the query has been raised with NHS Improvement.

4th January 2018
2 – Patient Story. There is a financial impact on producing all outpatient clinical letters on yellow paper of approximately £15 - £16 per week. This will be checked and the decision to proceed will be made by the Executive team as it is within their delegated powers. It was therefore agreed to close this action.

5th October 2017
1 – Perinatal Mortality Peer Review. A draft will be presented to the May Board and the assignee to be amended to the incumbent Chief Nurse – Paula Gardner.

6th July 2017
1 - Smoking Cessation. A set of locations to be provided to the next meeting.

17. Matters arising	**Chair**
There were no matters arising for discussion.	
18. Any other business	**Chair**
No other items of business were received.	
19. Date and time of next meeting	**Chair**
The next public Trust Board will be held on 3rd May 2018 2018 in the Training Room at Rowley Regis Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Public Trust Board Action Log – 5th April 2018

	Action	Assigned to	Due Date	Status / Response
From Meeting held on 5th April 2018				
1	Questions from members of the public. • Ms Barlow to review data reported in IPR on missed appointments and ascertain tolerable levels	RB	May 2018	Verbal update to May Board Meeting
2	Trust Risk Register. Update to be provided on the issues of how to resolve tests/results sent to a named doctor once left the Trust. Obtaining assurance that another colleague are receiving results	RB	June 2018	Not yet due
3	Amenable Mortality and Learning from Deaths Trajectory. Action Plan to be presented to the Trust Board showing interventions to reduce deaths from 109 to 95	DC	May 2018	Report provided for May Board meeting
4	Decreasing Sickness Absence and Improving Employee Mental Wellbeing. • Examine changing contracts of employment for new employees to mandate attendance at stress assessments • A report on how the sickness target will be achieved	RG RG	June 2018 May 2018	Not yet due Report provided for May Board Meeting
5	Financial Plan 2018/20 Update. A list of budget approved caveats to be circulated.	TL	May 2018	Completed
From Meeting held on 1st March 2018				
3	Update Quality & Safety Committee – 23.2.18. Q&S Committee to receive an update on Sepsis (to April Meeting) and Board (May Meeting)	KD	May 2018	Report provided for May Board Meeting
From Meeting held on 1st February 2018				
1	Audit & Risk Management Committee – 24th January 2018. The Trust Board to receive the action plan on the GDPR.	KD	May 2018	Report provided for May Board Meeting and detailed discussion at May A&RMC

From Meeting held on 5th October 2017				
1	Perinatal Mortality Peer Review: Provide an update to the Trust Board in 6 months to highlight improvements actions which have taken place	PG	May 2018	Report provided for May Board Meeting
2	Financial performance: P05. Outstanding debt of Birmingham City Council to be progressed with Graham Betts.	TL	~~Nov 2017~~ ~~Feb 2018~~ ~~May 2018~~ ~~June 2018~~	Not yet due
From Meeting held on 6th July 2017:				
1	Smoking cessation: matter to be resolved and reported to Trust Board. This will be discussed at the Public Health, Community Development and Equality Committee	TL	~~Dec 2017~~ ~~Feb 2018~~ May 2018	Verbal update to May Board Meeting

Paper ref:	TB (05/18) 023

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Q4 Complaints Report		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author	Karen Wood, Head of Complaints		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Committee should focus on]*

The Complaints Report provides a summary of complaints received during Quarter 4 2017/18, breaking down these complaints by Clinical Groups and Corporate Directorates, themes of complaints and learning as a result. Of particular note

- A total of 239 formal complaints, and 518 informal complaints were made against the Trust in Q4 2017/18.
- The increased number of complaints that have breached their target response date, against the fact that 92% of complaints have been responded to in time.
- A report on the first 2 months of the Purple Point initiative. Detailed are calls received and how they were managed.
- Examples of learning as a result of complaints investigations, from Medicine and Emergency Care, Women and Child Health, Surgical Services and Primary Care and Community and Therapies; and moving forward, details on the renewed focus on recording and monitoring learning, supported by the complaints team.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan		Public Health Plan		People Plan & Education Plan	
Quality Plan		Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	X

3. Previous consideration *[where has this paper been previously discussed?]*

None

4. Recommendation(s)

The Trust Board is asked to:

a.	It is recommended that the committee DISCUSS and NOTE the contents of the report.
b.	
c.	

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s):					
Board Assurance Framework		Risk Number(s):					
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Complaints Report

2017/18: Quarter 4

Where EVERYONE Matters

At a glance

239

Formal complaints dealt with in Q4 2017/18

704

Informal complaints dealt with in Q4 2017/18

32.73

The average number of days taken to complete a formal complaint

83% (160)

Complaints were responded to on or prior to their target date in Q4 2017/18, that were received in 2017/18.

86% (174)

Complaints responded to in Q4 2017/18 on or prior to their target date to date (regardless of when they were received)

2.5

Number of complaints received per 1000 bed days

5.6

Number of complaints received per 1000 finished consultant episodes (FCEs)

68% (162)

Of the complaints received were about the clinical care provided

73% (151)

Of resolved complaints were either partially or wholly upheld in favour of the complainant

37

Complaint were reopened in Q4 2017/18 because of dissatisfaction with the original response

1 new / 3 closed

PHSO investigations for Q4 2017/18

In detail

The total number of compliments for this quarter was not available as a Trust total, but data relating to satisfaction is now coming through from the Purple Points. To date, the collection of this data has not been recorded consistently but as calls start to come in from the new Purple Points, compliments will be reported in amongst these results. In Q4 2017/18, Purple Points have collected 4 compliments.

A total of 269 complaints were presented to the Trust in Q4 2017/18 with 30 cases being withdrawn leaving a total of 239 to manage.

A total of 518 informal complaints were registered in Q4 2017/18 (previously referred to as PALS enquiries) which is consistent with previous quarters. There were a number of additional calls fielded through the team during this period and this is detailed in Appendix 2, Cancer Service calls.

The average number of days taken to resolved complaints in Q4 2017/18 (those that have been received since 1 April 2017) is 32.73 with 27 cases breaching their target date in Q4 2017/18, which is 87% against a target of 97%.

The average number of days taken to conclude the all cases closed in Q4 2017/18 was 30.76, exceeding the 30 day KPI.

The number of complaints per 1000 bed days has increased for the first time since Q4 2016/17 rising to 2.5 in Q4 2017/18. Surgery still has the highest complaints rate, but the differential remains less prevalent this quarter with a continued downward trend.

The number of complaints per 1000 FCEs has also increased to 5.6 in Q4 2017/18 compared to 4.7 in Q3 2017/18. Surgery still also has the highest complaints rate for FCE with a similar differential, compared with other Groups, to the previous quarters.

The most complained about theme, continues to be clinical care, at 68% (162). Last quarter, the second most complained about issue was the attitude of staff at 11% of (and was also the case for the last three quarters), but in this quarter there was a 4% decrease in the number complaints about staff attitude, making it the third most complained about issue. The second most complained issue in Q4 2017/18 being related to outpatient appointments.

73% of complaints (151) closed in Q4 2017/18 were either partially or wholly upheld in favour of the complainant. This is the highest rate of upheld complaints since Q2 2015/16.

37 complaints were reopened as a result of the complainant's dissatisfaction with their original response, in Q4 2017/18. 1 of these cases was reopened because we had not answered all issues in the complaint; the average number reopened for this reason over the last 2 years has dropped to 1.75 per quarter.

There was only 1 new PHSO case open in Q4 2017/18, which remains unusually low, with 3 cases being closed in Q4 2017/18. 2 were not upheld and 1 was upheld with an apology letter required as remedy.

Learning from patient feedback

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

It is the Trust's responsibility to ensure that this feedback is used to improve patient safety, the delivery of service, and patient experience.

Below are some examples, one from Surgical Services, Medicine and Emergency Care, Women and Child Health and Primary Care and Community and Therapies

Surgical Services

There have been problems in ordering lenses the same day as patients have been seen in Ophthalmology, and this was reported through a patient complaint. The department has now implemented a more efficient system that will ensure urgent lenses are ordered by the end of each day ensuring that delays.

Primary Care and Community and Therapies

The Physiotherapy Department have committed to changing the letter template when a patient does not attend an appointment. Feedback through complaints indicated that information was not being edited to reflect the patient's individual circumstances. Regular discharge letter audits for all clinical staff are now in place, to ensure that the information contained is appropriate and accurate.

Medicine and Emergency Care

Following concerns raised about the attitude of nurses in ED, the family of a patient logged a formal complaint about this and other aspects of care. It was evident that this formal complaint may have been more effectively resolved locally at the time, instead of being advised to log a complaint.

The ED matron has undertaken to improve the skills and knowledge of the team to resolve patient/relative complaints in real time locally rather than referring to complaints/PALS. Complaint's training is currently underway in the department for senior nurses and managers.

Women and Child Health

A patient had been involved in an road traffic accident and was taken to Maternity Triage by ambulance crew. There was a considerable delay in the patient being seen, even though there were vacant beds and other patients waiting had offered that she could go in before them. However the receptionist advised the patient to wait her turn. Eventually the patient was seen and because baby's heartrate caused concern, baby was quickly delivered by c-section but was transferred to the Neonatal Unit (NNU).

As a result of the complaint, the patient was invited to an event called "Whose Shoes". This event provides an opportunity for patients to share experiences and to focus on developing maternity services in the Black Country.

Positive
Complainant feedback

A patient called to raise a concern (an informal complaint) and took the trouble to call back to compliment the person they spoke to. Following their intervention, things started to happen, and the patient genuinely felt that they had the support that they needed. They are really grateful for her help.

A complaint was logged about delays in arranging a scan for the complainants wife, who had recently been diagnosed with lung cancer. Before logging the complaint complaints staff intervened, to see if the scan could be arranged. Once this was done, the patient and her husband were advised. The complainant revoked this complaint. Due to the help and support of the team without the scan was arranged, and his wife was diagnosed and treated without further delay. As a result the complainant requested that the complaint be withdrawn as the issue been dealt with.

In summary

- 60 cases received since 1 April 2017 have exceeded their due date, resulting in a 92% compliance rate for this year. Whilst this means that only 8% of cases have exceeded their target date, the number of responses breaching this target has increased despite the contingency measures that had been implemented and is reported as largely to do with staffing issues. Recruitment is now complete, and all cases that have breached their target date and are still outstanding, will be completed by the end of April 2018.

- In previous reports, it was noted that although complaints numbers had been declining, numbers had started to increase. In Q4 2017/18, there has been a notable increase in formal (but not informal) complaints, and this rise is most noticeable in Surgery (70 compared to 53 in Q3 2017/18) and Women Child Health (41 compared to 18 in Q3 2017/18).

- The time taken to turn cases around has again averaged over the accepted 30 day quality standard, both in terms of the overall case load, and those that have been received since 1 April 2017. The result for Q4 2017/8, for those complaints brought against the Trust since April 2017 is 32.73 days.

- Whilst the main theme of complaints has not changed this quarter (all aspects of clinical care) in previous reports, it was reported that the number of complaints and concerns about appointments was on the decline. This is not the case for Q4 2017/18. Also of note is the fact that the most informally complained about issues is our management of appointments.

- PHSO cases continue to decrease with again only 1 new case being opened in Q4 2017/18. 3 cases were closed this quarter, resulting in 8 being closed in 2017/18 at a 50% not upheld rate for this year.

Key areas for focus from the financial year 2018/19 and Q4 2017/18

As previously reported, there are a number of quality improvement initiatives that are being undertaken by the Complaints Team, many of which are still ongoing.

1. To ensure that no complaint breaches its target date in 2018/19, and the introduction of a new KPI.
2. The need to engage with complainants who have used the complaints service, and better understand their experience.
3. The launch of Purple Points and evaluation of the first 2 months in operation.
4. Consideration of the complaints rate of different ethnic groups.
5. Feedback from an initiative that was managed by the Complaints team in regard to the redirecting of cancer services patients to other Trusts in the West Midlands.
6. A review of the way that lessons learnt as a result of complaints, are recorded, and monitored.

1. In Q4 2017/18 complaints that were managed on or before target date decreased. As some complaints from March 2018 are still being managed (as they are still within their target date) it is not possible to accurately report the final years result but this is likely to be between 90-92%. This falls short of the 97% target set for 2017/18. The target for 2018/19 is also 97%. The complaints team have reflected that one of reasons for missing this KPI in 2017/18 was the volume of cases from the previous year that needed responses on top of the new case load. Whilst there are still some cases left to manage from 2017/18 (both those in date and those breached cases still to be finalised) they are not in high numbers. The team have committed to finalising all F17 cases already breached by the end of April and the remaining cases will stay in date. This will in turn start 2018/19 in a position where the team are only dealing with new cases that are made against the Trust, without the added case load that breached cases bring. A new KPI has been introduced to ensure more focus on timely turn around and fast tracking of low graded complaints for 2018/19. The average turnaround across the case load of complaints that do not have agreed over 30 day targets (complex cases, cases that involve other Trusts etc) will be 28 days.

2. It is recognised that the current survey method used for complaint service feedback is not effective and as such a meeting was held with Healthwatch in October 2017. To date, this has not been progressed any further, but remains a key focus of 2018/19.

3. See appendix 3 for a report on the first month of this service.

4. Over many reports, it has been recognised that there is a need to acknowledge and better understand why certain ethnic groups make disproportionate numbers of complaints, compared to their patient numbers.

In Q3 2017/18 it was noted that the complaints numbers by ethnicity are much more reflective of the patient population, and this is the same for Q4 2017/18. On that basis, this area of focus will be removed from future quarterly reports unless disproportionality becomes apparent in the future.

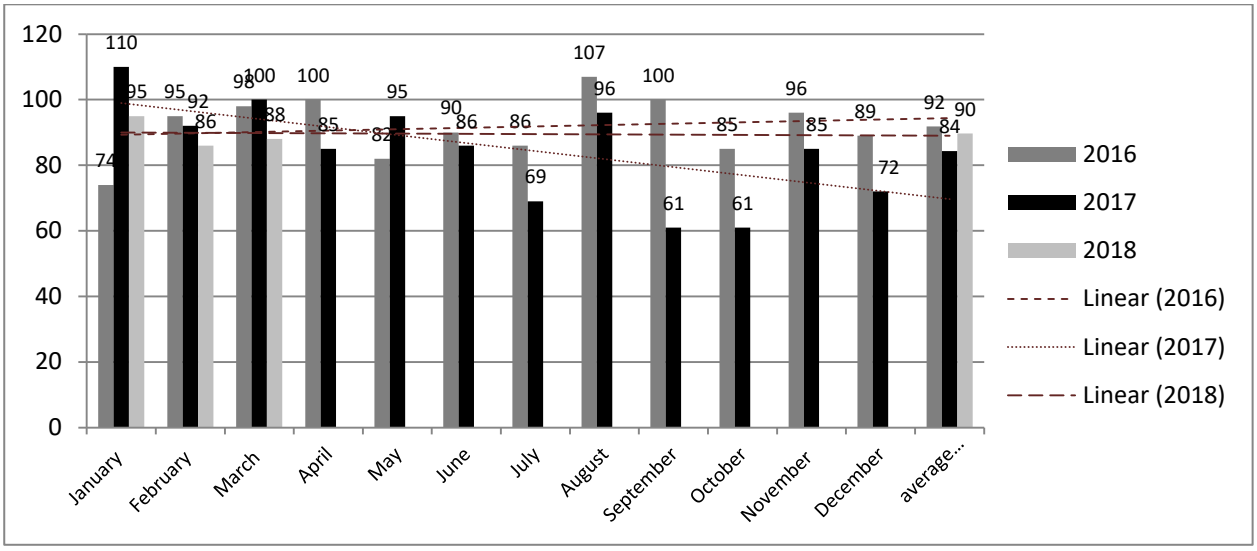
5. In October 2017 Cancer services were re modelled in the region, resulting in specialist care being moved to other Hospitals in the region. Our patients redirected into those services and invited to call the PALS (Complaints) team if further reassurance was required. See Appendix 2 for a summary of these calls.

6. In order to ensure that learning is taking place as a result of complaints, quality improvements, and system changes are recorded on the complaints data base. To improve this element of complaint management, and to build upon the sharing of learning, a change in practice has been implemented. When cases are being quality assured (QA), the data base will be checked to ensure the learning is recorded. Any further actions will also be monitored to ensure that these actions are implemented in the time frame that was communicated to the complainant at the time of the response. This includes the option to evidence this change to the complainant.

Appendix 1

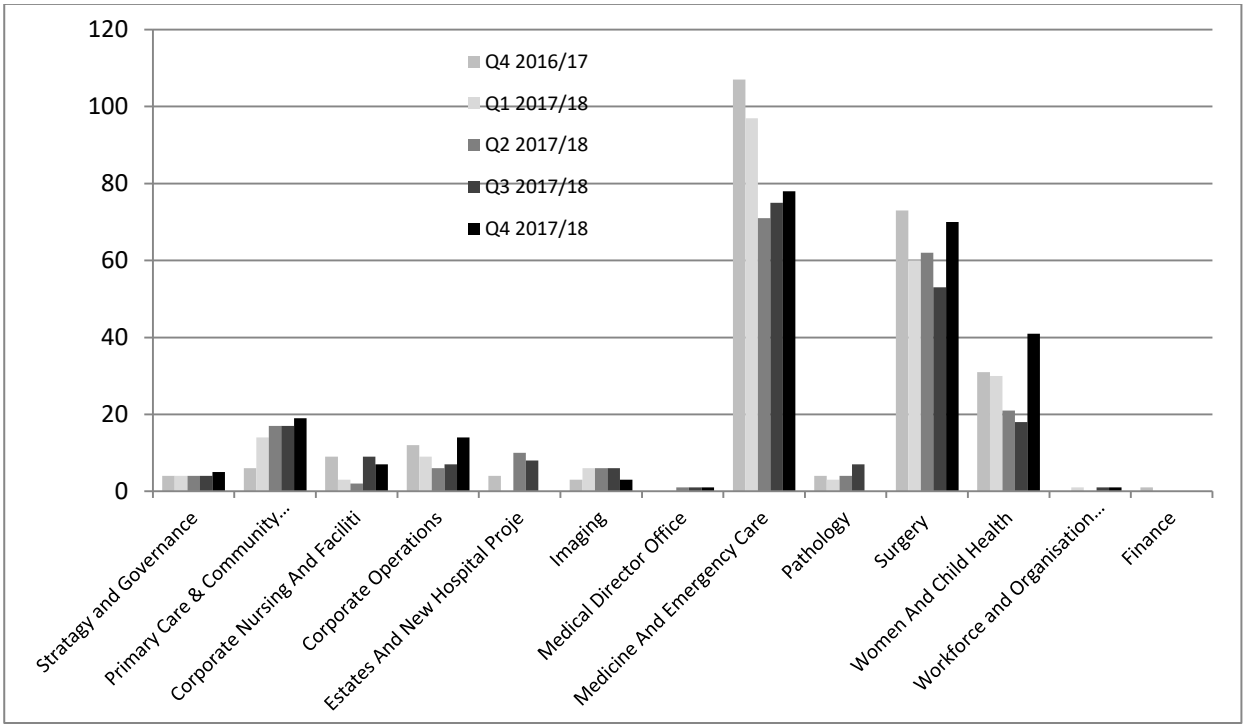
Table showing trends form the workbook across main themes

Complaint numbers for Q4 3017/18 compared to 2016/17/18



Comparison numbers year on year show a decline in complaint numbers with the trend line for 2017 showing a decline toward the end of the year also. Whilst the 2018 result remains flat, the 2018 result will be more meaningful as the calendar year progresses.

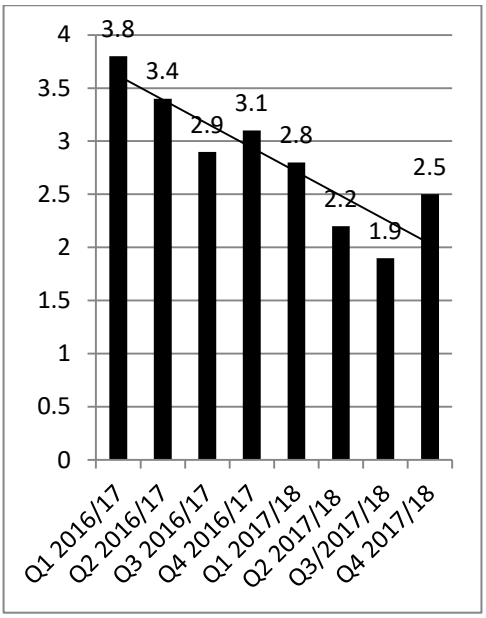
Complaints received by Clinical Group and Corporate Directorate for Q4 2017/18 compared to previous 3 quarters.



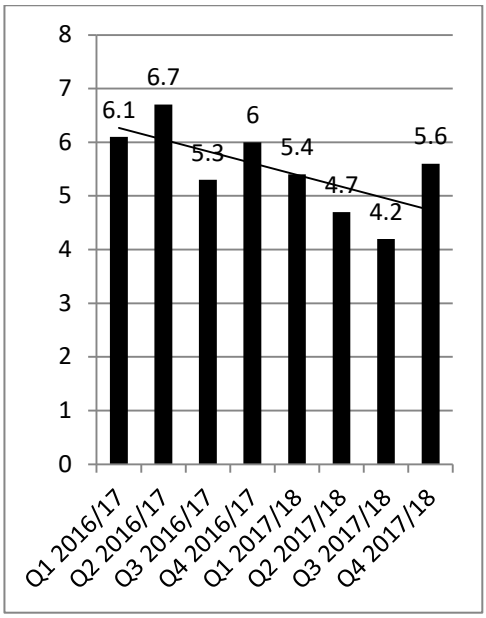
The increase in complaint numbers is evident in all clinical groups, and most notably in Woman and child Health, and to a lesser degree, Surgical Services.

Complaints rates by FCE and bed days for Q4 2017/18 compared to the last 2 years

Bed days

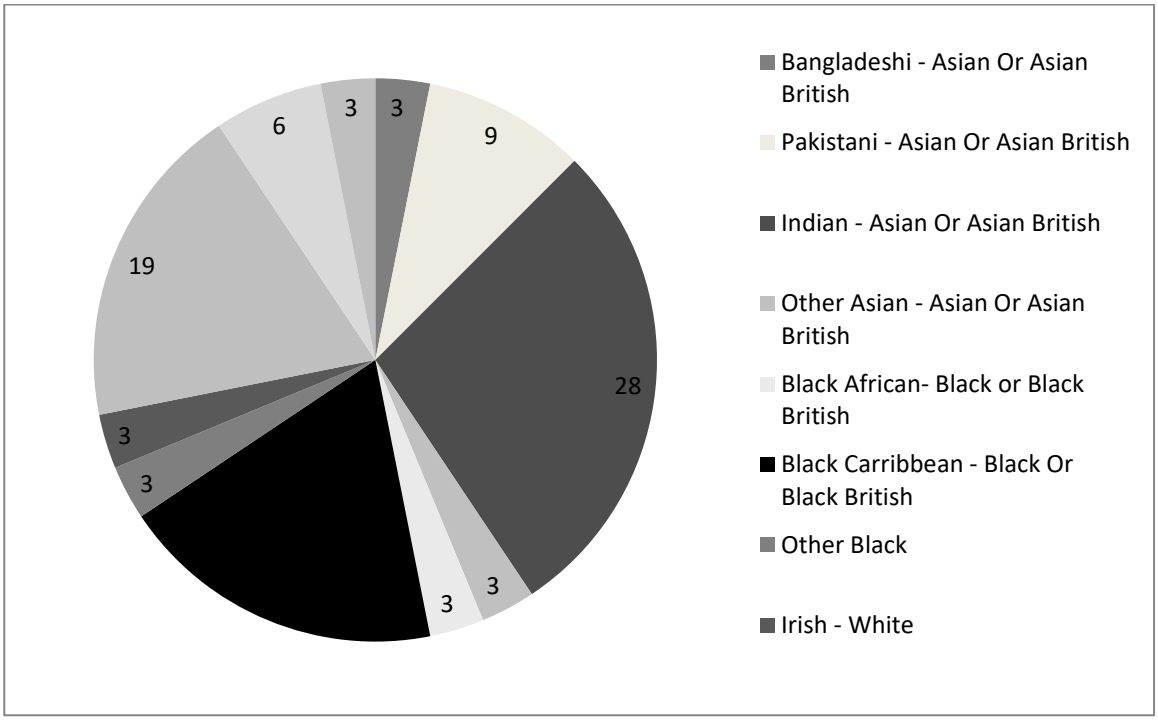


FCEs



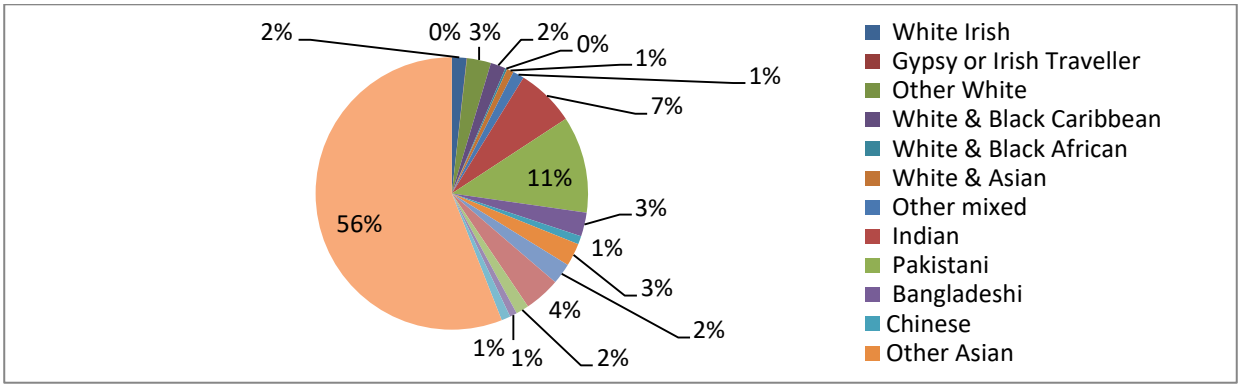
Whether the measure is by Bed days or FCE, there is a declining trend for both and this is notable in all Clinical Groups and Corporate directorates for FCEs and all but Women and Child Health for Bed days.

A breakdown of all complainants by % of those where ethnicity was recorded for Q3 2017/18

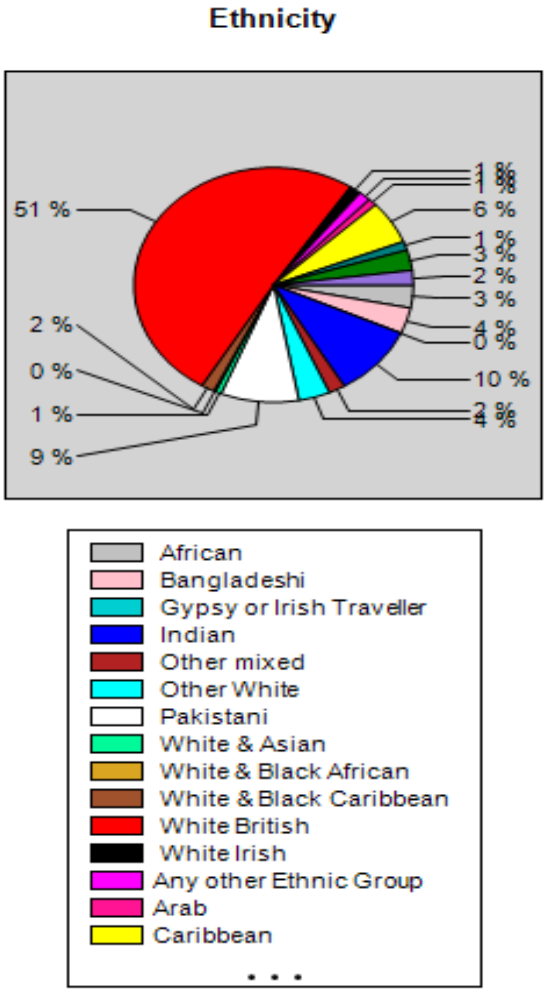


Shown here is a much more representative complaint split, than in previous quarters

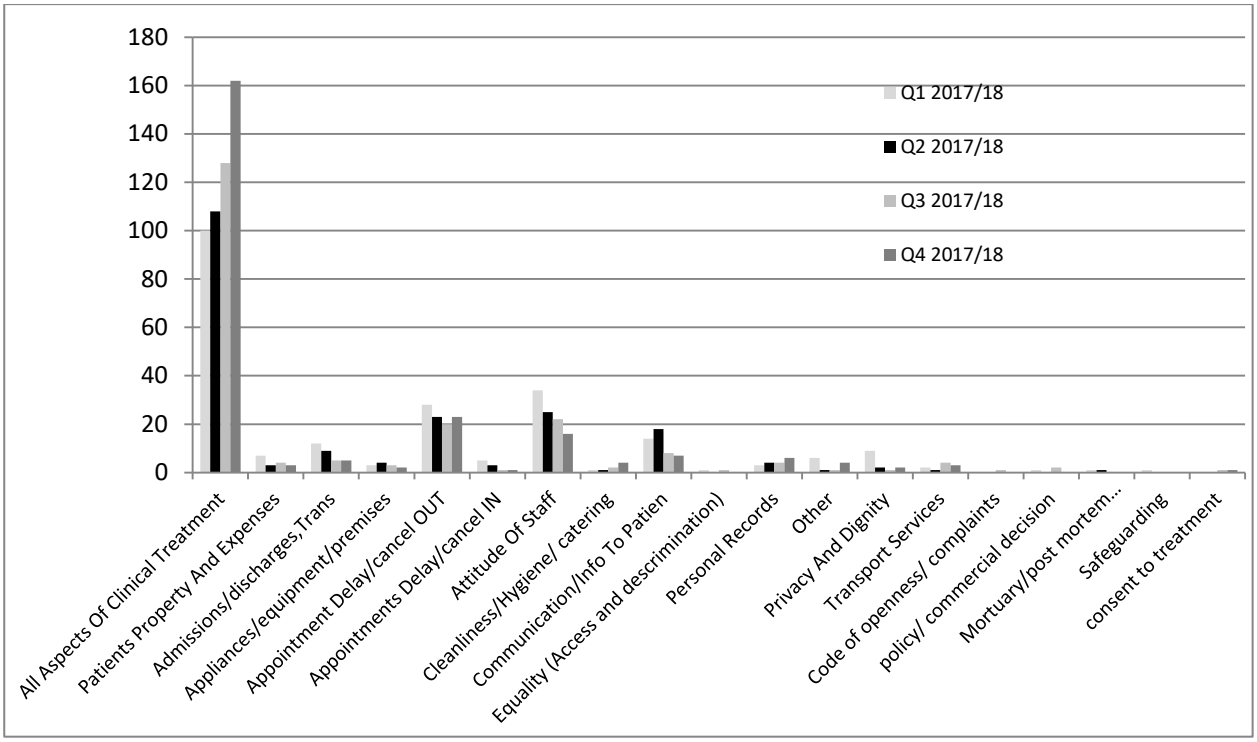
Ethnicity split by Sandwell and West Birmingham Population as taken from the 2011 census and quoted out to the Local Demography report prepared by the Trusts Equality and Diversity team in 2013.



Ethnicity split of patient population

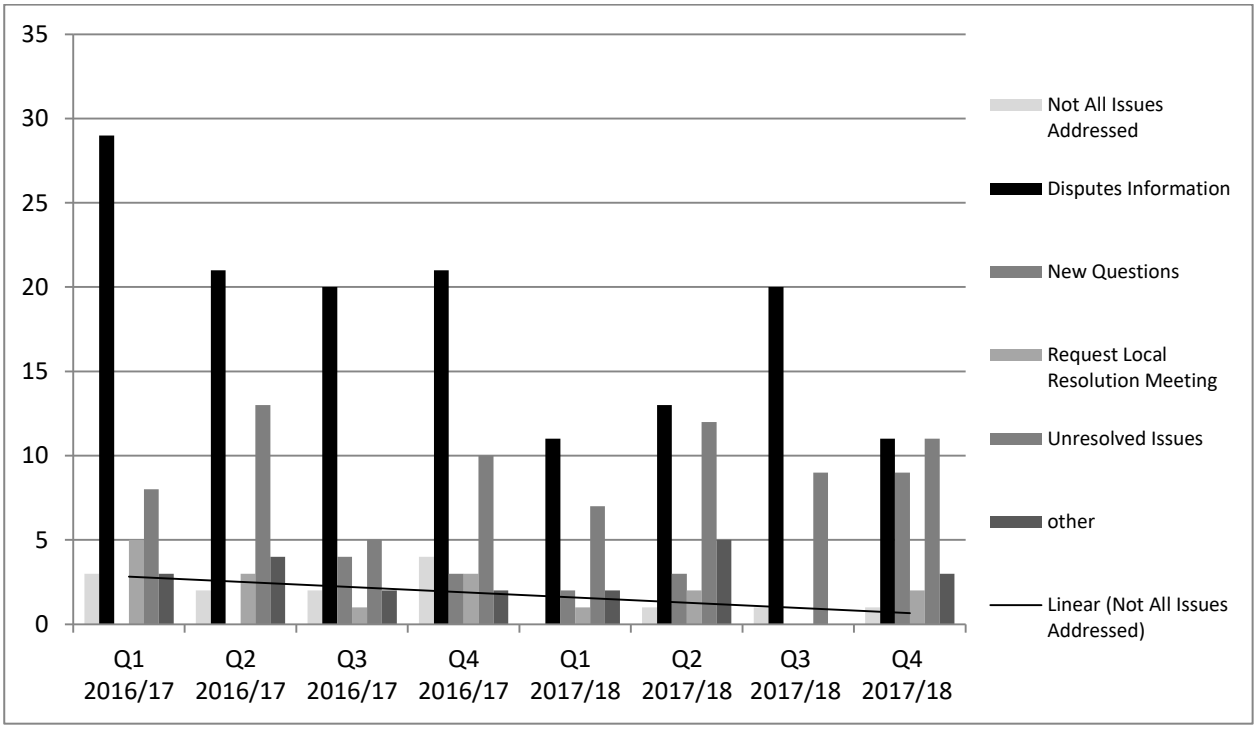


A breakdown of the top three complaint themes, for Q4 2017/18 compared to the last for 2017/18



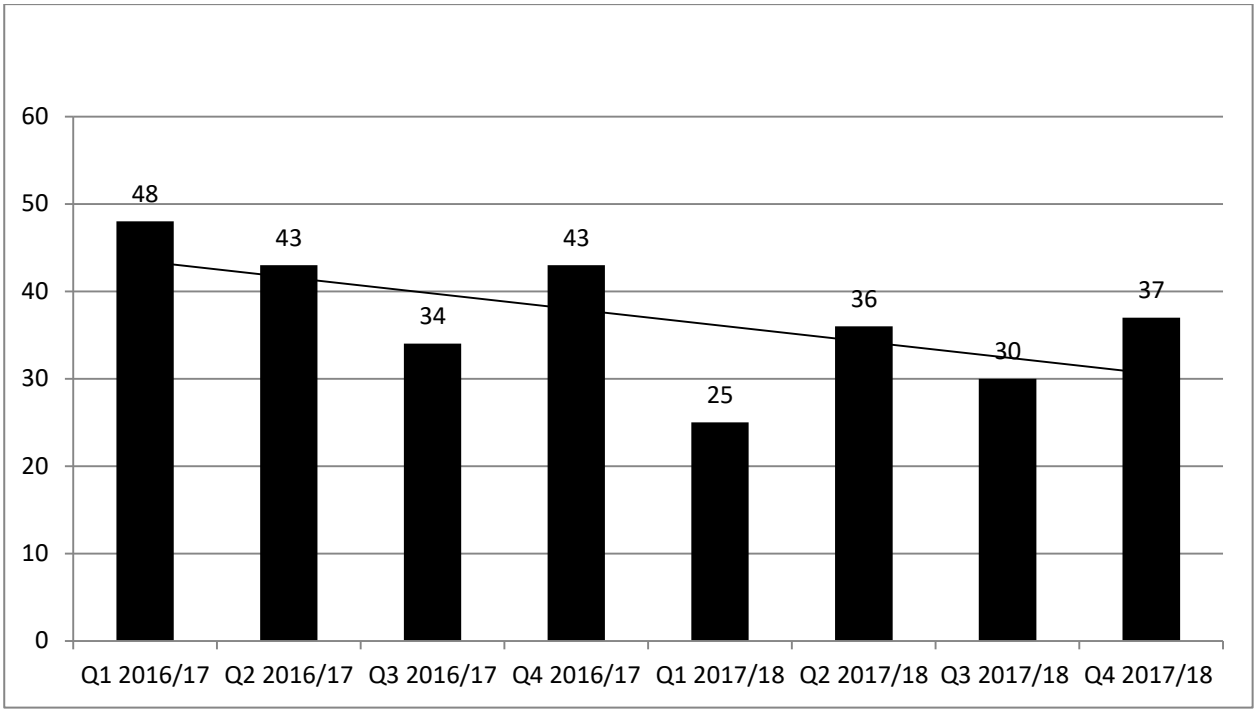
Clinical treatment remains the most complained about issue, with an increase noted over the last 12 months, with complaints about the management of appointments, whilst previously in decline, is once again the second ranked topic to be complained about.

Complaints that have been reopened in Q3 2017/18 compared to the last 7 quarters.



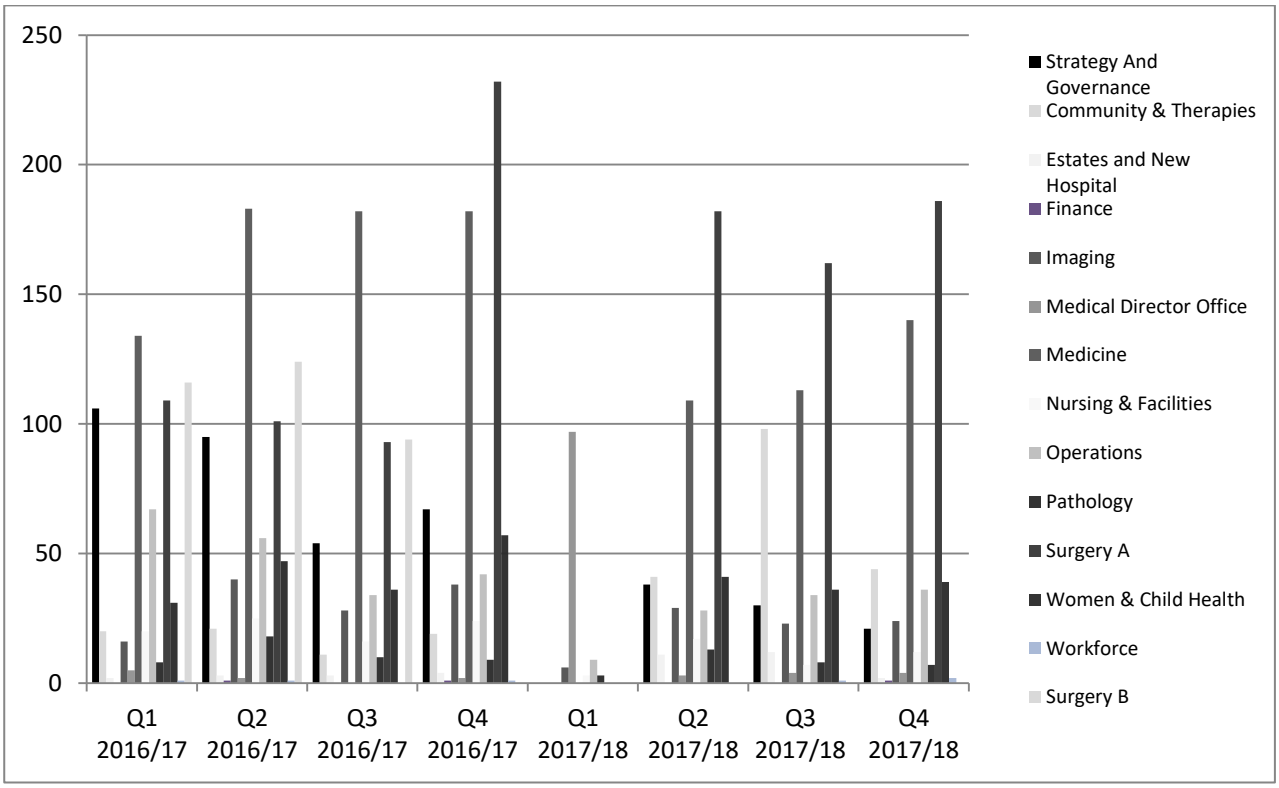
Showing an overall decline in the number of cases reopened due to the dissatisfaction of the original response

Complaints that have been reopened in Q 2017/18 compared to the last 2 years.



Showing an overall decline in the number of cases reopened because not all issues were addressed in the original response

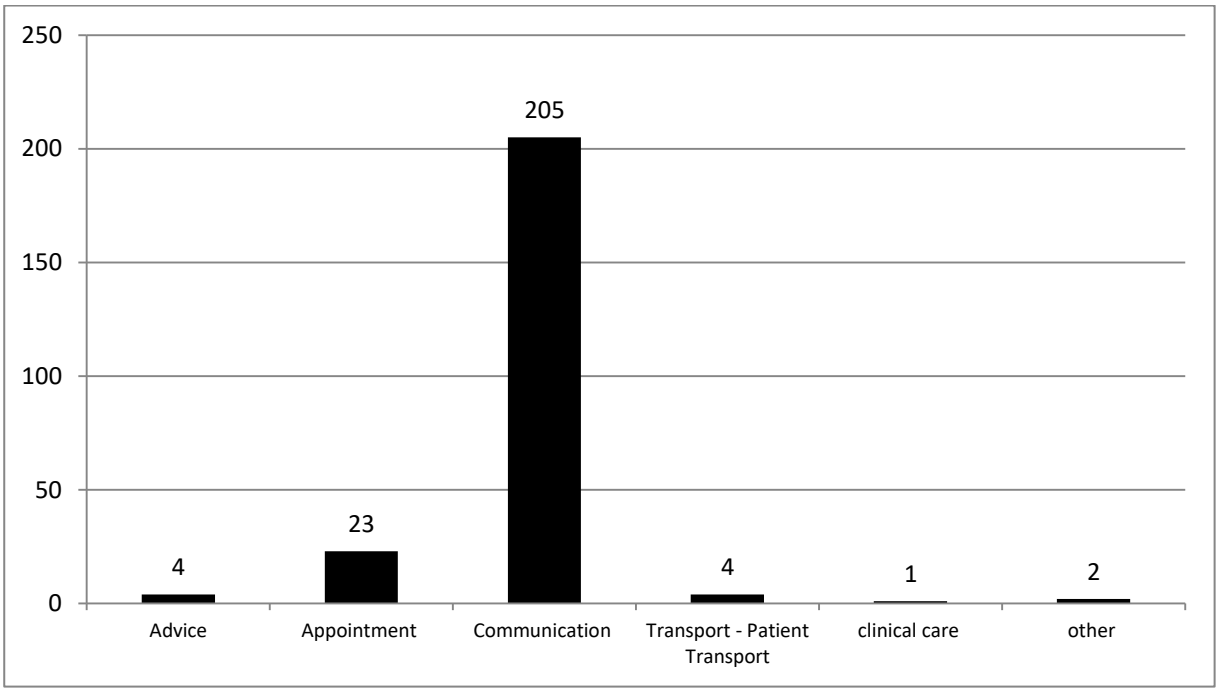
PALS (informal complaints) enquiries broken down by group Q4 2017/18 compared to the last 2 years



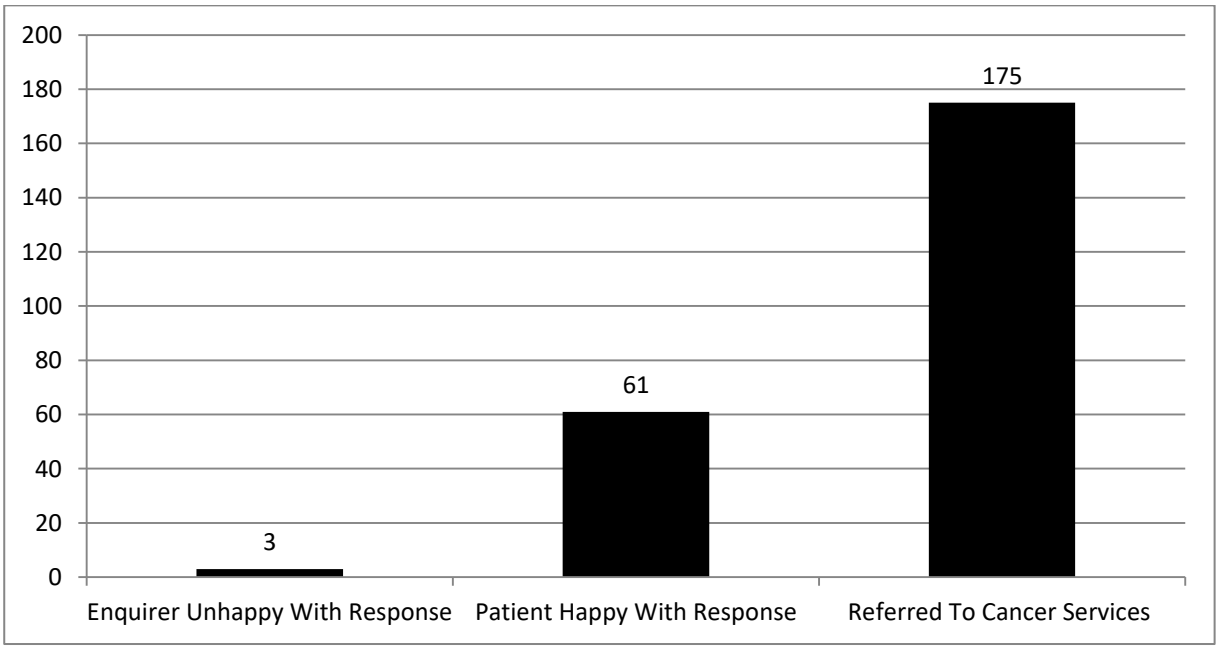
Showing that by Clinical Group and Corporate Directorate the trend of declining enquiry numbers has steadied, an notably in medicine has declined more so than in any other group, although those enquiries belonging to scheduled care (that used to report to Medicine and Emergency care) now belong to PCCT)

Appendix 2

The split of enquiry type between October 2017 and March 2018 for callers with concerns about the transfer of their cancer care.



The outcome of each enquiry, in relation to how PALs were able to reassure the patient, or facilitate a more specialist call back from Cancer Services to discuss the impact on clinical care.



Appendix 3

Purple Point – 1 month on.

As you know we went fully live across our three Hospital sites on 28 February 2018. Since then we have taken 11 calls that came through our Purple Points.

Calls by week – the third week in saw a minor spike.

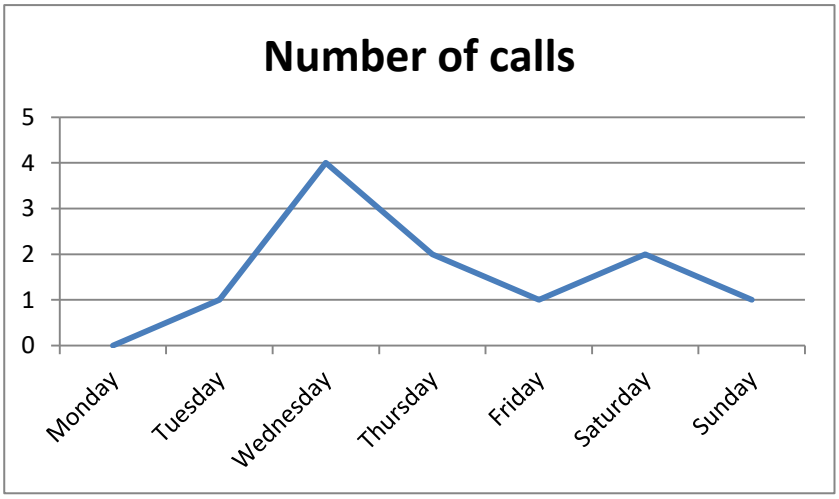
Week Commencing	Number of calls
26/02/2018	2
05/03/2018	2
12/03/2018	6
19/03/2018	1
26/03/2018	0…so far

Timing of calls – 6 of the calls have come in what we would term out of hours (after 5pm and at weekends) the latest of which was 8.38pm.

The weekend calls have been at 2.22, 5.17 and 8.38 pm

The earliest call was at 9.58am on a Friday.

Calls by day of the week – Wednesdays appear to be the most popular day to call.



Calls by Clinical Group – Medicine has attracted the most calls. 5 Calls have come from Sandwell and 6 from City.

Clinical Group	**Number of calls**
Surgery	3
Primary Care, Community & Therapies	1
Medicine & Emergency care	7

Paper ref:	TB (05/18) 024

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Trust Board Declarations		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author	Clare Dooley, Head of Corporate Governance		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

The Trust Board are asked to review and note assurance of compliance against the National Fit and Proper Persons Test for 2017/18 and the current Trust Board Member register of interests.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan		Public Health Plan		People Plan & Education Plan	
Quality Plan		Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	X

3. Previous consideration *[where has this paper been previously discussed?]*

4. Recommendation(s)

The Trust Board is asked to:

a.	Note the Fit and Proper Persons assessment declaration for 2017/18.
b.	Approve publication of the Register of Interests on the Trust website.
c.	

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s): N/A					
Board Assurance Framework		Risk Number(s): N/A					
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD DECLARATIONS 2017/18

FIT AND PROPER PERSON DECLARATION

1. All Trust Board members have signed their annual Fit and Proper Person declaration for 2017/18, and acknowledged the extracts from the Provider Licence, Regulated Activities Regulations and the Trust's Constitution (see Appendix 1).

2. All Trust Board Members confirmed that they do not fit within the definition of an "unfit person" (as listed in Appendix 1), and that there are no other grounds under which they would be ineligible to continue in post.

3. Trust Board Members agreed to undertake to notify the Trust immediately if they no longer satisfy the criteria to be a "fit and proper person", or other grounds, under which they would be ineligible to continue in post, that come to their attention.

REGISTER OF DECLARED INTERESTS

4. All Trust Board Members and Board Advisors have reviewed, updated and signed their declarations of interest. Provided at Appendix 2 is the Register of Interests which will be published on the Sandwell and West Birmingham Hospitals NHS Trust public-facing website.

Clare Dooley
Head of Corporate Governance
May 2018

Appendix 1

FIT AND PROPER PERSONS DECLARATION

BACKGROUND

1. It is a condition of employment that those holding Board director level posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 ("the Regulated Activities Regulations") and the Trust's constitution.

2. By signing the declaration, Trust Board Members are confirming that they do not fall within the definition of an "unfit person" or any other criteria (set out below), and that they are not aware of any pending proceedings or matters which may call such a declaration into question.

Fit and proper persons Regulation 5 (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

3. The registration conditions of the Care Quality Commission require that the Trust shall not appoint as a director any person who is an unfit person. An "unfit person" is defined as:

   (a) **an individual:**
   - (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or
   - (ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or
   - (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or
   - (iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

   (b) **a body corporate, or a body corporate with a parent body corporate:**
   - (i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph; or
   - (ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986; or
   - (iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking; or
   - (iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; or
   - (v) which passes any resolution for winding up; or
   - (vi) which becomes subject to an order of a Court for winding up.

Regulated Activities Regulations

4. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a director, or performing the functions of or equivalent or similar to the functions of, such a director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

    (a) the individual is of good character;
    (b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;
    (c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;
    (d) the individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and
    (e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

5. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

    (a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;
    (b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
    (c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;
    (d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
    (e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
    (f) the person is prohibited from holding the relevant office or position, or in the case of an individual for carrying on the regulated activity, by or under any enactment.

Trust's constitution

6. The Trust's constitution places a number of restrictions on an individual's ability to become or continue as a director. A person may not become or continue as a director of the Trust if:

a) they are a member of the council of governors, or a governor or director of an NHS body or another NHS foundation trust;
(b) they are a member of the patients' forum of an NHS organisation;
(c) they are the spouse, partner, parent or child of a member of the board of directors of the Trust;
(d) they are a member of a local authority's scrutiny committee covering health matters;
(e) they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;
(f) they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;
(g) they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;
(h) they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;
(i) in the case of a non-executive director, they are no longer a member of the public constituency;
(j) they are a person whose tenure of office as a Chair or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
(k) they have had their name removed, other than by reason of resignation, from any list prepared under sections 91, 106, 123 and 146 of the 2006 Act and have not subsequently had their name included on such a list;
(l) they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
(m) in the case of a non-executive director they have refused to fulfil any training requirement established by the Board of Directors; or
(n) they have refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for directors.

Appendix 2

TRUST BOARD REGISTER OF DECLARED INTERESTS 2017/18

Name/Title	Interests Declared
Chair	
Richard Samuda	• Trustee – 'Kissing It Better' • Non-Executive Director – Warwick Racecourse
Non-Executive Directors	
Olwen Dutton	• Partner – Anthony Collins LLP • Fellow – Royal Society of Arts • Trustee – Writing West Midlands • Trustee - The Almshouse Charity of Thomas Huntbach & Francis Tongue Croxall • Member – Lunar Society • Member – Labour Party
Michael Hoare	• Director - Metech Consulting • Director - CCL Group • Director - Nobu Ltd
Harjinder Kang	• Trustee – Birmingham Botanical Gardens • Director – Abnasia Ltd • Management Consultant – Vectura Group PLC
Marie Perry	• Head of Finance & Procurement - Consumer Council for Water
Waseem Zaffar	• Elected Councillor – Lozells & East Handsworth Ward (Birmingham City Council) • School Governor - Heathfield Primary School. • Member - Unite the Union and the Labour Party. • Director - Simmer Down CIC • Director – Midlands Community Solutions CIC • Director – West Side BID
Kate Thomas	• Vice Dean of Medicine and Programme Director MBChB - University of Birmingham • Salaried GP – Our Health Partnership • Sessional Post – GMC (Outcomes for Graduates) • Sessional Examiner – Universities of Oxford and Exeter • Sessional Validation Reviewer – University of Keele
Executive Directors	
Toby Lewis (Chief Executive)	• Board member – Sandwell University Technical College • Independent Member and Chair of Audit Committee - Council of Aston University

Rachel Barlow (Chief Operating Officer)	None
Elaine Newell (Chief Nurse)	None
David Carruthers (Medical Director)	None
Tony Waite (Director of Finance)	None
Raffaela Goodby (Director of People & OD)	• Independent Member of Governing Body – Sandwell College • Director - Multi Academy Trust, Sandwell College • Chair - Local Workforce Action Board (LWAB) Recruitment and Retention Workstream
Kam Dhami (Director of Governance)	None
Board Advisors	
Mark Reynolds (Chief Information Officer)	None
Alan Kenny (Director of Estates & New Hospital)	None
Ruth Wilkin (Director of Communications)	None
Dave Baker (Director of Partnerships & Innovation)	None

Paper ref:	TB (05/18) 025

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	The General Data Protection Regulation: Trust Preparedness		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author	Refeth Mirza, Head of Risk Management		
Meeting	Trust Board	Date	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Committee should focus on]*

The Trust's Information Governance (IG) Team has been managing preparations for GDPR for 6 months, with the first briefing paper coming to the Trust Board in December 2017. The work has been methodical and incorporated wherever possible into other scheduled reviews of policies and procedures. Some areas have though been dependant on the release of national guidance which has been significantly delayed.

With the release of that national guidance, the Trust will be able to update a number of areas in the GDPR action plan from the position reported previously. Given that further guidance is expected, and the new Data Protection Act has yet to be approved, the Trust Board should be assured that it currently has plans in place to ensure compliance from 25 May 2018.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	✓	Public Health Plan		People Plan & Education Plan	
Quality Plan	✓	Research and Development		Estates Plan	
Financial Plan	✓	Digital Plan		Other *[specify in the paper]*	X

3. Previous consideration *[where has this paper been previously discussed?]*

Nine

4. Recommendation(s)

The Trust Board is asked to:

a.	Note the new requirements and management actions
b.	
c.	

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s): n/a					
Board Assurance Framework		Risk Number(s): n/a					
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 3 May 2018

The General Data Protection Regulation (GDPR)

1. Introduction

This report provides an update to the Trust Board on progress with preparing for the GDPR. The GDPR was approved in 2016 and will become directly applicable as law in the UK from 25 May 2018. The current Data Protection Bill, which will become the Data Protection Act 2018 (DPA18), fills in the gaps of the GDPR, addressing areas in which flexibility and derogations are permitted. Achievement of compliance with the regulation will be overseen by the Trust's Information Governance & GDPR Task & Finish Group and reported through the Risk Management Committee.

It is important to note that the GDPR is an evolution of the Data Protection Act 1998 (which the Trust already complies with) and is aimed at raising IG standards within all industries across the EU. The Trust has maintained high levels of IG for many years with assurance provided through the achievement of Level 2 compliance with the IG Toolkit (IGTK). The journey to GDPR compliance is therefore evolutionary rather than revolutionary as it is in some other sectors. However, the Information Commissioners Officer (ICO), as the regulator, can impose high penalties for non-compliance of up to £20m for serious breaches.

2. Background

A paper submitted to the December 2017 Trust Board contained a copy of the Trust's GDPR Gap Analysis. Since then an Action Plan has been produced which confirms the Trust's position as at December 2017 and identified a number of areas for concern with most associated with a lack of national guidance on key issues. In mid-February 2018, further national guidance [1, 2] was released by the Information Governance Alliance (IGA[3]) which clarified a number of key points. The action plan has been updated accordingly with clearer ownership assigned and delivery timeframes being added.

3. Compliance

A key provision of the GDPR is the principle of 'accountability'. Organisations (data controllers) must be able to demonstrate compliance with the GDPR principles and in particular that they have appropriate technical and organisational measures in place. For the Trust, the principle demonstrations of compliance are:

- IGTK Level 2 with some areas achieving level 3
- Extensive existing policies and procedures associated with IG which are currently being updated to reflect specific requirements of GDPR
- Significant review of the Information Asset Register

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4. GDPR ISSUES

Key requirements of the GDPR include:

4.1 Awareness

The Trust needs to ensure the decision makers and key people in the organisation are aware that the law is changing to the GDPR. A GDPR & Information Governance Task & Finish Group is being formed. The purpose of the Group is to:

1. To develop and maintain implementation of the General Data Protection Regulation (GDPR) and the Information Governance (IG) framework supporting the GDPR across the Trust, in line with related legislation and Department of Health (DH), NHS England and NHS Digital guidance.

2. To provide assurance on Trust GDPR & IG compliance to the Risk Management Committee (RMC), including action plan progress for matters not yet achieving full compliance. (RMC subsequently reports GDPR & IG matters to the Clinical Leadership Executive, which reports to Trust Board).

4.2 Consent

The issue of consent has caused significant confusion when discussing GDPR in many sectors. Many interpretations were that, as the rules for gaining consent were being tightened by GDPR, then measures would have to be put in place to more explicitly gain patient consent when processing their data. This is only the case where consent is used as the legal basis for data processing, however most NHS organisations including the Trust expect to use the following:

For processing 'Personal data':
– Article 6(1)(e) – Processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller

For processing 'Special category data':
– Article 9(2)(h) – Processing is necessary for the purposes of preventative or occupational medicine, for assessing the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or management of health or social care systems and services on the basis of Union or Member State law or a contract with a health professional

These bases for processing are subject to finalisation of the new Data Protection Act and may be updated prior to 25 May 2018 if required.

4.3 Breach notification

The Trust will be required to report data breaches to the ICO within 72 hours of becoming aware of it. The Trust already has processes in place to deal with data breaches.

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4.4 Right to access

The Trust already provides access to copies of Health Records where requested by patients/ other authorised parties. The current charge is £50 per record but GDPR requires it to be free which will place a cost pressure on the Trust which currently receives income in the order of £100k. Additionally the timeframe for record access is being reduced from 40 days to 30. There is a risk that there may be a surge in applications for records access from 25 May 2018 which may be difficult to meet.

4.5 Right to be forgotten

This element was previously a concern as it was not clear how this could be managed for health records. Recent guidance has confirmed that this is not applicable where the legal basis for processing is Article 9(2)(h) – 'Processing is necessary for …, the provision of health or social care or treatment..' which will be the case in the Trust.

4.6 Data Portability

This was another area of concern due to the lack of clear standards for exchange of health records electronically between Trusts. This has now also been clarified as only being applicable where the legal basis is consent and the processing is automated which will not be applicable within the Trust.

4.7 Privacy by Design

The Trust executes existing processes to include Privacy Impact Assessments in the design/ procurement of new systems. These processes are being reviewed but are not expected to change significantly.

5.0 Key issues

Two key issues have been identified at this point, which are:

- The role of the Data protection Officer has not yet been filled. National guidance now states that this role cannot be held by the Trust's existing SIRO or Caldicott Guardian, due to a potential conflict of interest. The Trust's previous decision was the Director of Governance / SIRO would hold this position which clearly is not now possible. Options are being considered on who could take on this role. Having no DPO at this stage in the implementation period may expose the Trust to non-compliance.

- The removal of fees for accessing health records and the publicity expected around the implementation of GDPR may lead to a surge in requests that may be difficult to meet in the reduced timeframe. Mitigations plans for the above continue to be developed.

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6.0 Conclusion

The Trust's existing IG framework and programme in place will incorporate the required changes needed for the Trust to meet its obligations of the GDPR.

An action plan has been developed to facilitate GDPR compliance by May 2018, using national guidance as it becomes available.

The Trust has continued to take a pragmatic approach to the implementation of GDPR in the confidence that the Trust is already compliant with the Data Protection Act (DPA) 1998 and assured by achieving the Information Governance Toolkit Level 2. Following the recent release of further national guidance, the Trust is now more able to assess its readiness and will be updating its action plan accordingly. This will include wider communication with Trust staff to ensure that they are ready to respond to patient enquiries.

Whilst the priority for the Trust has been working on ensuring that it is compliant against the requirements of GDPR, further work will be undertaken in areas such as Human Resources, Information Security and Information Technology to assure wider organisational readiness. More work will be required in these areas however this is being brought within the overall work-plan. Overall the Trust Board should feel assured that the Trust will be ready for GDPR adoption from the 25 May 2018.

7.0 **Recommendation**

The Board is asked to note the new requirements and management actions.

Refeth Mirza
Head of Risk Management

25 April 2018

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Paper ref:	TB (05/18) 026

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Application of Trust Seal		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author	Clare Dooley, Head of Corporate Governance		
Meeting	Trust Board	**Date**	3rd May 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

In accordance with Trust practice, the Trust Board is asked to approve the affixation of the Trust seal as follows:

No	Description	Signed by	Date
243	Lease renewal of medical physics building with University of Birmingham.	Chief Executive Director of Finance	17/04/18
244	Deed of Grant with Western Power (West Midlands) PLC for access to new high voltage sub-stations on City site.	Chief Executive Director of Finance	30/04/18
245	License to assign premises know as Dudley Road Hospital – lease from National Grid Plan to Cadent Gas Ltd.	Chief Executive Director of Finance	30/04/18

2. Alignment to 2020 Vision *[indicate with an **'X'** which Plan this paper supports]*

Safety Plan		Public Health Plan		People Plan & Education Plan	
Quality Plan		Research and Development		Estates Plan	**X**
Financial Plan		Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

N/A

4. Recommendation(s)

The Trust Board is asked to:

a.	Approve the affixation of the Trust Seal (as set out above).
b.	
c.	

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s): N/A					
Board Assurance Framework		Risk Number(s): N/A					
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	