Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION AGENDA

Venue: Anne Gibson Boardroom, City Hospital **Date:** Thursday 7th June, 0930h – 1300h

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	(PG)	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 E Quinn	(EQ)	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: Prof K Thomas and Ms O Dutton**	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	(a) receive the update from the **Charitable Funds Committee** meeting held on 17th May 2018 (b) receive the minutes from **Charitable Funds Committee** meeting held on 15th February 2018	TB (06/18) 001 TB (06/18) 002	**WZ** **WZ**
1005h	5b	(a) receive the update from the **Audit and Risk Management Committee** meeting held on 23rd May 2018 (b) **Note and accept 2017/18 Annual Report and Accounts** (c) receive the minutes from **Audit and Risk Management Committee** meeting held 4th May on 2018	TB (06/18) 003 *To follow* TB (06/18) 004 TB (06/18) 005	**MP** **MP** **MP**
1015h	5c	(a) receive the update from the **Major Projects Authority** meeting held on 18th May 2018 (b) receive the minutes from **Major Projects Authority** meeting held on 20th April 2018	TB (06/18) 006 TB (06/18) 007	**RS** **RS**

Time	Item	Title	Reference Number	Lead
1020h	5d	(a) receive the update from the **Quality and Safety Committee** held on 25th May 2018 (b) receive the minutes from the **Quality and Safety Committee** held on 27th April 2018	TB (06/18) 008 TB (06/18) 009	**MP** **MP**
1025h	5e	a) receive the update from the **Finance and Investment Committee** held on 25th May 2018 b) receive the minutes from the **Finance and Investment Committee** held on 27th April 2018	TB (06/18) 010 *to follow* TB (06/18) 011	**MH** **MH**
1030h	5f	(a) receive the update from the **Public Health, Community Development and Equality Committee** held on 1st June 2018 (b) receive the minutes from the **Public Health, Community Development and Equality Committee** held on 15th February 2018	TB (06/18) 012 *to follow* TB (06/18) 013	**KT** **KT**
	MATTERS FOR APPROVAL OR DISCUSSION			
1035h	**6.**	**Chief Executive's Summary on Organisation Wide Issues**	TB (06/18) 014	**TL**
1050h	**7.**	**Analysis of Mortality**	TB (06/18) 015	**DC**
1105h	**8.**	**Trust Risk Register**	TB (06/18) 016	**KD**
1115h	**8.1**	**Results Acknowledgement**	TB (06/18) 017	**DC**
1130h	**8.2**	**Patient Handover / Staff Exit SOP and Implementation**	TB (06/18) 018	**RB**
1140h	**BREAK**			
1150h	**9.**	**CQC Improvement Plan: BMEC Response and Delivery**	TB (06/18) 019	**KD**
1200h	**10.**	**Unity Implementation - December 2018**	TB (06/18) 020	**RB**
1215h	**11.**	**Quality Plan Implementation**	TB (06/18) 021	**DC**
1230h	**12.**	**Strategic Board Assurance Framework**	TB (06/18) 022	**KD**
1235h	**13.**	**Integrated Quality & Performance Report**	TB (06/18) 023	**TL**
	13.1	**Financial Performance – P01 2018/19**	TB (06/18) 024	**TW**
1245h	**14.**	**Midland Met: Financial Impact of delay & Service Re-configuration**	TB (06/18) 025	**TW**
	UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS			
1255h	**15.**	**Minutes of the previous meeting and action log** To approve the minutes of the meeting held on 3rd May 2018 as a true/accurate record of discussions, and update on actions from previous meetings	TB (06/18) 026 TB (06/18) 027	**Chair** **Chair**
	MATTERS FOR INFORMATION			
1300h	**16.**	**Any other business**	Verbal	**Chair**
	17.	**Details of next meeting: Public Trust Board meeting will be held on** Thursday 5th July 2018, 9.30 – 13.15 at the Yemini Community Association, Tildasley Street, West Bromwich, B70 9SJ **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

CHARITABLE FUNDS COMMITTEE UPDATE	
Date of meeting	17th May 2018
Attendees	Cllr Waseem Zaffar (Chair), Mr Richard Samuda, Mrs Ruth Wilkin, Mr Johnny Shah, Mr Tony Waite, Mr Bill Devitt and Miss Yulander Charles.
Apologies	Apologies were received from Mr Toby Lewis, Mrs Paula Gardner and Mr David Carruthers
Key points of discussion relevant to the Board	The key areas of focus were: • **Major Grants Progress report** • **Annual accounts**
Positive highlights of note	• **Leukaemia research proposal –** collaboration has begun with the University of Birmingham around Leukaemia research. This will be a match funded research proposal with the university securing £128K**.**
Matters of concern or key risks to escalate to the Board	• **Major Grants Progress report** – there are two schemes which if further co-funding are not found run the risk of closing. The schemes are; Domestic Abuse project and the Sapphire Project. The team are currently awaiting confirmation as to whether recent bids have been successful i.e. WMPCC application for the Domestic Abuse project and BCF application for the Sapphire project. If both are unsuccessful then the projects will close 30.06.18 and 01.06.18 respectively. • **Annual accounts** –Audit for the charity accounts will begin on 29th May. Charity annual report and accounts to be included as document alongside the Trust annual report and presented to the Trust AGM on 21st June. Audit findings report to be issued 7th June.
Matters presented for information or noting	• None
Decisions made	No specific decisions beyond those being progressed by management.
Actions agreed	No specific additional actions beyond those being progressed by management. Next meeting 13th September 2018

Cllr Waseem Zaffar
Chair of Charitable Funds Committee
For the meeting of the Trust Board scheduled for 7th June 2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SWBCF (02/18) 008

CHARITABLE FUNDS COMMITTEE - MINUTES

Venue: Anne Gibson Committee room, City Hospital **Date:** 15th February 2018; 1130 - 1300

Members present:
Cllr W Zaffar – Chair **(WZ)**
Mr T Waite –Finance Director (TW)
Ms E Newell – Chief Nurse **(EN)**

In attendance:
Mrs R Wilkin, Director of Communications **(RW)**
Mr J Shah, Head of the Trust Charity **(JS)**

Committee support:
Miss Y Charles – Executive Assistant **(YC)**

Minutes	**Paper Reference**
1. Welcome, apologies and declarations of interest	Verbal
Apologies was received from Mr R Samuda and Mr T Lewis	
2. Minutes of the previous meeting held on 16th November 2017	**SWBCF (11/17) 031**
The minutes were approved as a true record	
3. **Matters arising from the previous meeting (action log)**	**SWBCF (02/18) 002**
The following actions were discussed and updated; • ***Volunteer Service:*** Opportunity to undertake joint recruitment with Birmingham City Council to be explored – these posts have now been recruited via NHS Jobs so this action can be ***closed*** • ***Legacy pack*** to be provided in a number of languages – this is being updated as part of the later life planning proposition and can be ***closed*** • ***SLA*** with Women's Aid to include caveat for Black Country Women's Aid and Birmingham and Solihull Women's Aid to work together – this was done in May so can be ***closed*** • Information regarding ***founder patrons*** to be circulated to the Board with a view to members sharing within their networks – this has been incorporated within the campaign plan and will be covered in the proposed orientation session with Board • Mr Lewis asked whether similar ***income streams*** through the Charity were investigated to ensure they were being corrected routed - This has been researched –so this action can be ***closed*** • ***Later Life Planning Proposal*** - Mr Shah to work closely with Mr Hooton and Mrs Newell to pre-empt and elevate any concerns raised as to the engagement of this service with vulnerable patients and their families and to ensure mechanisms are in place to counteract these – this has taken place and can be ***closed***	

4. Head of Trust Charity's program report	SWBCF (02/18)
Mr. Shah provided an overview of the program report highlighting the following areas as primary issues. • Overview of 5 objectives for the Head of Trust Charity, as agreed in the annual PDR (June 2017) • Payroll Giving - Update Note • Your Trust Charity Calendar of Events 2018 There have been several successful fundraising events, Bike rides; Bollywood Ball; plus some unexpected late receipts which have resulted in us being ahead of target. Final figures on the investment gains will be announced at the end of the financial year however at the present we are on target. The Committee was then asked to discuss and approve the following recommendations in relation to the Payroll Giving - Update Note: • To update contact details with the PGAs • Access promotional materials and online access (CAF GAYE only) • Register a 'Your Trust Staff Charity Fund' with CAF GAYE It was explained that although Payroll giving was employed within the Trust for the past 30years the level of communications around this was minimal therefore the team are working on a revised communication strategy to raise its profile amongst staff. The Chair raised concerns around the objective of Midland Met – Secure pledge and asked that a paper on how the current situation will impact the charity. Ms Wilkin suggested that in light of the current situation perhaps this could be noted as an Risk assessment and be included as an ongoing agenda item. This was agreed. The Chair also asked that a calendar of events be included in the regular report so that the committee can see forthcoming events.	
5. Major Grants Programme – existing grants and pipeline for end of funding	**SWBCF (02/18) 004**
Following on from the last meeting Mr Shah announced that the team has successfully secured funding to enable a further six months of funding for the IDVA project run in partnership with Black Country Women's Aid. Alternative options for external funding continue to be pursued. If unsuccessful, to committee will be asked to consider the following options: o Embedding project into corporate nursing; or to o Regretfully close project on 30.06.18 The chair expressed his approval in the teams' achievements and also suggested contacting the Police Commission – Victim's fund with the possibility of match funding with Better care. **Action:** It was agreed for JShah to put together application highlighting outputs and achievements which the Chair would forward to the CEO – Jonathan Jardine	

Further update on progress and performance achieved to date and sustainability development of flagship initiatives/projects from the Grants Programme 2014-15 & 2016-17 was provided to the committee along with an outline paper to propose changing from an open grants program to a commissioning model strategically aligned to Your Trust Charity's fundraising strategy and appeals
 	
As a summary the Committee approve the following:
 	
• Allocate remaining underspend of £45,000 from 5 projects (2014-15) to the Domestic Abuse project, enabling it to run until 30.06.18
• Await outcome of BCF application for Domestic Abuse project. If unsuccessful, to consider:
  o Embedding project into corporate nursing; or to
  o Regretfully close project on 30.06.18
• Extend end date to Sapphire project to 01.06.18
• Await outcome of DoH & BCF application for Sapphire project. If unsuccessful, to consider:
  o Regretfully closing project on 01.06.18
• The outline proposal for a commissioning model
  The example commissions of £4,254 from Fund 0125 and £25,980 from Fund 5082 respectively	

6. Payroll Giving	**SWBCF (02/18) 005**
This was briefing discussed within the Head of Trust Charity's program report Payroll Giving – At the December 2017 Board Development session the team was asked to look into the establishment of payroll giving within the Trust. Although the scheme has been active within the trust it was not widely promoted. As a result this will be re-energised by the team and is now being promoted as a Staff Benefit. The revived process will enable staff to donate to any charity via payroll giving The Your Trust Charity will also be promoted as one of the charities employees can donate to directly from their pay. This would create a Staff Charity Fund and we would recruit staff representatives to contribute to how the fund is expended.	
7. Midland Met Hospital fundraising appeal	**SWBCF (02/18) 006**
A risk assessment has been developed by the campaign team and was presented to the Committee. The initial risk assessment showed that, due to the current situation with the construction, the costs associated with the fundraising team will increase over the lifetime of the appeal. Any delay however allows a longer period of time to plan for the public appeal and secure major gifts. The teams work has been re-profiled. The Chair asked that this item be kept on the agenda to ensure that the committee is kept abreast of any issues which may be of concern.	

Wellcome Trust bid for Arts funding for Midland Met Appeal has been submitted and a response is due by end of March 2018.	
8. Finances	**SWBCF (02/18) 007**
The Committee was asked to discuss and approve the following: • The format of the report • Reforecasting of KPIs for the 2018/2019 and subsequent financial years due to change in Midland Met campaign timescales • The creation of digital signage and promotional material to be used by fund managers • Continuing to robustly measure expenditure in line with four priority areas • Reporting progress on monitoring trading income • Receiving future updates on the automated process for donations After a lengthy discussion the several proposals were made as to the format of the proposed report. Proposals included making the report tell a story rather than purely financial; to split by theme rather than fund. JShah to continue re-profiling the KPIs to incorporate the delay of Midland Metropolitan Hospital.	

9. Matters to raise to the Board and Audit & Risk Management Committee	**Verbal**
The committee agreed to share the following themes; • Annual Accounts • Funding proposal for the Domestic Violence project	
10. Meeting effectiveness	
The committee agreed that the meeting was content was robust	
11. Any other business	**Verbal**
- **Barclay performance:** T Waite updated on the performance of our investment with Barclays. Barclays are achieving what we anticipated. TWaite to liaise with Mike Hoare as to how best to further invest. - **Parish news:** The Chair formally thanked Ms ENewell on her contribution to the committee and the Trust and wishes her well for on her retirement.	
Date and time of next meeting: 17th May 2018 at 11:30 in Anne Gibson Committee room, City Hospital	

Sandwell and
West Birmingham
NHS Trust

70 YEARS OF THE NHS 1948 - 2018

INTEGRATED ANNUAL REPORT AND ACCOUNTS
INCORPORATING THE QUALITY ACCOUNT

2017–2018

CONSISTENCY OF CARE

where everyone matters

swbh.nhs.uk


70
YEARS
OF THE NHS
1948 - 2018

Contents

Front cover captions

Pic 1: Staff Nurse, Anthea Forsythe completing the Ten out of Ten safety plan checklist

Pic 2: Nicola Ager, Service Development Librarian, supporting Speak Up Day, by signing a Promise.

Pic 3: District nurse Rebecca Vivian looking after patient Hanif Harvey at his home.

Pic 4: The launch of our Purple Point service with Ian McGarry (centre) from Healthwatch Sandwell.

Pic 5: Sickle cell and thalassemia centre Nurses Liz Green and Amanda Tembedza.

Staff on Priory 2 ward at Sandwell Hospital gather for the opening of the new surgical monitored unit which aims to reduce admissions to our intensive care unit.

1 Introduction

Welcome to our 2017/18 annual report and accounts that includes out quality account and the annual report for our Trust Charity.

This year the report theme is "Consistency of Care" as we have focused throughout the year on getting our basic safety checks in place and fully embedded into our Trust's day by day and shift by shift practices. We are delighted that at the time this report is published we have successfully been shortlisted for the patient safety award in the culture change category for our Safety Plan work. Throughout this report you will see stories from colleagues and patients that relate back to Consistency of Care – getting the basics of good care right, every time. We hope you are inspired by reading about their experiences.

There are many achievements to be proud of during the year, where we have demonstrated excellent care and innovation to better serve our patients and communities. These quality improvements have been recognised by the Care Quality Commission who returned for a re-inspection in parts of our Trust in March 2017 and published their reports in October. Whilst our overall rating remained unchanged, the inspectors were able to recognise our improvements in key areas giving us outstanding ratings for end of life care and in the caring domain. Our aim before their next inspection is to sustain and further build improvements so that we achieve an overall "good" rating.

We were able to meet our financial plans and are one of the few NHS Trusts reporting a small surplus at year end. The work to create sustainable services continues and the next two years will see us work more collaboratively with commissioners and primary care providers to create an integrated care system that seeks to boldly challenge the way we invest and plan our care services. We aim to focus of course on health care but also on the other factors that have a significant impact on people's health such as housing and employment.

We have continued to support the Black Country and West Birmingham Sustainability and Transformation Partnership, aiming to develop and deliver financially and clinically sustainable health and care plans across the Black County that will improve the health and wellbeing of our residents. The Partnership has identified three distinct but interconnected aims or 'accountabilities' that sum up what we are trying to achieve together. They are: Integrating hospital, community, primary and social care services on a place by place basis. Collaborating as NHS partners across the Black Country on key areas such as mental health and cancer services and working at scale across the Black Country with the Combined Authority, our local councils and other stakeholders to address the wider, economic and social determinants of health that can make such a difference to people's wellbeing.

Some services have necessitated change throughout the year. Cancer services remain a vital part of our provision but there have been changes to patient pathways for oncology treatment for some cancer patients. We look forward to the wider review of cancer care that is being led by NHS England during 2017/18 and are pleased that commissioners remain committed to providing chemotherapy services locally at the convenience of patients.

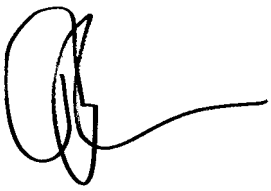
Construction of the Midland Metropolitan Hospital unfortunately paused from the middle of January 2018 due to the insolvency of Carillion, our construction partner. We have worked closely with government officials, our private finance partner and local and national partners on future arrangements so that any delay to the opening is minimised. We recognise the impact that any delay has on patients, on our staff and other care providers and are doing all we can to seek a favourable resolution that is not at local taxpayers' expense. It does appear likely that the delay will be considerable and that interim safety measures may be needed.

This year we will go live with our new electronic patient record, Unity, that means a big investment in capital and staff time and effort. The new system promises to provide clinicians with more time to care as they are less reliant on paper systems and duplication of entries into multiple existing systems. We expect one of the major benefits to be the introduction of electronic prescribing, reducing medication errors significantly.

We know of course that our workforce are our biggest assets and in 2017/18 we will give our attention to improving our organisation as a place to work and to do a great job. Our engagement plans will involve listening closely to what colleagues are saying and acting on that. Our Speak Up Day in September was a good example of our commitment to encourage people to speak up and then make sure we listen and act.

We enter 2018/19 with much optimism about the future, yet recognising and understanding the challenges ahead. We are grateful for the support we have had from many of our partners during the year and continue to believe that it is in collaboration with others that we will truly meet our 2020 vision to integrate care locally..

Richard Samuda, Chairman



Toby Lewis, Chief Executive

About Sandwell and West Birmingham Hospitals NHS Trust

Sandwell and West Birmingham Hospitals NHS Trust is an integrated care organisation. We are dedicated to improving the lives of local people, to maintaining an outstanding reputation for teaching and education, and to embedding innovation and research.

We employ over 7,000 people and spend around £430m of public money, largely drawn from our local Clinical Commissioning Group. That Group and this Trust is responsible for the care of 530,000 local people from across North-West Birmingham and all the towns within Sandwell.

Our teams are committed to providing compassionate, high quality care from City Hospital on Birmingham's Dudley Road, from Sandwell General Hospital in West Bromwich, and from our intermediate care hubs at Rowley Regis and at Leasowes in Smethwick.

The Trust includes the Birmingham and Midland Eye Centre (a supra-regional eye hospital), our Sickle Cell and Thalassaemia Centre, and is the regional base for the National Poisons Information Service – all based at City. Inpatient paediatrics, most general surgery, and our stroke specialist centre are located at Sandwell. We have significant academic departments in cardiology, rheumatology, ophthalmology, and neurology.

Our community teams deliver care across Sandwell providing integrated services in GP practices and at home, and offering both general and specialist home care for adults, in nursing homes and hospice locations. Our new hospital – the Midland Metropolitan – is around two thirds built and is located on Grove Lane, on the Smethwick border with west Birmingham.

We are a key partner in efforts to change the shape of care in our area. We have built strong partnerships in primary care and are changing some of our care pathways so that patients can receive follow-up care locally rather than having to rely on a visit to one of our acute hospital sites. Our intention is to provide substantially more care at home and rely less on acute hospitals. We expect to progress a local integrated care system during the year that will be focused around improving outcomes for patients at the start and end of life, and linking up other determinants of health such as employment and housing.

Most of our patient contacts are out in the community and we have expanded our clinical group for communities by introducing three medical specialties. This demonstrates our commitment to delivering care for people with long term conditions on much more of a community basis than it is today.

Our training and education team are outward facing in sourcing the workforce we need for the long term. We have a very active programme of apprentices and school experience joint working. We have a partnership with Sandwell University Technical College and Sandwell Colleage and more widely work closely with Birmingham City University, Wolverhampton University, Birmingham and Aston Universities. The Learning Works is our community-based recruitment and training resource.

We are committed to developing ever more consistent links into our local communities, working with voluntary sector, faith, and grassroots organisations. We continue to make major investments in the skills and training of our workforce; in the technology we use to both care for and communicate with patients and partners; and in our estate – in part through the construction of the Midland Metropolitan Hospital that changes where acute care is delivered care.

Over the last year:

- 5,795 babies were born at our Trust.
- There were 191,497 patient attendances plus 31,627 attendances seen under GP triage at our emergency departments with over 40,570 people admitted for a hospital stay.
- 44,533 day case procedures were carried out.
- 517,431 patients were seen in our outpatient departments.
- Over 618,000 patients were seen by community staff.

Consistency of Care

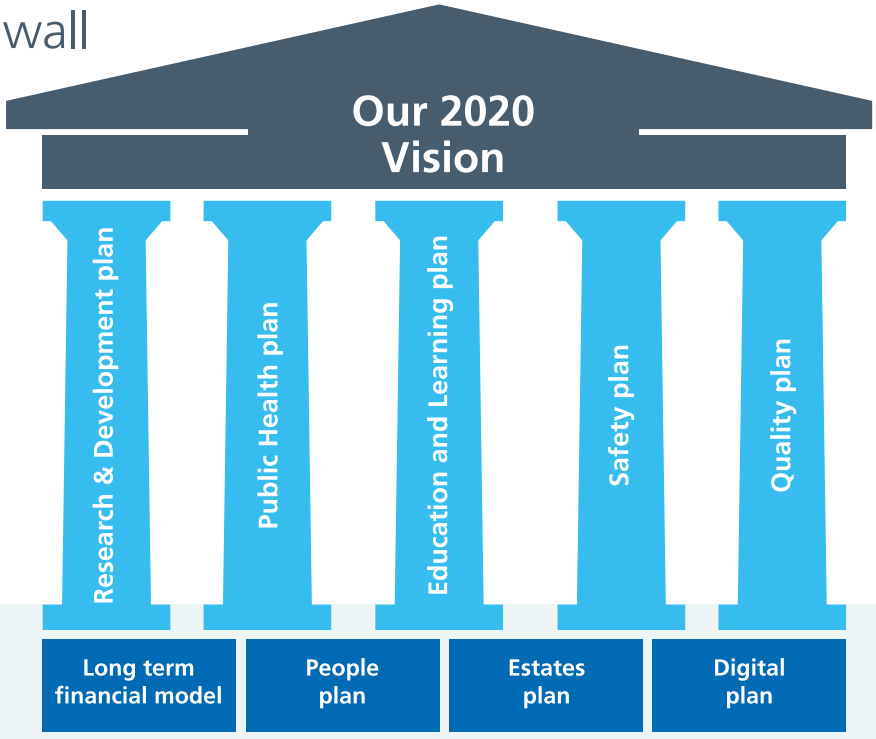
Ann Robinson, Senior Sister on D11, said: "Part of our greatest achievements through the Consistency of Care programme, would have to be improving documentation. We have made great strides with this. We have also significantly improved engagement with staff, who have really jumped on board with the initiative. They didn't want their ward to be seen as underperforming. This has led to ensuring patients and their families that they are being cared for well."

2 Performance Report

Introduction to performance report

Our work is driven by our 2020 vision and the plans and enablers that support it. This year we focussed on embedding our safety plan across all our wards and launching the Consistency of Care programme in our medical group. We decided to have a refreshed emphasis on our quality plan in 2018/19 once we were confident that the project supporting patient safety had completed.

Our 2020 wall



During the year we developed a new public health plan in conjunction with Sandwell Metropolitan Borough Council. This plan recognises the value in addressing people's quality of life rather than just extending life and we are pleased to be part of that endeavour. Our research and development efforts continue to expand not just the number of patients who take part in clinical trials here but also in the range of specialties where we are running or participating in research. All of this is evidence that our Trust is a leader in research and some of our research in fields such as cardiology and diabetes are world renowned.

We have supported our people this year in continued protected training budgets, a new personal development review process that rewards performance as well as behaviours recognising potential so that we can talent spot and further support individual careers. All our managers are receiving standardised training that is enabling them to learn from each other and apply consistent, good management practice.

Performance Overview

The performance overview sets out a summary of our performance throughout the year against our key priorities and plans. It includes our top ten achievements and also explains any priorities that we were not able to fully deliver during the year.

We have made great progress during the year on projects supporting our 2020 vision. Read about our top ten highlights here;

1 Embedding our Safety Plan

The safety initiative introduced in January 2017 has delivered impressive results in wards across the Trust. Involving multi-disciplinary clinical staff, the plan relies on the completion of a series of safety checks, also known as Always Events, when assessing a patient. This happens within the first 24 hours of admission. In addition to the 30 per cent reduction in falls, figures also show that 99 per cent of patients are receiving all checks within 24 hours following admission. A system is in place to ensure that any of those missed are then completed within 48 hours. The process has been judged a success at the Trust, with more chances of potentially dangerous conditions, like Venous Thromboembolisms (VTE) being picked up and treated in a timely manner. Once the condition of the patient is assessed a treatment plan is devised which includes looking at their medical history, as well as looking at their current prescriptions and an expected date of discharge. We introduced the safety plan in our surgical wards and then rolled it out to medical and community inpatient facilities. Our work has been recognised by the national Patient Safety Awards for 2018.

2 Consistency of Care

During the year our Consistency of Care programme began beginning with our medical inpatient wards. We wanted to be assured that basic good standards of care were being met for every patient on every shift. The programme was led by our Director of Governance, Kam Dhami, and her executive director colleagues but the improvement ideas and delivery of those came from the ward multi-disciplinary teams. Lead consultants for each ward were established who, in conjunction with the nurse and therapy leads, developed their own improvement plans. A big part of the programme was participation by ward teams in a series of Listening into Action events where they generated their own ideas and then put them into practice. Throughout this report you will see stories from many of those who took part in the programme. In 2018/19 the programme progresses to include our emergency departments and community services.

3 Speak up Day sees hundreds make a commitment to raise concerns

Hundreds of colleagues from all areas of the organisation took part in our first ever Speak up Day on 27 September 2017. Speak Up Day aimed to raise awareness of the number of ways colleagues can raise a concern about safety at work. As part of the day, hundreds of our employees made a promise to speak up. Our Trust has high levels of reporting for incidents in comparison to other, similar organisations but we wanted to continue to make sure that everyone knows how to raise a concern and where they can go for help, recognising that by raising concerns we will create safer care for our patients. It wasn't just our employees who recognise the importance of speaking up. On the day we were supported by positive feedback from patients, GPs and even people in the media. Speak Up Day will take place at least once in 2018/19 but of course the spirit of speaking up continues throughout the year.

4 Purple Point phone line launches to give immediate help to patients

The new hospital hotline 'Purple Point' has been installed outside ward areas at Sandwell, City and Rowley Regis Hospitals, which have phones that link directly to a team of advisors. The aim is to address concerns about inpatient care quickly, before the patient is discharged. The move comes after a survey was conducted by Healthwatch Sandwell which found patients wanted concerns resolved in a more timely manner. The phone line is manned between 9am and 9pm every day and is available in English and other languages. The service is not intended to replace the many ways we already have to act on patient feedback. It is an additional option for patients or relatives who want to give a compliment or need to have an issue dealt with promptly.

5 Successful recruitment leads the way

Nursing recruitment remains one of the Trust's key priorities as we aim to ensure safe staffing levels and deliver outstanding care to our patients. Since April last year, more than 100 conditional job offers were made to nurses through nursing recruitment events, held at City Hospital, and also at the RCNi (Royal College of Nursing) Jobs Fairs in Birmingham, London, Liverpool and Nottingham. With 240 vacancies last year, we currently have just over 90 to fill by the end of 2018. This is a remarkable result, especially in challenging times when the NHS nationally is experiencing a shortage of nurses across the country. Our new branding 'Bring your Ambition to Life', award-winning employee benefits schemes, and opportunities for nurses to develop their skills through training and team support, are some of the key things that have encouraged nurses to join us. We are pleased that our success in running local recruitment fairs has also been highlighted by NHS Employers for best practice and has been promoted widely across the NHS and in the local and national media.

6 Research and development

Across our research and development we are currently working to a three year plan which takes us up to 2020. The plan includes 11 objectives which cover the increase of the breadth of research we carry out, the number of patients we recruit onto studies, empowering patients to influence the research we pursue and increasing involvement of non-medical healthcare professionals in research and development. We have currently over 150 clinical trials on our books with almost 3'000 patients recruited across a wide

Consistency of Care

Sophia Panton, Sister AMU 1 and 2, said: "Consistency of Care is very important to us. However, it isn't a new thing within our profession, as we were always taught to look at the patient as a whole, not just their illness that has brought them into hospital. An example of this would be how we admitted a lady on one occasion, who aside from her illness, was struggling with alcohol and smoking issues. As a result we were able to refer her to our cessation services."

range of specialities including ophthalmology, cardiology, sickle cell, maternity and dermatology.

7 Investing in our people

During the year we launched a new personal development review (PDR) (appraisal) process that support employees and their managers in setting clear objectives, and recognises people's performance as well as the behaviours they have exhibited as part of our workforce. The PDR, Aspiring for Excellence, asks employees to demonstrate how well they have lived up to the Trust's nine care promises. For the first time, managers are scoring employees on their performance and behaviours as well as giving them a score for their potential. All our managers have been trained in this new process that formed part of the new accredited manager training programme. Included in the programme are bespoke courses on managing wellbeing, recruiting for success, managing resources effectively and governance. On completion of the programme each manager receives accreditation and a passport that will form part of their own performance development. A big investment was made in our estate with the opening of the new Education Centre for the benefit of all colleagues. The newly refurbished centre at Sandwell Hospital is hosting hundreds of employees every week for course, training, learning and meetings. The library facilities are available to all and it even hosts our very own Amazon drop box for those important deliveries!

8 Tackling alcohol misuse

A £250,000 grant from Your Trust Charity is transforming patient lives and saving our organisation a significant number of bed days a month by funding a specialised alcohol team to work with patients at City and Sandwell Hospitals. The grant has enabled the creation of the team, which consists of alcohol specialist nurses and alcohol practitioners, under the management of Consultant Toxicologist, Dr Sally Bradberry. The team are based at both City and Sandwell Hospitals and offer clinical and psychosocial support. They advise colleagues on the treatment of alcohol withdrawal and support them in the clinical management of these patients. The project began in December 2017 and is already delivering some impressive results having seen and treated over 260 people with ages ranging from 17 to over 65. 72 per cent of these were admitted into hospital for treatment and since then most have continued to access outpatient appointments through the dedicated work of the specialist team, and have been referred into other services, including counselling and rehabilitation sessions.

9 Meeting our financial commitments

We are one of the few NHS Trusts who were able to report a small surplus at year end. We benefited from the sale of land at the City Hospital site that will not be retained when we move to Midland Met. Our financial plans going forward are challenging and we are working closely with commissioners so that we can make the cost savings required, support them in their quality, innovation, productivity and prevention programme and generate investment so that we are able to balance our books, retain control over our finances and make new investments.

10 Working with partners

We continue to work closely with partners from across a range of sectors, both nationally and locally. We have received considerable support from third sector organisations in volunteering projects across our Trust such as Agewell, Kissing it Better, Sandwell Cares, the West Bromwich African Caribbean Resource Centre and many others. Our partnerships with primary care providers have progressed considerably during the year with a signed agreement with the Modality group of GP practices. We seek to further build on this during 2017/18. Acute and community providers have continued to collaborate together and within the Black Country and Birmingham Sustainability and Transformation Partnerships. We have agreed to be part of the Black Country Pathology Service, which we expect will be the largest pathology service in the country and will service four hospital Trusts and local general practice.

How we performed against our priorities

2017/18 Table of priorities

Strategic Plan	Priorities	Delivered?
Quality	Review our Care Quality Commission report that is due during the year and implement our action plan to continue improving safety standards and quality of care.	✔
	Implement the improvement plans to reduce avoidable mortality in surgery, cardiology, deaths due to sepsis and perinatal mortality.	X
Safety	Improve care in medicine by comprehensive implementation of Consistency of Care in all of our inpatient wards.	✔
	Implement the Safety Plan in all inpatient areas (including community wards) so that patients have all safety checks as standard.	✔
	Complete targeted recruitment for our hard to fill nurse roles that will create fully staffed teams reducing reliance on temporary workers.	✔
Service performance	Meet our four hour AandE waiting time commitment to patients sustainably in Q4.	X
	Reduce length of stay by increasing the number of morning discharges and cutting delayed transfers of care	X
	Deliver reductions in wait time and improved productivity through successful execution of our annual production plan for elective care.	✔
Our people	Cut sickness absence to below 3%.	X
	Create a more engaged workforce through promoting opportunities to speak up, make suggestions and listen to colleagues.	Partially
	Implement the changes needed to meet our workforce plans for 2018 – 2020.	X
	Deliver our Aspiring for Excellence: New PDR process.	✔
Digital workstream	Successfully implement our new electronic patient record during the Autumn supporting our journey towards a paper-free environment.	X
	Fully embed digital dictation and speech recognition, reducing time taken for patients and healthcare professionals to receive Trust correspondence.	Partially
	Ensure robust, improved infrastructure for our technology.	X
Our places	Finalise and publish our final location plans for services in the Sandwell Treatment Centre.	✔
	Exit 2017/18 with delivery plan for Midland Met on track and seven day service model developed, costed and agreed.	X
Long-term financial plan	Reduce agency spend by £10m during the year.	✔
	Meet financial commitments to generate a surplus by year end with all groups meeting their income and expenditure budgets.	X
	Work with the Black Country Alliance and STP partners to deliver efficiency savings including across corporate back office functions and in procurement of supplies and services.	Partially

Priorities we did not fully deliver

We chose to focus on embedding the safety plan this year and the programme around delivering our quality plan will be refreshed in 2018/19 which will mean that we will see improvements in avoidable mortality in cardiology, stroke, surgery and deaths from sepsis. We are working with others across the Black Country on doing more to reduce perinatal mortality.

Along with other Trusts in the NHS, our performance on four hour waits for treatment in our emergency departments have not reached the standard we planned for by year end. Throughout the year we put plans in place to improve the patient journey through from emergency admission to discharge so that we could minimise delays for patients. The benefits of those plans are yet to be fully

realised. Our length of stay has also not improved at the rate needed and we have had to staff additional beds to care for patients. We plan to return to our sustainable bed base by Q1 of 2018/19 and continue to progress improvements in patient flow that will have an impact on our time to see and treat patients at the front door.

We have held a number of engagement activities with our colleagues including Listening into Action events and our Speak Up Day to ensure that colleagues feel heard and valued within the organisation. Our health and wellbeing offer is extensive and the services are well-used. In 2018/19 we will create even more opportunities for colleagues to feel engaged and empowered.

Our long-term workforce plans for 2018-2020 are currently being finalised to ensure that they meet our long-term financial plan and enable us to have the right skilled staff in the right places in preparation for our move to a new hospital and single site working for some teams. Each group is looking at their own workforce plans so that we can build the right training support and workforce change programmes. We have more to do to further reduce absence due to sickness and will in the year ahead put in place a dedicated programme of support for colleagues experiencing mental ill-health.

We delayed the implementation of the electronic patient record to 2018 to ensure we were ready to implement well this large-scale change that touches the majority of our workforce who are involved in clinical care. Our Trust has introduced a number of improvements to our infrastructure and hardware and continues to drive forwards the digital infrastructure plan. We were not affected by the cyber-attack that impacted on many NHS organisations and we ensure the security and safety of our systems are robust. Case note scanning went live during the year as preparation for electronic patient notes. Despite a difficult start, the system is now working reasonably well and has enabled the paper notes on site to be dramatically reduced. We continue to experience difficulties with the system for digital dictation and speech recognition and recognise that, when fully functioning, it will save considerable time for our clinicians and their support staff.

The Midland Metropolitan Hospital has experienced a pause in construction work due to the regrettable liquidation of our construction partner, Carillion. We continue to work with others to find a solution to complete this vital new hospital. This delay has impacted on our ability to finalise the Sandwell Treatment Centre locations as well as our seven day working model within the new hospital.

We met our financial commitments during the year, with a small surplus at year end. Not all groups met their group income and expenditure budgets. Our work with Black Country partners has continued as part of the Sustainability and Transformation Partnership. Acute providers have worked together on shared pathology services to form a hub and spoke model with the hub provided at New Cross Hospital, Wolverhampton. The business case has been reviewed by all four Trusts in the Black Country who have committed to moving forwards on this exciting new venture.

Working with Primary Care

GP partnerships

Forming close collaborations with partners continues to be a strong value of the Trust and this year we have further strengthened and formalised some of our GP partnerships, taking great strides towards our vision to be the best integrated care organisation in the NHS.The focus of the partnership working this year has been on building strong governance and working relationships with organisations in our area, including the local authorities, mental health trusts, GP networks and other acute and community providers. We are committed to working closely with all providers delivering health and social care so that care is seamless for patients and their families.

In some areas of Sandwell and West Birmingham our partnerships mean we are working as one team across primary and secondary care delivering joined up care for people. In West Birmingham we have a formal agreement with GP partnership Modality to work together on non-clinical and clinical services for three years. Dr Naresh Rati, of Modality Partnership, commented: "The agreement is a commitment to work collaboratively over the next three to five years with a view to forming more seamlessly integrated care pathways for patients."

There are also informal agreements in place with two other GP groups, Pioneers for Health and Intelligent Commissioning Federation (ICOF). In Sandwell there is an agreement place to work with the Modality practices and Your Health Partnership and we have also had initial discussions with three other GP networks. We have worked together on specialties including cardiology, gynaecology, dermatology, rheumatology and ophthalmology, developing joint primary and secondary care clinics. In 2018 we will focus on Ear Nose and Throat (ENT), gastroenterology, pain management, neurology, urology and musculoskeletal.

We will continue to look at new ways to provide seamless care for our whole population in collaboration with our partners.

How our groups performed

Primary Care, Community and Therapies
Budget: £71.5m
Headcount: 992 WTE

A medical workforce, including primary care has strengthened our community services further and prepared us to deliver new models of care. It means many different services are now delivered to acute inpatients, intermediate care and re-ablement beds, outpatients clinics, emergency and assessment departments, outpatients clinics, patient's homes and a diverse range of community locations.

Key achievements:
Community matrons Sue Wills and Dena Ross scooped a prestigious award for their hard work in reducing elderly admissions in July. The pair, from the community matron care homes team, won the Nursing Older People category at the Royal College of Nursing (RCNi) Awards. The matrons' project saw a reduction in elderly patient admissions to AandE by 18 per cent, and to hospital by 29 per cent. Initially they worked with West Midlands Ambulance Service (WMAS) to deliver the well-known First-Person-On-Scene (FPOS) course to 50 carers from 10 care homes in the area. However, following feedback, Sue and Dena decided the programme needed to be more tailored to meet the needs of care home staff. A bespoke course was devised, in collaboration with WMAS and then delivered to carers who work at a further 11 homes.

A unique collaboration between the British Red Cross and our organisation has been benefitting patients within the community. Two support workers from the Red Cross are visiting patients at home following their discharge from our care and offering them a befriending service, as well as carrying out essential errands such as shopping and collecting prescriptions. The initiative helps those who are at risk of being readmitted to hospital and it ensures that people can often remain in their own homes. External funding for the 18-month project will pay for both the support worker roles and a service coordinator. All three are based at Sandwell Hospital and work alongside the communities and therapies team, who will identify patients in need of extra support. One of those patients is Graham Harrison, of Oldbury. He has hailed the service as a "brilliant idea".

The Diabetes Team was recognised for its innovative work after being shortlisted for a national award. Judges sitting on the panel for the Healthcare Transformation Awards 2017 were impressed with the team's DiCE (Diabetes in Community Extension) service, which works closely with GP surgeries in providing the right care, in the right place, to the right patients. As a result of their on-going successful work, they were named as finalists in July last year for the Innovation in Diabetes award 2017. The DiCE model involves upskilling Primary care with GPs and Practice Nurses identifying challenging patient cases, who need support from our hospital diabetes specialists. The team then provide advice and management plans for those patients. These sessions have been carried out in many forms, such as virtual clinics, joint consultations, case notes review or communication through emails and telephones along with on-going education. This model was commissioned by Sandwell and West Birmingham Clinical Commissioning Group (CCG) in 2014 to deliver it to all 89 practices in the area.

The iCares 'care homes' team have been working with care home residents to decorate their walking frames, an initiative that has proved extremely successful in reducing falls in other parts of the country. Residents in Dovedale Court, Wednesbury have benefitted from the scheme, in the hope that it will encourage them to use their frames more regularly. Clinicians found that residents in care homes weren't using their frames as often as they should, which results in falls and admission to hospital. Sometimes they forget their frames, or use someone else's because they look the same. The team believe the project will see a huge benefit to patients.

In early 2018 we signed an Memorandum of Understanding (MOU) with the Modality Partnership, one of the largest GP super-partnerships in the region.

The long term deal means a wide range of specialist services will be delivered to patients within the community setting, such as joint appointments with specialists and their GP at surgeries and hospitals run by the Trust. The goal is to take each of the major adult and children outpatient services that we offer and deliver them into a community setting, giving patients more access to specialist care. We want to particularly focus on patients who are most in need, and those with long term conditions. We want to deliver better care for those patients. We are also working with a number of other GP partnerships in the region to provide similar services. Cardiology, dermatology, gynaecology and rheumatology teams from the Trust are already working as an integrated service within practices run by the Modality Partnership.

Community Matrons (L-R) Sue Wills and Dena Ross who scooped an award for their hard work in reducing elderly admissions.

Future plans:
The iCares team will be undertaking a collaborative project working with West Midlands Ambulance Service (WMAS) to identify patients requesting emergency support who could be successfully cared for at home. iCares is expanding its team of advanced practitioners consisting of nurses and therapists with extended clinical skills to support the existing staff in their aim to provide integrated high quality care for patients in their own homes. The collaborative project will see iCares and WMAS working together to ensure patients receive the right care from the right source and in the right location. Dedicated referral pathways will be finalised to enable WMAS to liaise directly with iCares and staff from both services will work together during sessions in our emergency departments. It is anticipated that this will lead to a reduction in unnecessary hospital admissions and an increase in patient satisfaction and outcomes.

We will also continue to work with local GPs on a number of initiatives aimed at improving patient outcomes and eliminating delays and barriers to care across different providers. For example the Musculoskeletal (MSK) service is commencing a dedicated support and telephone triage to ensure that patients are seen by the most appropriate professional. This will also reduce delays experienced by patients with MSK issues who initially wait for GP appointments prior to being referred to a physiotherapist. In addition a new collaborative project between us and the Black Country Family Practice is planned to examine health and social care provision for patients in care homes and sheltered accommodation. The joint pilot project will identify the needs of this particular patient group and develop services to meet their unique need.

Consistency of Care

Phoebe Spooner, Acute Medical Unit A (AMU) Healthcare Assistant, added: "As part of the Consistency of Care plan, the Adapt programme, was introduced to our unit. It is a discussion between therapists, social workers and nursing staff to ensure if there are any issues social or medical needs, they can be met before the patient is discharged."

Imaging
Budget: £10.7m
Headcount: 279 WTE

Our patients benefit from a wide range of imaging services which includes x-ray, interventional radiology, CT and MRI scans, Dexa, ultrasound, nuclear medicine and breast screening. We also provide a direct access service for GPs. An increase in equipment means shorter waiting times and also the opportunity for patients to have more choice over where they would like to receive their treatment.

Key achievements:
Our nuclear medicine department offers patient-centred functional imaging and reporting services to patients from hospitals across the West Midlands. They have recently introduced a new system which allows results to be shared with neighbouring trusts much quicker. There are many types of test which the department performs, including myocardial perfusion scans, which is a test to look for any blockages in the artery which supplies blood to the heart muscle, and a Datscan which looks for Parkinson's in the brain. Previously, the results of these and other tests had to be sent to the referring doctor by post. But sometimes this took up to a week to reach the correct person. The imaging team worked with informatics and the PACS team to devise a system whereby the report and images can be sent electronically to the external hospital's PACS systems. This now means that our state of the art images can appear on the referring hospital's PACS team and patient information system, which helps to convey the information written in the report. This export can take just a few hours, rather than days as we experienced when we were posting them.

(L-R) Dr Roger Stedman, with Dr Nicola Strickland, President of the Royal College of Radiologists, and Dr Sarah Yusuf, Group Director for Imaging.

A number of radiographers have undergone additional training which allows them to report on a number of x-rays and CT scans. The reporting radiographers assist in managerial aspects of the department and also have a set time to report on images. They undertake additional training in the form of modules from a master's degree in in diagnostic imaging. Each of the modules means they can report on different areas of the body – for example after completing one module the trainee can report on the appendicular skeleton (shoulders to the fingers and then the hips to the toes) a second module would enable them to report on axial skeleton images (skull and facial bones) and completion of the full masters would enable a radiographer to report on most images, including chest and abdomen. Essentially the workload is being lifted off some radiologists which frees them up to look at more complex cases such as CT scans, ultrasound and MRI scans. This improves the turnaround times and reduces the amount of time that patients are waiting for a diagnosis.

The recruitment strategy for radiologists was praised by Dr Nicola Strickland, president of the Royal College of Radiologists. The Trust has been bucking the trend and is close to filling all radiologists and radiographer posts.

A new process, which will improve the way emergency patients and inpatients are managed by the imaging department has been introduced. The duty radiologist system will streamline the requesting process and reduce the number of calls needed to arrange a scan for a patient. It means that one radiologist will take all the calls on that particular day, with a contact number on each site. This means that colleagues on the wards do not have to ring for every scan, or that our other radiologists can report on scans without getting interrupted. We aim to complete the vetting and scheduling process for urgent cases within 30 minutes of receiving the request, and as soon possible for emergency deparmtents.

Future plans:
This year will see the continued refreshment of equipment with new CT and MRI scanners being installed in the Birmingham Treatment Centre (BTC). This will fit with the model of working envisaged once the acute site moves to BTC. Three new consultants have been recruited and will join the Trust in late summer; two breast/general and one nuclear medicine. The interventional radiology service continues to participate in the Black Country Alliance intervantial radiology out of hours service and is gearing up to full participation later this year. We are also looking at working with partners to investigate the use of artificial intelligence as an adjunct to our services.

Pathology
Budget: £21.3m
Headcount: 337 WTE

Within our pathology department, we offer a wide range of services which allow speedy results, as well as services that go out to meet patients such as anticoagulation services and point of care testing. We offer comprehensive services that all us to apply modern clinical science to the diagnosis, treatment and monitoring of disease.

Key achievements:
Since 2011 our clinical biochemistry department has offered a direct to the public service for vitamin D levels. This service is based on a vitamin D dried blood spot test card that was developed in clinical biochemistry, with its unique design allowing samples to dry in an enclosed space without blood spot deterioration. Initially the service used a telephone order line however, it is now mainly online. We are seeing considerable growth with requests coming from right across the United Kingdom and from countries around the world. The service determines those members of the public who do not produce enough vitamin D naturally from sunlight on their skin. Many of us have sub-optimal vitamin D levels and our pathology team send back thousands of reports every year to members of the public who are clearly deficient in vitamin D. However, they also detect people who have been taking far too much vitamin D with the risk of toxicity.

A team of our clinicians have joined forces with Sandwell and West Birmingham CCG to bring screening for TB and blood-borne viruses to the community. This initiative has seen our practitioners visit key places within the area to promote and carry out tests for Tuberculosis (TB), HIV, Hepatitis B and C. Patients who have the test must be aged between 16 and 35 and must have arrived in the UK from a number of countries in Asia, and Africa, but also Vietnam and Peru, within the last five years, countries known to have a high incidence of TB.

Our serology team have produced a dried blood spot testing service which is being used in particular in secure units where we are diagnosing people with serious conditions including Hepatitis and HIV.

Our expertise has gained media attention, when we were asked to test a lethal substance called DNP, which is being used as a diet pill. We highlighted the dangers of the drug, an industrial compound which is sometimes inserted into capsules and sold on the internet as a weight loss agent. Our modern equipment, which includes a screen of 1,500 drugs and metabolites, enables us to detect the misused substances in a timely manner, so that clinicians can have the right information to treat patients effectively.

The histopathology department welcomed 10 new recruits to the team. Two new senior biomedical scientists, as well as newly qualified biomedical science degree students, a medical secretary and a multi-disciplinary team coordinator have joined the service. The senior members are involved in using advanced dissection techniques to prepare specimens for diagnosis, whilst also playing a role in training their junior colleagues.

A new handbook has been produced by us, which offers help and guidance on how effective use of complex services can positively impact the patient sample journey. The publication has been circulated to users in primary care and around our hospital sites. The 16-page book includes general information about pathology, the different laboratory services, and clear details on how to take the perfect blood sample.

Future plans:
We are now part of the Black Country Pathology initiative which aims to take forward Pathology across the Black Country. This is a long term process with staff across Pathology now involved in meetings looking at all aspects of the services that we provide. A main hub department will be based at New Cross hospital with satellite facilities in other hospitals including ours.

A team of our clinicians bring screening for TB and blood-borne viruses to the community. (L-r) Afzol Hussain, Medical Laboratory Assistant , with Alamgir Khandoker, Health Advice Officer at the Bangladeshi Islamic Centre, Pav Jheeta, Cassandra Craig, Medical Laboratory Assistant, and Tracy Morrod, Clinical Nurse Specialist for TB.

Surgical Services
Budget: £113.7m
Headcount: 1,368 WTE

The Surgery group has combined all surgical specialities together, providing seamless services to patients and enhancing cross learning for staff. We provide general surgery, orthopaedics, plastics, urology, vascular, anaesthetics and critical care, as well as ophthalmology at the Birmingham and Midland Eye Centre (BMEC), which is based at our City Hospital site. We treat patients who present to our AandE departments with acute surgical or orthopaedic emergencies and perform a large number of elective operations.

Key achievements:
We opened a new surgical monitored unit at Sandwell Hospital to enable the surgery team to provide level one care to patients, allowing us to optimise patient recovery, with the aim of preventing intensive care unit (ITU) admissions where possible.

Our clinicians have been using a new less invasive way of removing kidney stones from patients which drastically reduces their time in hospital. The new procedure called Percutaneous nephrolithotomy (BCNL) involves using a thin telescopic instrument called a nephroscope. It is less risky and more convenient, reducing the length of time the patient has to stay in hospital from five days to just one.

We established a new nurse led service to reduce waiting time for yag laser capsulotomy. This procedure is to improve patient's vision after cataract surgery. In the past, it was carried out by doctors and a handful of nurses across the region. Now, with this established nurse led service, patients are able to access the treatment in a timely manner.

Surgeons at BMEC became one of the first in the UK to perform a sight-saving operation, known as the GATT procedure (Gonioscopic Abinterno Transluminal Trabeculotomy). The patient, a 20-year-old man had been diagnosed with glaucoma and was suffering from excruciating headaches

Patient Daniyaal Farooq (left) became one of the first and youngest patients to undergo the GATT procedure carried out by Mr Imran Masood (right), consultant Ophthalmic Surgeon.

and blurred vision. Our surgeon suggested a more advanced and minimally invasive technique and the patient underwent the procedure in both eyes with a positive outcome..

Our breast team were selected to take part in a UK multi-centre study, testing a device called MarginProbe. The device uses electromagnetic waves to identify breast cancer cells at the margin of specimens. It was developed to allow surgeons to be able to establish how much tissue should be removed during a lumpectomy - an operation in which a lump is removed from the breast. If the outcome is successful, using MarginProbe in our unit may save our patients around 50 extra operations a year.

Future Plans:
The opening of a 23 hour unit in the Birmingham Treatment Centre will see a reduction in the number of short notice cancellations due to bed availability and a shorter wait on their surgical pathways.

Plans are also in development to provide a 23 hour unit on the Sandwell site to support surgical pathways with a short length of stay for orthopaedic and general surgery specialities. It will also lead to improved access to specialist support in community settings (e.g., GP surgeries).

Our breast team were selected to take part in a UK multi-centre study, testing a device called MarginProbe.

Consistency of Care

Alice Sibanda, a sister on Priory 5, said: "On Priory 5 we have created a checklist for all the documentation. This has made a huge impact on patient care, which means they get their medication on time, and are checked regularly. It has reduced pressure sores on the ward."

Medicine and Emergency Care
Budget: £120.9m
Headcount: 1,429 WTE

The Clinical Group of Medicine and Emergency Care group includes over 300 medical staff, over 1,300 nursing staff, a range of administration and allied health professionals working across the two directorates - Emergency Care and Admitted Care. We have recruited over 300 people during the past year. The directorate of emergency care covers Emergency Medicine, Acute Medicine, the Mental Health Service, RAID and toxicology. The directorate of Admitted Care covers elderly care, stroke, neurology, neurophysiology, cardiology, gastroenterology, respiratory; haematology, oncology, endoscopy and all ward clinical teams.

Key achievements:
In the last 12 months, the group has successfully recruited to all of the key senior clinical and managerial roles, creating a solid foundation to enable sustained improvements to care delivery going forward.

Through the Consistency of Care Programme, the group has demonstrated improved quality in the way in which care has and is being delivered.

The latter part of 2017/18 has seen the implementation of a 'Consultant of the Week' model to enable consistency in the approach to medical management of our patients and to support safe and timely discharging.

The Group has successfully recruited into the consultant workforce in the Emergency Department, Respiratory Medicine, Cardiology and Elderly Care and the nursing workforce across all specialities.

New initiatives have included a dedicated Older Persons Assessment Unit based at Sandwell Hospita. The Ambulatory Assessment Units both at City Hospital and Sandwell Hospital have expanded their portfolios both in terms of access and pathways and now see, treat and discharge in excess of 30 patients a day and has made a significant contribution toward admission avoidance. These units are planned to expand further in 2018/19.

There was double success for the Acute Medicine team who showcased their new clinical skills lab at a Royal College of Physicians conference, and also went onto win first prize for innovation in a training poster explaining the concept. Judges were impressed, not only with the design of the poster, but how this unique training model enables junior doctors and nurses to put their learning into practice improving patient safety as their skills and confidence grow. Since the launch of the clinical skills lab, the unit has seen a much improved discharge and patient satisfaction rate, as patients on the unit are seen in under four hours and have a more efficient patient journey. The clinical skills lab is believed to be the first in the country, providing short training sessions in an acute medical unit that is accessed 24/7. The lab contains extensive medical equipment ranging from lumbar punctures, chest drains and central venous puncture kits, to an ultrasound machine and a patient simulator. Medical trainees are taught how to perform procedures and have the opportunity to practice in the lab supervised by senior doctors.

Our sickle cell patients became the first recruits for a worldwide study that looked into trialling a new medicine. Nurses Liz Green and Amanda Tembedza helped to recruit patients to the trial.

Our sickle cell patients became the first recruits for a worldwide study that looked into trialling the new medicine IMR-687 to help prevent sickling, therefore reducing the number of painful sickle cell crises. Four centres in the UK and 10 centres in the US are taking part in this trial.

Our Cardiology team implemented e-prescribing to ensure accurate and timely prescribing while carrying out procedures, enhancing patient safety.

Patients who need that extra bit of help and support with their breathing are now able to benefit from Non Invasive Ventilation (NIV) following the opening of a new specialised unit on Priory 5. NIV is a treatment which helps patients to breathe in and out by using a ventilator. Patients are able to recover and breathe naturally whilst wearing a mask as opposed to a tracheal tube or tracheostomy. Patients on traditional ventilators are put to sleep and a tube is inserted into the throat. However, those patients who undergo NIV are fully conscious and breathing support is provided through a face mask. The advantages of are that the patient can eat and drink as normal, maintain their oral health, they can communicate with their friends and family, and they can remove the mask for short periods of time. We also find that NIV treatment gives improved outcomes for patients, reduces mortality and allows reduced hospital stays. The majority of patients who have NIV treatment suffer from Chronic Obstructive Pulmonary Disease (COPD), but we also treat those with breathing difficulties as a result of obesity, deformities in the chest wall and muscle weakness. The NIV unit is open seven days a week, so that patients are continuously receiving treatment.

We continue to achieve almost 100 per cent in seeing the TIA referrals within 24 hour if high risk and seven day if low risk. We saw around 1,000 patients last year (almost 30 per cent more to what the service was designed to manage in 2013). We see people outside our area because of the Birmingham and Midland Eye Centre referrals.

The Chronic Total Occlusion (CTO) angioplasty programme has expanded and is one of the largest in the country, with very high success rates.

We have been committed to developing the CESR program for middle grade doctors within our Emergency Department, who are not on a Deanery training scheme. It has already been hailed a success and has also been recognised as such by the Trust board members. This program stabilises our staffing in the future for our ED Departments.

Future plans:
We are building on the collaboration with Modality which started in 2017, by training another GP as a 'GP with special interest' in cardiology. Collaborative community Atrial Fibrillation clinics will also be set up in the future. Community clinics and diagnostics including echocardiography are planned for surgeries in Tipton and Handsworth. Modality have pledged to see cardiology follow-up cases in their community clinics, allowing SWBH to see more new clinic patients and keep all the lab work. Work to develop AMU continues and there are a number of initiatives ongoing, including collaborating with radiology to improve diagnostics accessibility seven days a week. A new research project with the University of Birmingham will look at fluid resuscitation and IVC. Within the clinical group, there is an ongoing recruitment activity with a view of hiring more consultants and clinical nurse specialists. We are also looking at upgrading our endoscopy software.

Members of the team, from the Non Invasive Ventilation Unit (NIV), which was launched in 2017.

Consistency of Care

Joy Walker, senior sister on D26, said: "Consistency of Care means cohesiveness to us within our team. Without this we cannot work together. In order to have cohesiveness, we have to have structure, which is something we were lacking. We've implemented that by having the 'rhythm of the day'. It sets up what our plan is throughout the day. We talk about our board meetings, we have huddles as a team, and meet with the relatives of our patients, because that is important. The clinical team also has time to meet with patients. From a quality point of view, our surveys are quite positive, in that patients report they have had a good experience. Patients can see we are working together and there is structure. It instils confidence and quality in the patient that they are receiving good care."

Women's and Child Health
Budget: £76.2m
Headcount: 917 WTE

The Women's and Child Health clinical group encompasses gynaecology services, maternity and neonatal services, and acute and community paediatric services which includes health visiting and best start practitioners services.

Key achievements:
We have been working with a number of organisations in wave one of a new national maternity safety initiative which aims to improve services and reduce death rates. We are part of the first wave of trusts to take part in The National Maternal and Neonatal Health Safety Collaborative, which has been set up by NHS Improvement (NHSi). It has seen a Government investment of £40,000. We are also working closely with charities, including Kicks Count, to raise awareness around preventing neo-natal deaths and stillbirths. The project is focusing on four main areas with a view to improving care provided to all who access our maternity and neonatal services.

Our paediatric service is leading the way when it comes to treating children for a wide range of allergies. The story of Louis Malanaphy gained national media attention, after his desensitisation treatment for an extreme allergy to grass, has transformed his life. The youngster was unable to play his favourite sports outside because he would suffer a severe reaction. He was put on a special treatment plan, which involves dissolving a special tablet containing small amounts of grass pollen under his tongue every day so that he would get used to it. Since starting the treatment, Louis can now play outdoor cricket and football without any reaction.

The Best Start Programme, which provides advice and support to pregnant women and new mums was launched by us in July. We were commissioned by Sandwell Council to deliver the scheme, which helps women who are pregnant with their physical and emotional health, as well as those in their first year of motherhood. They receive practical tips on their parenting skills, and advice on how to strengthen relationships with close family and friends, including their baby, which in turn will ensure that their child will achieve their full potential. Women taking part are offered six home visits in the antenatal period and 12 home visits from birth to one year. In certain circumstances the Best Start Programme can continue until the child's second birthday. Best Start replaced the Family Nurse Partnership (FNP) programme which had been running since 2009.

We are one of the best when it comes to training and support for obstetrics and gynaecology students. Eighty-one per cent of students told the survey, carried out by the School of Obstetrics and Gynaecology that they would recommend a placement at SWBH. When our trainees come here to carry out their training, we arrange for each of them to have a consultant as their supervisor so they will always have the close support that they need. The trainees are encouraged to give feedback and share with us any problems that they have so we can address them immediately. We also provide engaging training sessions to ensure they have hands-on experience.

Our infant feeding team have worked with the Southern and West Midlands Newborn Network to create a short film encouraging women who have had preterm babies to express milk. The film is being viewed locally by fellow trusts and will also be shared nationally.

Future plans:
We are working collaboratively with key stakeholders as part of the Black Country Local Maternity System which is chaired by our Chief Executive. This is an exciting time as we implement the recommendations of the national maternity review, Better Births. The key objectives are to achieve Consistency in Care across all four providers with a focus nationally on continuity of care being the driver for success in improving safety, experience and outcomes for all women and babies. Engagement of our multi-disciplinary team is key to this, with work having begun and opportunities for all to become involved.

We continue our work to reduce perinatal mortality in line with the national agenda with a number of initiatives to progress this. We recognise the need to further increase surveillance in pregnancy for babies whose growth may reduce as the pregnancy progresses. To achieve this we need to increase our third trimester scanning service.

We are actively engaging with Health Education England projects to successfully secure funding to train more midwives and identify opportunities to seek support for the additional equipment and staff to achieve this ambition. Our consultants will also be present on wards, seven days a week.

We are also implementing a model of support and advocacy for our midwives through the training of Professional Midwifery Advocates; our first cohort are expected to have qualified by May 2018. The model replaces the previous statutory supervision of midwives with inclusion of four mandated components: clinical supervision, personal action for quality improvement, education and development and monitoring and evaluation. Restorative supervision is a key change in this model which we are embracing as a supportive model to empower our midwives to strive for excellence and ultimately improve the care provided to women, babies and families.

Rachel Carter, Director of Midwifery, at the launch of the National Maternal and Neonatal Health Safety Collaborative.

Work is underway to extend the type procedures offered under local anaesthetic for women requiring gynaecology surgery. A new purpose built unit opens at Sandwell in July 2018 allowing more women to have surgery in a dedicated outpatient setting.

Our incredibly successful Allergy Service is extending its capacity and scope with the recruitment of a Consultant Allergy Nurse and a second Paediatric Allergy Consultant. This will provide additional capacity and capability to deliver excellent outcomes for children that enter our service.

Consistency of Care

Emma Ward, a sister on Newton 5, said: "We focused our Consistency of Care project onto our clinical team, improving communications between the nurses and doctors on the ward. We did this by introducing a clinical meeting on a weekly basis, which followed our Multi-Disciplinary-Team meetings. This involves the consultants, nurses, clinical nurse specialists and pharmacists discussing how the ward has been over the past week and any issues or concerns we have experienced. We will discuss ways we can improve the care that we can offer to our patients. We openly and honestly discuss problems, and the lessons learned. This has impacted on patient care by improving the information we have given to them as it is now consistent. It has made us more efficient as a team."

Corporate
Budget: £17.5m
Headcount: 1,500 WTE

The Corporate function covers our workforce and organisational development, estates, strategy, governance, communications, operations, nursing and facilities, finance and the medical director's office.

Key achievements:
We launched a brand new initiative - the first in the NHS - which supports and promotes career development of healthcare assistants and nurses for bands 2 through to band 6 colleagues. The Band 2-6 nursing career accelerator programme provides intensive training, supporting people to develop their nursing careers from healthcare assistant roles through to band 6 nurse roles. Band 5 nurses who progress successfully through the programme will also receive financial rewards at the start and end of the scheme. The programme creates opportunities for bands 2- 6 who want to develop their nursing careers.

Our organisation is one of the first trusts in the region to introduce charge points for electric vehicles. We have recently installed six new charge points at Sandwell, City and Rowley Regis Hospitals for colleagues, patients and visitors. The project has been part funded by salary sacrifice provider Tusker and the Office for Low Emission Vehicles (OLEV), and installed by 'EV Charging Solutions'. The move is part of the organisation's strategy to curb emissions and tackle pollution. We have already won a number of national awards this year for our environmentally-friendly approach.

As part of our commitment to supporting colleagues within our organisation with training opportunities, we have launched a brand new programme called 'SWBH – Learn a Language.' Our hospital sites are situated within a very diverse community, which means we see many patients who don't speak English as their first language. We wanted to offer an opportunity for colleagues across the organisation to learn basic language skills so that they can help our patients to feel more at ease during their stay with us. We are working with Brasshouse Languages who are providing 10 week training courses, either on-site or at their training centre in Birmingham City Centre. Twenty-two different languages are on offer including British Sign Language, Polish and Arabic and colleagues will need to commit to 1.5 hours of learning per week.

We have seen the launch of our new Purple Point phone service, to help patients who are staying with us as inpatients get the help that they need immediately. This is a new way for patients and relatives to raise concerns about care on our wards and will enable us to make a difference straight away to people's experiences. The new phone service can also be used to record a thank you or pay a compliment to our hard-working teams. The phone service should provide us with rich feedback on our services and will help us to understand what really matters to our patients and their loved ones.

Nicola Ager, Service Development Librarian, supports Speak Up Day, by signing a Promise.

We have approximately 750 line managers within our organisation and over half of them are already on their way to becoming 'SWBH accredited managers' and by the end of March 2018, every line manager will have been through our internal training programme. Each manager will undertake five core modules in Year one, which started in January this year and will run until the end of March, following which any new managers entering our organisation will also attend the accredited manager modules.

After extensive refurbishment, The Education Centre reopened at Sandwell Hospital in November. Described as a "fantastic asset", the building has been extended and fully refurbished and houses state-of-the-art learning facilities for all that use it, and a well-stocked library. Since opening its doors, the Education Centre has been well used by colleagues, with the new-look conference room playing host to its first Trust Board meeting in December. Residents of Sandwell will be able to use the facilities on offer at the centre.

Hundreds of colleagues from all areas of the organisation took part in our first ever Speak up Day in September. Our Freedom to Speak up Guardians were joined by executive directors, trade union colleagues and Trust specialists on stands at Rowley Regis Hospital, City and Sandwell sites as well visiting Leasowes Intermediate Care Centre. Across the Trust, colleagues were encouraged to make a promise, either online via Connect or on a promise card, to speak up should they have a concern. The message of the day was simple -

The Education Centre was officially opened in December. Medical Director David Carruthers welcomes guests to the event

if you see a concern at work, don't just walk by. There are lots of ways you can speak up, so take the opportunity of speak up day to find out how to raise a concern and make a promise to speak up.

Our "Safety Plan" initiative for patients has seen a 30 per cent reduction in falls since June. The project involves clinical staff completing 10 safety checks, also known as Always Events, when assessing a patient. This happens within the first 24 hours of admission. Statistics show the number of falls which have resulted in an injury has decreased by 30 per cent a week as a result of the safety plan being implemented across the Trust. Figures also show that 99 per cent of patients are receiving all 10 checks within 24 hours following admission. A system is in place to ensure that any of those missed are then completed within 48 hours. The process has been hailed a success at the Trust, with more chances of potentially dangerous conditions, like Venous Thromboembolisms (VTE) being picked up and treated in a timely manner. This is down to a more detailed check being completed by clinicians upon admission. Once the condition of the patient is assessed a treatment plan is devised which includes looking at their medical history, as well as looking at their current prescriptions and an expected date of discharge.

More than 100 conditional job offers have been handed out to nurses through our successful year-long recruitment campaign. This outstanding number is the result of a series of recruitment initiatives, which saw the organisation carry out two successful major recruitment events at City Hospital in July and November, as well as attending RCNi (Royal College of Nursing) jobs fairs in Birmingham, London, Liverpool and Nottingham. Vacancies for Band 5 nurses were at 150 last year, but now there are 40 to fill.

Future plans:
Work is continuing on our project to reduce our huge spend on postage by signing up patients to receive appointment letters by email. It is essential that we sign up as many patients as possible to receive email communications, provide a more efficient service to patients, contribute to reducing missed appointments and as this will save us money. We're already gathering email addresses through a number of routes including directly through our website, call centres and face to face through volunteers working across our outpatient areas.

This year we will confirm our rewards and sanctions as a consequence of the scores within our new performance development review process, Aspiring for Excellence. These will support people who perform well and ensure that the right support and consequences are in place for those who have not been able to achieve the standards required.

In 2018 we will go live with Unity, our new electronic patient record. Over 400 digital champions have been appointed and trained. End user training as begun in part and takes place in earnest in Q1 2018/19. Unity brings together many of our existing clinical systems as well as introducing electronic systems where none existed before such as electronic prescribing. Hundreds of colleagues have been involved in the programme during 2016/17 and even more will be engaged during 2018. The Oracle Trust wide Finance and Procurement System went live in April. The programme gives us the potential to use more modules within the system, help manage stock and has an advanced reporting structure, which will improve the management of the Trust. The system changes impacts all users of the existing finance and procurement system. This includes requisitioners, budget holders, finance and procurement colleagues. If we use the system to its potential we can reduce non-pay spend. The more we can save on non-pay the less we will have to deliver in pay savings.

The Nursing Escalator Programme was launched in March. (L-r) Cordu Jarra, Senior Staff Nurse, Gemma Stone, Healthcare Assistant, Nina Faroon, Senior Staff Nurse, Elaine Newell, former Chief Nurse, Shirley Castro, Clinical Lead Nurse and Susan Grantham, Ward Manager.

Our Quality Account

Chief Executive's Statement

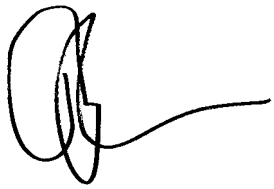
Our Quality Account includes information on our performance against a range of quality and safety indicators. Our main achievements in the year include our success in embedding the safety plan and engaging medical ward teams on our Consistency of Care programme. Both of these schemes have aimed to ensure that the basics of good care are always in place for every patient, every day and every shift. We are beginning to see improvements in patient outcomes as a result of the efforts of the ward team.

We chose to focus on our quality plan in 2018/19 and are looking forward to the changes we can make to achieve our ambitions to be among the best in the region or the best in the country for certain health conditions, services or treatments.

I am pleased that inspectors from the Care Quality Commission recognised the strides we have taken in improving safety and quality and have rated us good or outstanding in over 70 per cent of our service areas. The inadequate rating for safety has been removed and we achieved outstanding ratings for the caring domain and our innovative end of life care service, delivered in partnership with different providers – a truly integrated service.

I am looking forward to the year ahead and with that another inspection visit where, if we deliver our plans as described in this document, we should achieve a "good" rating from the Care Quality Commission, which will be a well-deserved reflection on the improvements our committed staff are making in safety and quality.

The data within this report is drawn from our performance dashboard that is reported to our Trust Board monthly, in public. To the best of my knowledge the information within this report is accurate.



Toby Lewis, Chief Executive

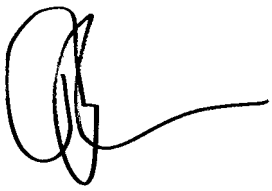
Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2012 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011). In preparing the Quality Account, directors are required to take steps to satisfy themselves that:
The Quality Account presents a balanced picture of the Trust's performance over the period covered;

- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable and conforms to specified data quality standards and prescribed definitions, and is subject to scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Trust's directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

Richard Samuda, Chairman



Toby Lewis, Chief Executive

Priorities for Improvement in 2018/19

We have made great strides in ensuring our Safety Plan is embedded across our Trust. During the year we will continue to progress our Consistency of Care programme and we will make progress on objectives within our quality plan. Listening and learning from the experience of patients in our care and their relatives and carers is a priority for the year.

Priority 1

Improved outcomes from patients presenting with signs and symptoms of Sepsis as a first step in delivering our Quality Plan

Rationale and measurement

Patients presenting with or developing infection while in hospital have an increased risk of prolonged hospital stay, poor health outcomes and a higher mortality. Early identification of sepsis with appropriate assessment of those at risk and prompt commencement of antibiotics is key to successful management. Our Safety Plan has contributed to improvements in the care of sepsis but there is room for improvement, particularly in the management of those receiving cancer or immunosuppressive treatment who, as a consequence, are at risk of neutropenic sepsis.

Patients with suspected neutropenic sepsis should receive antibiotics within an hour of arrival in AandE and achievement of this target will be monitored.

In addition we will monitor the percentage of patients who are assessed for sepsis who have triggered on the wards for an assessment to occur (early warning NEWS score of >5) using the Sepsis Action Tool.

Reporting

The outcomes of sepsis management will be reported and monitored by clinical leaders at the Executive Quality Committee and for the Board by our monthly Quality and Safety Committee.

Priority 2

Achieving a good rating under the framework of the CQC assessment

Rationale and measurement

The Trust was inspected in 2014 and 2017, and the latest report demonstrates material progress in very many services. More than 70% of our services are now rated as good or outstanding.

We have a well-developed and detailed plan for improvement which is closely monitored. We aim to deliver that plan during Q1 of 2018/19 and spend the balance of the year testing and retesting our compliance. In particular we need to see significant changes in:

- our A&E departments
- urgent and emergency admitted care wards
- Birmingham and Midland Eye Centre (BMEC)

Reporting

Progress against our improvement plan is reported and monitored by clinical leaders at the Executive Quality Committee and for the Board by our monthly Quality and Safety Committee.

Priority 3

We will improve the Consistency of Care provided to patients while on our wards and sustain our Safety Plan delivery

Rationale and measurement

Having Consistency of Care provided is very important both with respect to having the right documentation completed at the right time, but also when considering consistency of staff involved in making those care decisions. Making sure that the correct documentation and risk assessments are completed on all patients at the time they are admitted to our wards is part of providing Consistency of Care.

Actions based on these assessments, particularly around patient safety, are important to maintaining high quality care. A regular ward based team, particularly around senior decision makers supports the consistency model. Changes in junior staff rostering to improve care in our assessment unit also provides more consistency on the ward.

The new initiative of consultant of the week, along with the changes in junior staff working allow closer cooperation with nursing and therapy teams to plan care more effectively, improving communication to patients and relatives and planning for timely discharge. Links with community teams to make sure that clear handover for ongoing care are a crucial part of this aim.

We will regularly review completion of documentation so that Consistency of Care can be achieved and monitored. This will allow us to make sure that every time we are getting the basics right. Having an expected date of discharge is an important part of planning care so that families and staff can work towards a safe and supported discharge. Improvements in achieving this target date will be monitored.

For those patients recognised to be in the last months, weeks or days of their life, application of the supportive care pathway will be monitored.

Reporting

These initiatives will be reported and monitored by clinical leaders at the Executive Quality Committee and for the Board by our monthly Quality and Safety Committee.

D11 and D26 at a Listenning into Action event to promote their best practices in implementing safety plan.

Quality Plan 2017 – 20	
1	We will reduce deaths in hospital that could be avoided so that we are among the top 20 per cent of comparable NHS Trusts in the UK. We will take action to cut avoidable deaths from Sepsis, Hospital Acquired Venous Thromboembolism, Stroke, Acute Myocardial Infarction (Heart Attack), Fractured Neck of Femur and High Risk Abdominal Surgery.
2	Cancer patients will have early access to diagnostic services to support their management pathway as the new models of cancer service provision at SWBH develop.
3	We will coordinate care well across different services so that patients who are discharged are cared for safely at home and don't need to come back for an unplanned further hospital stay.
4	We will deliver outstanding quality of outcomes in our work to save people's eyesight, with results among the top 20 per cent of comparable NHS Trusts in the UK.
5	More Sandwell and West Birmingham residents will take up the health screening services that we provide than in other parts of the West Midlands.
6	We will reduce the number of stillbirths and deaths in the first week of life so that we are providing a better service than others in the West Midlands.
7	Patients at the end of their lives will die in the place they choose, receiving compassionate end of life care.
8	We will ensure the wellbeing of the children we care for, in particular reducing lost days of school as a result of hospital care; and ensuring the safe transition of care to adult services at the appropriate time.
9	Patients will report that their health is better following treatment with us than elsewhere in England, ranking SWBH in the top 20 per cent of NHS trusts for patient-reported outcomes.
10	We will work in close partnership with mental health care partners to ensure that our children's, young people's, adult and older people's crisis and ongoing care services are among the best in the West Midlands.

Care Quality Commission Inspection

Over 50 inspectors from the Care Quality Commission (CQC) visited parts of the Trust in March 2017 over three days, followed by unannounced visits. They met, observed and talked to colleagues, patients and family members. The inspection reports were published in October 2017.

Although the overall Trust rating, 'requires improvement' has not changed, there are 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.

The Board is pleased with the success recognised by the CQC and real improvements made since the previous inspection in 2014, but acknowledges there is work to do. The Trust's successes in embedding the Safety Plan and putting in place the Consistency of Care programme on our medical and community wards provides the key strands in the Trust's plans to achieve an overall 'good' rating in the next CQC inspection.

How we performed against external measures

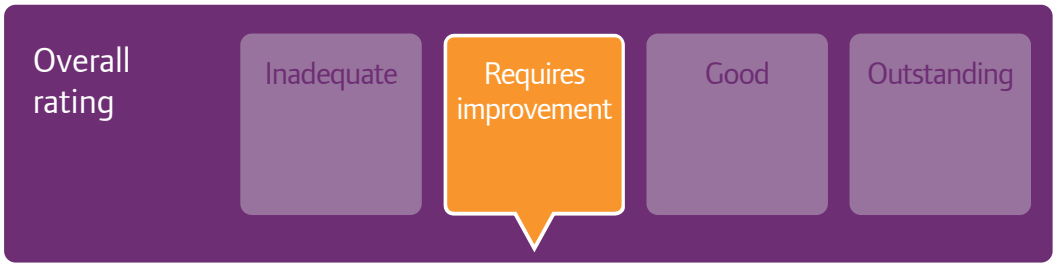
131 actions were detailed in the CQC report from our March 2017 inspection, which was published in October 2017. The aim was to deliver the planned actions by March 2018. A formal 'closeout' report will be presented to the May 2018 Trust Board confirming the position, but the indications are that the majority of concerns raised by the CQC have been addressed. The two actions which are proving challenging to complete within the set times are:

1. Addressing the requirement for substantive middle grade staff overnight in the Emergency Departments.
2. Working with other Trusts to implement a SLA to provide Paediatric Ophthalmology cover out-of-hours and substantive posts in hours

In respect of middle grades in ED, these are being advertised externally although it is recognised that there is a national shortage. A plan is in place being overseen by the Chief Operating Officer. The Medical Director is pursuing the plan with respect to ensuring adequate Paediatric Ophthalmology out-of-hours cover is in place. Both of these issues are being actively managed and progress will continue to be monitored by the Clinical Leadership Executive until resolved.

Sandwell and West Birmingham Hospitals NHS Trust is registered with the Care Quality Commission and has no conditions attached to that registration. The Care Quality Commission has not taken enforcement action against Sandwell and West Birmingham Hospitals NHS Trust during 2017/18 and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

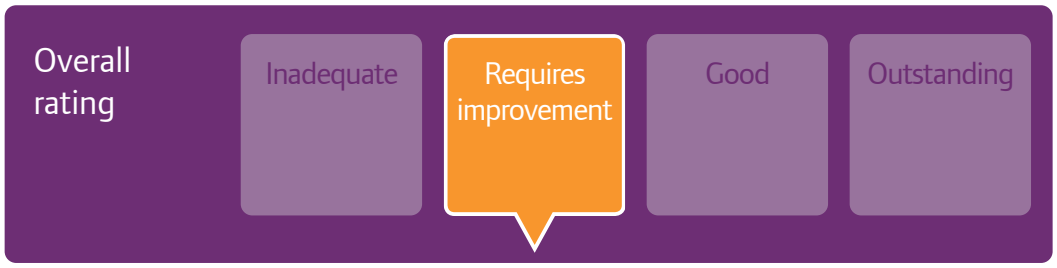
Sandwell and West Birmingham Hospitals NHS Trust



Are services

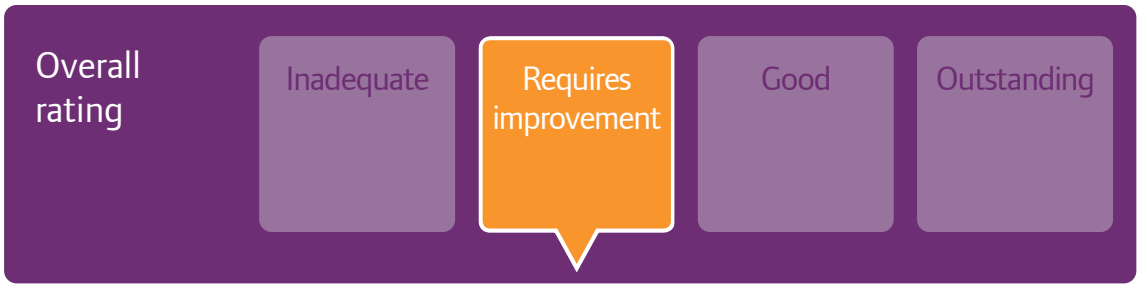
Safe?	Requires improvement
Effective?	Requires improvement
Caring?	Outstanding ☆
Responsive?	Requires improvement
Well led?	Good

City Hospital



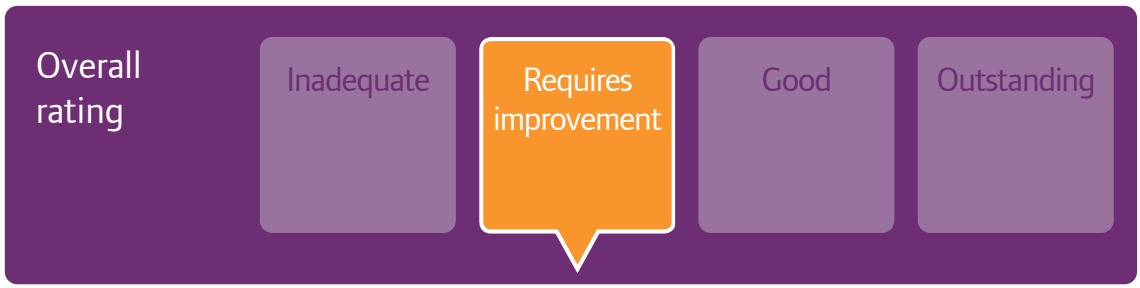
	Safe	Effective	Caring	Responsive	Well led	Overall
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Medical care (including older people's care)	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Urgent and emergency services (A&E)	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Requires improvement	Good
Intensive/critical care	Good	Good	Good	Good	Good	Good
Services for children & young people	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
End of life care	Good	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆
Outpatients	Good	Not rated	Good	Good	Good	Good

Sandwell General Hospital



	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Requires improvement	Good	Good	Good	Good	Good
Urgent and emergency services (A&E)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Intensive/critical care	Good	Good	Good	Good	Good	Good
Services for children & young people	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆
Outpatients	Good	Not rated	Good	Good	Good	Good

Sandwell and West Birmingham Hospitals NHS Trust (Community)



	Safe	Effective	Caring	Responsive	Well led	Overall
Community health inpatient services	Inadequate	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Community health services for children, young people and families	Good	Good	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
End of life care	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆

How we measure quality

We review our performance against external frameworks, primarily the NHSi Single Oversight Framework effective from September 2016, which sets out how trusts are overseen using one consistent approach, and CQC Framework. We also set internal performance targets on a broad range of indicators published in our Integrated Quality and Performance Report (IQPR). The IQPR is published monthly to a number of senior committees (including the Quality and Safety Committee) as well as the Trust Board. Performance is managed through Group Management meetings, overseen by dedicated Group Performance Review meetings.

We also audit the quality of clinical care we provide against a number of national standards that are published by external organisations for example National Institute for Clinical Excellence (NICE), National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) and specialty specific bodies for example; National Bowel Cancer Audit Programme (NBOCAP), National Hip Fracture Database (NHFD) and Sentinel Stroke National Audit Programme (SSNAP).

Data quality improvement aproach

The Trust has taken the following actions to improve data quality. We have implemented a performance indicator assessment process, the data quality kitemark, which provides assurance on underlying data quality published in the IQPR. Each indicator is assessed against seven data quality domains to provide an overall data quality assurance

rating, which is included in the IQPR. We have an annual audit data quality improvement plan in place to ensure that the quality of our performance information continues to improve. During the year we have improved data quality as reported in the IQPR. Our audit plan is a rolling programme covering all performance and quality indicators. We have established a Data Quality Committee whose scope is to identify and implement data quality improvements and address data quality issues as they are found and monitor their improvement to a compliance standard. Each Group is represented by a data quality lead.

The Trust's SUS (Secondary Users System) data quality is benchmarked monthly against others via the HSCIC SUS Data Quality Dashboards which are used to monitor compliance with mandatory fields and commissioning sets.

Hospital Episode Statistics

The Trust submitted records during April 2017 – January 2018 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data;

- which included the patient's valid NHS number was 98.1% for admitted patient care; 99.6% for out-patient care; and 97.7% for accident and emergency care.
- which included the patient's valid General Medical Practice Code was 98.89% for admitted patient care; 99.28% for out-patient care; and 97.13% for accident and emergency care.

Services provided and / or subcontracted

During 2017/18 we provided and/or subcontracted 44 NHS services. We have reviewed all the data available on the quality of the care in these services. Where we have subcontracted any activity, it would only be to a provider, who like us was registered with the CQC but has no conditions attached to that registration. Agreements between the Trust and the subcontracted providers require that the same high standards of care are given when giving care on our behalf. The health benefit and activity data undergo the same level of scrutiny as that delivered in the Trust. The Income generated by the NHS services reviewed in 2017/18 represents 100 per cent of the total income generated from the provision of NHS services by Trust.

How we performed in 2017/18

In 2016/2017 we launched important development plans to improve safety and quality. The Safety Plan was introduced in 2017 and takes a multi-disciplinary approach to ten evidence based clinical standards that have now become a standard part of care in the Trust. By improving the safety culture, the care provided to patients is improved and the risk of harm reduced. The Quality Plan, which aims to build on this Safety Plan, has elements that are specialty specific and those that cut across all disciplines in the Trust. It aims to improve evidence based care across the organisation by producing measurable and meaningful outcomes for patients. Full implementation of the ten objectives of the Quality Plan will be relaunched in 2018/19 on the foundation of the Safety Plan and in parallel with the introduction of our new electronic patient record and service plans for a new single site hospital.

Safety Plan - 99.6% of all safety checks completed

During the year our Safety Plan has been deployed within all assessment and ward based areas (43 areas in total). Input of data has become part of the ward's daily core business – evident by daily reports showing significantly improved input compliance. Our wards have exhibited sustained compliance by completing more than 98 per cent of all checks within the first 24 hours of admission. On average, 1.5 checks per day are missed out of an average of 2,500 total checks. Daily reporting continues and includes information on missed checks, allowing senior staff and ward managers to check, challenge, address and complete any missed checks within the next 24 hours on a shift by shift basis.

Our Safety Plan Standards

	Standard	Output
1.	Ten out of Ten – The starting point for safety risk assessment of which care plans are then built upon	A safety checklist made up of ten sub-standards that must be completed for every admitted patient within 24 hours.
2a.	Pressure Ulcer	A plan of care is in place for patients identified to be at a tissue viability risk.
2b.	Falls	A plan of care is in place for patients identified to be at a risk of a fall.
3.	Infection Control	A plan of care is in place for patients identified to be at a risk of acquiring a hospital aquired infection (HAI) or having a HAI on admission to be managed.
4.	Observations – Early Warning Score (EWS) reporting and management	Monitoring vital signs as clinically required - taking in time appropriate action(s) to prevent an avoidable deterioration in a patient . Early warning scores are recorded (vital Pac or paper)– EWS were acted upon and this is evidenced in the patient's health care records.
5.	Care Plans signed by patients and carers/family	Nursing care plans are in place and individualised; reflecting risks identified (physical, social and psychological) through discussion with the patient /carer.
6.	Focused care /John's Campaign	A plan of care is in place for patients identified at risk from falls, absconding, self-harm, challenging behaviour or acutely unwell to ensure appropriate level of supervision with appropriately skilled HCP and reflecting partnership working with carers.
7.	Antibiotic review every 72 hours	Reduction in inappropriate prescribing of antibiotics - an assessment has been done and the outcomes are documented of all patients on IV/oral antibiotics after 72 hours that reflects appropriate or inappropriate use.
8.	Reduced omissions	Patient's drugs are prescribed, correctly given and taken within a window that is deemed to be the right prescribed time. That a clinical omission for not giving the drug is recorded in the designated area.
9.	Informed consent	All elective patients undergoing invasive procedures have been consented in accordance to policy.
10.	Expected date of discharge (EDD) and home care package	Accurate EDD and 48 hour follow up.

We are beginning to see improved outcomes which, whilst limited, show statistically significant improvements in key areas of patient safety such as falls, with a moderate to strong correlation with completing the safety checks and reduced falls with injury. Since 5th June 2017, compliance with the Safety Plan has increased from 96.8 per cent to 99.6 per cent on average. During the same period, falls with injury have decreased on average from 7.2 (per week) to five per week.

Commissioning for Quality and Innovation (CQUINs) 2018/19

The following CQUIN (commissioning for quality innovation) targets are agreed with our NHS commissioners. We assign CQUIN leads on clinical and operational levels to appropriately support each CQUIN. We publish monthly data on how we are doing against milestones and this is published in the Trust's Integrated Quality and Performance Report, which is discussed in our public board meetings. The NHS Commissioners are informed of progress on a quarterly basis.

Some CQUINs are part of a two year agreed target for 2017/19. The target period has been indicated against each initiative in the table below.

CQUINs for 2018/19		Target Periods
National	Staff Health and Wellbeing - annual staff survey results to improve by five per cent in two of the three NHS annual staff surveys: on health and well-being, MSK and stress.	2017/19
	Staff Health and Wellbeing - Maintain the four outcomes that were implemented in 2016/17. Introduce three new changes to food and drink provision in year one, 17/18 : 70 per cent of drinks stocked must be sugar free, b) 50 per cent of confectionary and sweets do not exceed 250 kcal c) 60 per cent or pre-packed sandwiches and other savoury pre-packed meals available contain 400kcals or less and do not exceed 5.0g saturated fat.	2017/19
	Staff Health and Wellbeing - year one - achieving update of flu vaccination for frontline clinical staff of 75 per cent.	2017/19

CQUINs for 2018/19		Target Periods
National	Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis): Timely identification of sepsis in emergency departments and acute inpatient settings - the percentage of patients who met the criteria for sepsis screening (needed it) and were screened for sepsis (applies to all adult and child patients arriving in ED and IP wards).	2017/19
	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Timely treatment for sepsis in emergency departments and acute inpatient settings - the percentage of patients who were found to have sepsis and received IV antibiotics within one hour (applies to all adult and child patients arriving in ED and IP wards).	2017/19
	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Antibiotic review - assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	2017/19
	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Reduction in antibiotic consumption per 1,000 admissions - there are three parts to this indicator. 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions.	2017/19
National	Improving services for people with mental health needs - Improving services for people with Mental Health needs who present to AandE.	2017/19
National	A&G support should be provided either through the NHS e-Referral Service (e-RS) or local solutions where systems agree this offers a better alternative.	2017/19
National	Supporting proactive and safe discharge - increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within seven days of admission by 2.5% points from baseline (Q3 and Q4 2016/17).	2017/19
Local	Improving the assessment of wounds - the indicator aims to increase the number of wounds which have failed to heal after four weeks that receive a full wound assessment.	2017/19
National	Personalised Care / support planning - this CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long term conditions. In the first year, activity will be focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be identified, the relevant workforce receive appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers.	2017/19
National	Preventing ill health by risky behaviours - tobacco screening.	2018/19
	Preventing ill health by risky behaviours - tobacco brief advice .	2018/19
	Preventing ill health by risky behaviours - tobacco referral and medication offer.	2018/19
	Preventing ill health by risky behaviours - alcohol screening.	2018/19
Specialised Services	Improving haemoglobinopathy pathways through Operational Delivery Networks (ODN).	2017/19
Specialised Services	Paediatric networked care to reduce recourse to critical care distant from home.	2017/19
Public Health	Bowel Screening - improving access and uptake through patient and public engagement.	2017/19
Public Health	Bowel Scoping.	2017/19
Public Health	Breast Cancer Screening - Improving access and uptake through patient and public engagement.	2017/19

CQUINs (Commissioning for Quality and Innovation)

A proportion of the Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. We were contracted to deliver the CQUIN schemes in the table below during 2017/18 which had a value of £8.8m on delivery. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at https://www.swbh.nhs.uk/about-us/trust-board/public-trust-board-papers/2017-2/

CQUINs for 2017/18			
National	1a	Staff Health and Wellbeing - annual staff survey results to improve by five per cent in two of the three NHS annual staff surveys: on health and well-being, MSK and stress	**No**
National	1b	Staff Health and Wellbeing - Maintain the four outcomes that were implemented in 2016/17. Introduce three new changes to food and drink provision in year 1, 17/18 : 70 per cent of drinks stocked must be sugar free, b) 50 per cent of confectionary and sweets do not exceed 250 kcal c) 60 per cent or pre-packed sandwiches and other savoury pre-packed meals available contain 400kcals or less and do not exceed 5.0g saturated fat	✓
National	1c	Staff Health and Wellbeing - Year one - achieving update of flu vaccination for frontline clinical staff of 75 per cent	✓
National	2a	Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis): Timely identification of sepsis in emergency departments and acute inpatient settings - The percentage of patients who met the criteria for sepsis screening (needed it) and were screened for sepsis (applies to all adult and child patients arriving in ED and IP wards)	**Partial**
National	2b	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Timely treatment for sepsis in emergency departments and acute inpatient settings - The percentage of patients who were found to have sepsis in 2a and received IV antibiotics within one hour (applies to all adult and child patients arriving in ED and IP wards).	**Partial**
National	2c	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Antibiotic review - Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	✓
National	2d	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Reduction in antibiotic consumption per 1,000 admissions - There are three parts to this indicator. 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions	**No**
National	4	Improving services for people with Mental Health needs - Improving services for people with Mental Health needs who present to AandE	✓
National	6	Offering advice and Guidance (AandG) - Providers to set up and operate AandG services for non-urgent GP referrals; AandG support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative.	✓
National	7	NHS e-Referrals CQUIN – GP referrals to consultant-led first outpatient services only and the availability of services and appointments on the NHS e-Referral Service.	✓
National	8	Supporting Proactive and Safe Discharge - Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within seven days of admission by 2.5% points from baseline (Q3 and Q4 2016/17).	✓

CQUINs for 2017/18			
National	10	Improving the assessment of wounds - The indicator aims to increase the number of wounds which have failed to heal after four weeks that receive a full wound assessment.	✓
National	11	Personalised Care / support planning - This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long term conditions. In the first year, activity will be focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be identified, the relevant workforce receive appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers.	✓
Specialised Services		Improving Haemoglobinopathy Pathways through ODN Networks	✓
Specialised Services		Paediatric networked care to reduce recourse to critical care distant from home	✓
Specialised Services		Activation system for patients with long term conditions – HIV – activate patients (the knowledge, skills and capacity to manage their own condition) to enable better outcomes including reduced frequency of exacerbations and associated high cost interventions.	**Partial**
Public Health		Secondary care dental - sugar free medicines audit - A prospective audit and re-audit of day-case activity carried out in the department in accordance with the terms of reference issued by the service commissioner.	**No**
Public Health		Bowel screening - Improving access and uptake through patient and public engagement.	✓
Public Health		Bowel scoping	✓
Public Health		Breast cancer screening - Improving access and uptake through patient and public engagement.	✓

The bowel cancer screening team. (left to right: Clair Millard, Ange Johnson, both Specialist Screening nurses, Maggie Preston, Programme Manager and John Rudge, Administrator.

Seven day hospital services

Working towards the same standards of care for patients over seven days is vital in ensuring that our patients receive consistent care no matter what day of the week they are admitted and whether they are staying in hospital or discharged.

Ten clinical standards have been identified that define what a seven day service should achieve. Of those ten standards, four have been identified as priority standards to be achieved by 2020.

- **Standard 2**: Time to first consultant review. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.
- **Standard 5**: Access to diagnostic tests. Consultant-directed diagnostic tests and completed reporting will be available seven days a week with a 24-hour turnaround time. For urgent requests this reduces to within one hour for critical patients and within 12 hours for urgent patients.
- **Standard 6**: Access to consultant-directed interventions. Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.
- **Standard 8**: Ongoing review by a consultant twice daily for high dependant patient's, daily for others. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

In March 2017 we completed a self-assessment survey which covered the management of patients admitted as an emergency, measured against the four priority standards. Our results from this survey are shown in the table below.

Trust Achievement of Priority Seven Day Service Standards (March 2017)				
	Standard 2	**Standard 5**	**Standard 6**	**Standard 8**
Weekday Results	73%	100%	100%	94%
Weekend Results	85%	95%	100%	83%
Seven Day results	77%	97%	100%	92%

This baseline information has informed our improvement focus and service development. This year we have established a Non Invasive Ventilation Unit and level one - two high dependency for surgery. Once we have implemented our new electronic patient record system, Unity, during 2018 we will be able to have a live data set on standards two and eight.

We planned to achieve standards two, five and six by March 2018. The delay to the new hospital, the Midland Metropolitan, will impact on our ability to achieve standard eight as we expect to be only able to fully meet this when we move to a single acute site. We have two service development and improvement plans agreed with the Sandwell and West Birmingham Clinical Commissioning Group for seven day urgent care and respiratory services.

NHS Staff Surveys

The NHS Staff Survey provides an opportunity for organisations to survey their staff in a consistent and systematic way. This makes it possible to build up a picture of staff experience and, with care, to compare and monitor change over time and to identify variations between different staff groups. Obtaining feedback from staff, and taking account of their views and priorities, is vital for driving real service improvements in the NHS.

The results are primarily intended for use by organisations to help them review and improve their staff experience so that their staff can provide better patient care. The Care Quality Commission use the results from the survey to monitor ongoing compliance with essential standards of quality and safety. The survey will also support accountability of the Secretary of State for Health to Parliament for delivery of the NHS Constitution.

The key finding below show a selection of results for our Trust (SWBH) compared with other combined acute and community trusts. We have included three core indicators required for the Quality Account and our highest three and lowest three results.

NHS Staff Surveys	2016 Survey	2017 Survey Results					
	SWBH 2016	SWBH 2017	National Average (Median score)	Threshold for below average	Threshold for above average	Lowest Trust	Highest Trust
Core Indicators							
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	86	80	85	82	88	71	93
Percentage experiencing harassment, bullying or abuse from staff in last 12 months (lower is better)	20	21	24	23	25	20	32
Staff who would recommend the Trust as a provider of care to their family and friends - performance is based on staff who agreed or strongly agreed as part of the NHS Staff Survey	59	58	69	N/A	N/A	N/A	N/A
SWBH Highest 3 Indicators							
Percentage reporting most recent experience of violence	82	82	67	65	70	59	82
Percentage agreeing that their role makes a difference to patients/service users	89	93	90	89	91	86	93
Percentage able to contribute towards improvements at work	66	74	70	68	71	60	77
SWBH Lowest 3 Indicators							
Percentage attending work in last three months despite feeling unwell because they felt pressure (lower is better)	56	60	53	52	54	47	60
Percentage feeling unwell due to work related stress in last 12 months (lower is better)	33	44	38	36	40	30	45
Quality of appraisals	2.95	2.97	3.11	3.05	3.14	2.87	3.46

Data Source: National NHS Staff Survey Co-ordination Centre
The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by implementing our nursing escalator programme, a dedicated development scheme to support health care assistant and nursing careers for bands 2-6. The programme offers bespoke training and support to enable colleagues to progress through the bands. Band 5 nurses who take part in the programme will also benefit from a bonus paid at the start and on successful completion of the scheme.

We are committed to a focused programme of engagement during the year so that colleagues are empowered to act to make improvements in their area of work. We expect to improve our staff engagement score to that of the national average by the end of the year.

During the year we held a Speak Up Day to raise awareness of the various ways for colleagues to speak up if they have a concern at work. Although predominantly about safety concerns we recognise that through continued promotion of the different routes to raise concern we can hope to address bullying and harassment behaviour. Our trade union colleagues are valuable sources of support and challenge to the Trust.

Responsiveness to personal needs of patients

This indicator measures hospitals' responsiveness to inpatients' personal needs based on a selection of five questions from the National Inpatient Survey. Each question describes a different element of the overarching theme, "responsiveness to patients' personal need". The survey is completed by a sample of patients aged 16 years and over who have been discharged from an acute or specialist trust, with at least one overnight stay.

An average weighted score (by age and sex) is calculated for each of the questions and Trust scores are calculated from a simple average of the question scores.

Responsiveness to inpatients personal needs	SWBH 15/16	2016-2017			
	SWBH 15/16	SWBH 16/17	National Average	Highest Trust	Lowest Trust
The Trust's responsiveness to the personal needs of its patients during the reporting period.	69	64.9	68.1	85.2	60.0

The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to collect patient experience information first hand to help improve patient care. This is one of our quality improvement priorities for 2018/19.

Patient Stories

During 2017/18 we have continued to include patient stories as part of our Trust board meetings. There has been considerable changes and actions taken during the last year in response to a series of very impactful patient stories. We are currently considering how we might better disseminate the valuable learning and insight, as well as the resulting actions, amongst our employees. The table below shows the actions that have been undertaken from patient stories this year.

Patient Stories 2017/18

Month	Key focus	Actions taken
April 17	Presentation from LGBT network Lead	• Numerous awareness raising sessions throughout the year including LGBT history month and the participation in Birmingham's Pride event. Diversity lead appointed; Transgender policy approved. The LGBT networks have been represented at a variety of recruitment events to raise awareness of the Trust's commitment to supporting diversity. • The Trust has become a Stonewall Diversity Champion thereby improving access to key resources. • The Trust has benchmarked against the Workplace Equality Index with a view to submitting to Stonewall in 2018 with an ambition to eventually being ranked within the top 100 employers.
May 17	Transition Diabetic services – young people to adult	• Appointment of Children's and Young Peoples Champion to lead on transition arrangements within the Trust. • Transition policy approved with agreed standards for young people who are in the process of transition between children's/adult services. • Ready, Steady, Go checklist introduced Trust-wide to assess readiness of young people for transition.
Jun 17	A patient who had experienced care within our Critical Care service and had subsequently stepped down to ward based care. The patient had experienced issues when receiving care from temporary staff members	• The Trust has worked proactively to reduce reliance on temporary staff – largely driven by a very successful recruitment campaign, addressing vacancy gaps. • More recently, we have introduced a checklist to check the competence of temporary staff at the start of every shift.

Month	Key focus	Actions taken
Jul 17	Spanish patient who spoke English but lost language skills during health crisis	• A trial involving clinicians and patients wearing an ear piece which would translate speech, the use of which would be monitored especially when translating complex medical jargon. • The interpreter service has renegotiated contracts which have increased the diversity of languages available via our translators.
Aug 17	Staff member presented a story on behalf of an end of life care patient for whom service provision was complicated due to cross boundary issues	• Equipment needs raised and rectified at time of event.
Sept 17	Paediatric patient with severe allergies	• Appointment of one nurse consultant, now in post. • The Trust has agreed to support appointment of another Consultant paediatrician with interest in allergy. • The service is currently supporting the in house development and training of a Band 5 nurse who will progress to the role of a Band 7 CNS on completion of training. • All of the above roles will enhance and extend service provision to meet the growing demand for this service.
Oct 17	We heard from a hearing and visually impaired patient who had experienced difficulties when arranging and accessing outpatient appointments	• Patient letter templates have been changed to ensure that the number for the contact centre is more clearly visible. • All template letters further adjusted to include the following wording: Please let us know if you require any support or have any disabilities that you would like to make us aware of. If you would like to discuss this please contact us on… • The Equality and Diversity (EandD) lead has met with all members of the contact centre team to raise awareness around requests for reasonable adjustments. Arrangements are in place to signpost those patients with specific individual requirements to the EandD team who will support the planning and facilitation of reasonable adjustments for these patients where necessary. • The Primary Care Liaison Manager is working with GPs to raise awareness about signposting patients with disabilities on referral letters. • All eye appointments printed on yellow paper. The Trust is exploring the potential for all outpatient appointments to be sent on yellow paper. • 140 staff have received deaf awareness and/or Basic Sign Language (BSL) training during last 12 months. Funding secured to continue BSL training in 2018/19 • Assistance dogs: Policy revised and agreed.
Dec 17	A Video was presented highlighting how patients learn techniques to deal with panic attacks, anxiety, and anger within the Fatigue, Anxiety and Breathlesness clinic.	No actions identified.

Month	Key focus	Actions taken
Jan 18	Maternity/Cardiology. A patient described her experience as a recent new and breastfeeding mother admitted to an area outside of Maternity showing the determined efforts made to ensure that mother and baby were not separated.	• New infant feeding policy about to be put on the intranet promotes zero separation when a mother is admitted to any area of the Trust. This will be promoted in all areas when it is on the intranet. • The Infant Feeding Team are producing posters (currently with medical illustration) to be put up in all areas of the trust where a mother may be cared for - signposting to local resources and support on all aspects of infant feeding. The emphasis of the poster, being that Health Care Practitioner's should not be the reason a woman stops breastfeeding. • Active social media campaign established to raise awareness of the Trust's commitment to supporting breastfeeding.
Feb 18	An elderly gentleman described his experience when transferred between our hospital sites out of hours	• Work to reduce the non-clinical patient bed moves out-of-hours will be focused in orthopaedics as this is a focal point in the data set and in medicine to increase morning discharge rates to 35 per cent - this will improve daytime bed moves from the assessment unit to the wards and address the avoidable non-clinical out-of-hours patient moves. • A review of our transport services in Q1 may also give opportunity for improvement.
March 18	Story from a patient who had used our recently established Level one care service	• The Group are monitoring the impact of this service on the release of ITU capacity.

Complaints

Our complaints management remains effective and timely, focusing on the needs of complainants. Establishing the outcomes sought from complainants upfront, and offering resolution meetings alongside, or instead of written responses continues to be a focus of the complaints team.

Patient complaints

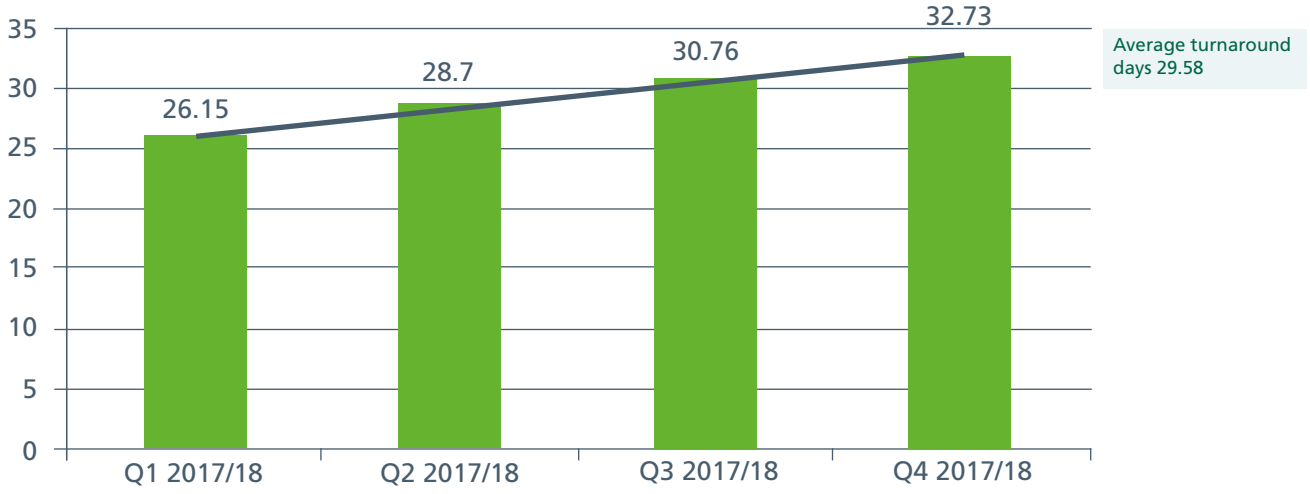
Patient experience	2016/2017	2017/2018
Complaints received- Formal	1176	1037

Of note, this total figure is made up of 990 new complaints made to the Trust (67 of which have since been withdrawn) and 127 were reopened complaints. This resulted in 876 new complaints being actively managed by the Trust, which is a decrease of formal complaint numbers managed. Whilst most of the Clinical Groups and Corporate Directorates have seen decreased numbers the most significant decrease is in Surgery. The KPI result for complaint resolution returned to a stronger result of 92% of formal complaints being responded to in time, with the average turnaround time for all cases presented to the Trust in 2017/18 being 29.58 days.

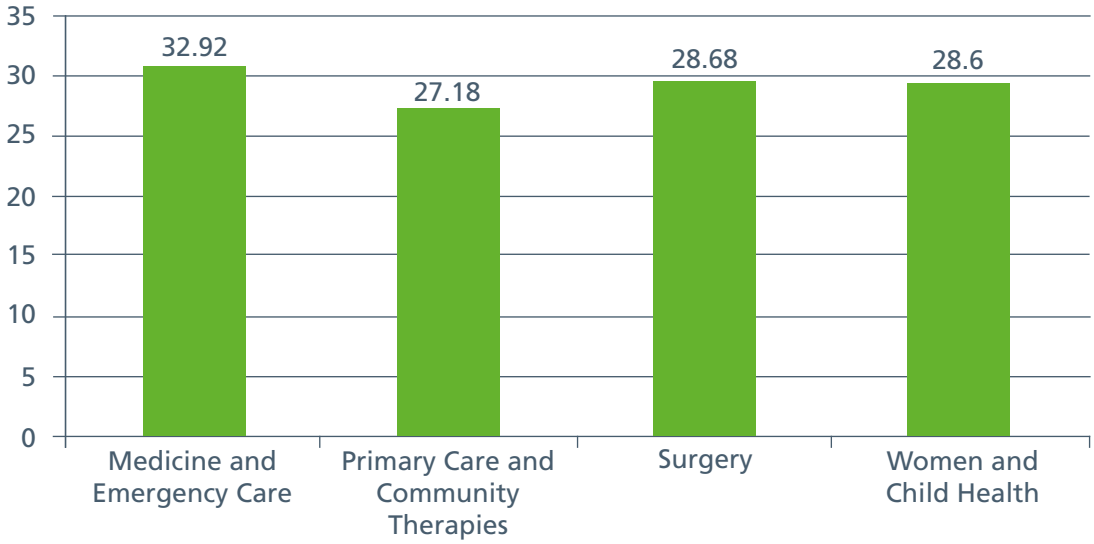
Our Trust recently launched the a new initiative, Purple Points, that allow patients and relatives to contact us more quickly if they have a complaint or want to compliment staff.

Ian McGarry from Sandwell Heathwatch.

Average number of days to respond to complaints by quarter



Average response time by Groups



Purple points

Our Purple Points initiative has been launched across our sites. Working with Healthwatch Sandwell, the Purple Points are a new way that inpatients and their relatives can address concerns they have, whilst they are still being treated in hospital. Patients and their loved ones can use the phone to call our Purple Point team and talk about any issues they may have, or they can compliment excellent care they have experienced.

The phones are located at 'Purple Points' which are near inpatient ward areas across our hospitals, so that concerns can be dealt with as quickly as possible. The Purple Point team will be answering these calls and facilitate a safe and quick resolution. In getting this right, we will be responding to issues as they arise and resolving problems before they escalate. This means we can make a difference at the time, rather than when our patients have gone home.

Lessons learned from complaints are still actively reported and when learning opportunities are identified they are recorded in order that they can be monitored for implementation. Learning from informal complaints and from Purple Point enquiries will also be added to this report in 2018/19.

Most common themes of complaints comparing 2016/17 – 2017/18

The most common themes	2016/2017 %	2017/2018 %
All Aspects of Clinical Treatment	48	57
Appointment Delay/cancel (outpatient)	16	11
Attitude of Staff	14	12
Communication/Info to Patient	7	6
Admissions/ discharges, Transfers	4	3
Privacy And Dignity	1	2
Personal Records	2	2
Patients Property And Expenses	1	2

Where learning can be evidenced, this is shared with the complainant even if this is sometime after the complaint has closed. The following are examples of learning that has taken place as a result of complaints.

As a result of a misunderstanding as to how fetal tissue is investigated following early pregnancy loss, a new patient leaflet is being developed explaining this in informative and sensitive terms. The leaflet is aimed at providing information about the purpose of investigating the fetal tissue so as to support women at this difficult time, but be clear that this is not to establish why the early pregnancy loss occurred but to ensure that the miscarriage is complete.

- A patient suffered a fall down the escalators in the Birmingham Treatment Centre and it was also reported that the signage to the lifts (their preferred mode of transporting from floor to floor) was not clear enough, resulting in them not knowing where the lifts were. They thought they had no alternative but to use escalators even though they knew that might mean risking a fall. There is now improved signage around the lift areas, and signage highlighting where the lifts are.
- A complaint was received about the fact that one of the Trust Patient Transport drivers did not actively support a patient who became very unwell in the Trust car park. The driver had the word Ambulance written on the back of their High Visibility jacket. It has since been recognised that this was a misleading indicator that the driver may have been able to offer clinical support, like that of a paramedic. The jackets with Ambulance written on them are no longer in use to avoid, this confusion in the future, and the resultant distress this caused both the patient's family, and the driver themselves.

PALS (informal complaints)

Local resolution is encouraged on the basis that wards and outpatient teams are well placed to deal with issues that arise on a day to day basis and is indeed emphasised even more now through the Purple Points. Where local resolution cannot be achieved, and where a formal complaint is not necessary, an informal complaint can be logged so that the complainant can get support from the PALS/complaints team to provide an essential liaison service between patient and the Trust. They can also support patients who need clarification, additional information about our services or where they are concerned about an aspect of care, but not yet sure if a complaint is warranted.

Total number of enquiries made to PALS 2016/17- 2017/18

The most common themes	2016/2017 %	2017/2018 %
Appointment issues	28	28
Clinical Issues	27	15
Communication	13	18
Attitude of staff	6	5

Engaging with patients and the public

During the year we have introduced increasingly innovative ways to engage with our communities. A series of Facebook Live events have engaged patients and the public with some of our leading clinicians on subjects such as the importance of bowel screening, paediatric medicine and heart health care.

Our carers group was established during the year and has helped to inform our carers' strategy which aims to better support relatives or carers whilst their loved one is receiving care within our Trust. Areas of improvement have included our support for John's Campaign, allowing people to stay in a bed alongside their relative and open visiting hours on all our wards.

Members' Leadership Group

We are privileged to have the support of many committed individuals who are part of our Members' Leadership Group. During the year, this group has supported many of our key initiatives and plans such as transport for the new Midland Metropolitan Hospital, our CQC inspections and improvement plans, our volunteer service and our safety plan. During 2018/19 we intend to work closely with other partners to better join up our formal patient engagement activities.

Local Interest Group

Our Local Interest Group (LIG) monitors and influences inclusion within our workplace for all protected characteristic groups including age, sex, race, religion, disability, sexual orientation, gender reassignment, marriage, civil partnership, pregnancy and maternity.

The LIG is made up of senior colleagues from our organisation including the leads from each of our staff networks and chaplaincy service and members of the public who have a desire to improve the diversity and inclusion within our organisation. The group works with the Trust to ensure a co-ordinated approach to service improvement to meet the needs of the protected characteristics and disadvantaged groups.

The public members of the LIG provide a critical role to the organisation, making sure we're being inclusive of all and promoting the ethos of diversity of thought. They do an amazing job that is purely voluntary and they are a fantastic sounding board for the Trust.

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs)				
	Health Status Questionnaire Percentage improving			
	Finalised data for April 15– March 16 (Published November 2017)		Provisional data for April 16– March 17 (Published February 18)	
	National	SWBH	National	SWBH
Hip replacement	89.6%	90.6%	88.8%	89.7%
Knee replacement	81.6%	77.5%	80.9%	82.1%

PROMs assess the quality of care delivered to NHS patients from the patient perspective. Currently these cover two clinical procedures where the health gains following surgical treatment is measured using pre- and post-operative surveys. The Health and Social Care Information Centre publish PROMs national-level headline data every month with additional organisation-level data made available each quarter. Data is provisional until a final annual publication is released each year.

The tables below shows the percentage of patients reporting an improvement in their health status following the procedure and the average adjusted health gain achieved compared against the average for England.

	Health Status Questionnaire Average adjusted health gain							
	Finalised data for April 15– March 16 (Published November 2017)				Provisional data for April 16– March 17 (Published February 18)			
	National	SWBH	Highest National	Lowest National	National	SWBH	Highest National	Lowest National
Hip replacement	0.438	0.435	0.495	0.348	0.437	0.467	0.508	0.366
Knee replacement	0.320	0.253	0.373	0.229	0.323	0.311	0.384	0.264

SWBH below England average

SWBH above England average

The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website and SWBH data is consistent with trust reported data.

The finalised data for 2015/16 and the provisional data for 2016/17 shows that there are areas where the reported outcome is above the average for England, however there are some areas for improvement. The Trust is not an outlier against national data in any of the measures.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by: Hip and knee replacement; Pre-operative questionnaires and an information leaflet explaining the importance of completing the pre-operative PROMs booklets are posted to patients at home with their admission letter for completion and return on the day of surgery. Information on the expected outcomes from surgery are communicated in a variety of formats. Patients attend a 'joint club' where advice and information is imparted. This includes discussion with patients so they are fully aware of the risks and benefits, as well as expected outcome. A contact point after discharge is provided if there are any problems and there is direct access to clinic if needed. Patient information regarding the importance of completing PROMs is displayed on waiting room TV screens in both fracture clinics cross site. Focused data gathering has also improved the return of completed questionnaires from patients.

How we performed in 17/18 against our Key Performance Indicator (KPI) standards

Access Metrics	Measure	Target	2016/17 positon	2017/18 positon	Comments
Cancer – 2 week GP referral to first out patient	%	=>93.0	94.6	95.3	Full year
Cancer – 2 week GP referral to first outpatient (breast symptoms)	%	=>93.0	95.7	96.5	Full year
Cancer – 31 day diagnosis to treatment all cancers	%	=>96.0	98.0	97.8	Full year
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (excluding rare cancer)	%	=>85.0	86.2	86.2	Full year
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (excluding rare cancer)	%	=>85.0	86.7	81.4	Full year
Cancer – 62 day wait for first treatment from NHS Cancer Screening Service referral	%	=>90.0	95.5	97.1	Full year
Emergency Care – 4 hour waits	%	=>95.0	87.2	83.4	Full year
Referral to treatment time – incomplete pathway < 18 weeks	%	=>92.0	93.1	92.0	Full year
Acute Diagnostic waits < 6 weeks	%	<1.0	1.32	1.16	Full year
Cancelled operations	%	0.8	1.1	1.2	Full year
Cancelled operations (breach of 28 day guarantee)	Number	0	10	8	Full year
Delayed transfers of care	%	=<3.5	2.1	2.3	Full Year
Outcome Metrics					
MRSA Bacteraemia	No	0	1	0	Full Year
C Diff	No	<30	21	29	Full Year
Mortality reviews	%	=<90	61	44	As at end Jan 2018
Risk adjusted mortality index (RAMI)	RAMI	<100	104	109	3 months in arrears
Summary hospital level mortality index (SHMI)	SHMI	<100	101	108	3 months in arrears
Caesarean Section rate	%	<=25.0	26.3	25.6	Full Year
Patient safety thermometer – harm free care	%	=<95	94.3	94.5	Full Year
Never Events	No	0	4	3	Full Year
VTE risk assessment (adult IP)	%	=>95.0	95.4	96.1	Full Year
WHO Safer Surgery Checklist (all 3 sections)	%	=>100	99.9	99.8	Full Year

Quality Governance Metrics					
Mixed sex accommodation breaches	No	0	51	314	Full year
Staff sickness absence (rolling 12 months)	%	=<2.5	4.67	4.50	Full Year
Staff appraisal (PDR)	%	=>95	87.9	81.9	Full Year
Medical staff appraisal and revalidation	%	=>95	84.9	81.4	Full year
Mandatory training compliance	%	=>95	87.2	91.5	Full year
Clinical Quality and Outcomes					
Stroke care – patients who spend more than 90% stay on Stroke Unit	%	=>90	94.5	92.8	To be validated
Stroke care – Patients admitted to an Acute Stroke Unit within 4 hours	%	=>80	78.4	75.2	To be validated
Stroke care – patients receiving a CT scan within 1 hour of presentation	%	=>50.0	72.0	72.2	To be validated
Stroke care – Admission to thrombolysis time (% within 60 minutes)	%	=>85	67.4	66.1	To be validated
TIA (High Risk) Treatment within 24 hours of presentation	%	=>70	98.0	94.9	Full year
TIA (Low Risk Treatment within 7 days of presentation	%	=>75	97.2	95.6	Full year
MRSA screening elective	%	=>80	91.2	89.0	Full year
MRSA screening non elective	%	=>80	93.0	91.4	Full year
Inpatient falls reduction – acute	No	<804	654	577	Full year
Inpatient falls reduction – community	No		340	366	Full year
Hip fractures – operation within 36 hours	%	=>85	74.7	69.4	Full year
Patient Experience					
Complaints received – formal and link	No	N/A	1176	1037	Full year
Patient average length of stay for all patients excluding elective day cases	Days	N/A	3.56	4.21	Full year
Coronary heart disease - primary angioplasty (<150 mins)	%	=>80	96.1	95.9	Full year
Coronary heart disease – rapid access chest pain (<2weeks)	%	=>98	99.7	100.0	Full year

Data in the table above is subject to final validation and year end results when available.

Children's Safeguarding

We continue to work closely with Sandwell and Birmingham Multi-agency Safeguarding Hubs (MASH) to raise awareness of safeguarding children among our frontline staff so that they are aware of their individual responsibilities. Our safeguarding team provide a programme of targeted training, advice and support. Currently our compliance rates for safeguarding training is over 85 per cent for key groups such as health visitors, midwives and emergency care staff. During the year the Emergency Department (ED) Domestic Abuse Advocacy Partnership Project with Black Country Women's Aid continues to prove to be a positive venture in increasing the visibility of domestic abuse in ED. We have seen an increase in Emergency Department Practitioner response, identification and onward referral to the Independent

Domestic Violence Advisors (IDVA) based in Sandwell and City Hospital's for victims of domestic violence and abuse. Analysis of current data demonstrates that there are an increased number of victims being identified from Black and Minority Ethnic Groups which have previously not been represented in groups accessing domestic abuse services. Data shows that 77 per cent of victims have accepted ongoing support following initial referral into the project.

Our Domestic Abuse Lead Nurse Team continues to contribute to the Multi-Agency Domestic Abuse Screening Process in MASH to ensure that information relating to risk is shared with health professionals involved with the victim and children in order to protect, safeguard and reduce the negative impact that domestic violence and abuse poses.

The team have delivered specific training to staff across the Trust on Safe Lives (formerly CAADA/DASH Risk Assessment) and domestic abuse training forms part of our Safeguarding Children and Adult Safeguarding Mandatory Training requirements. Earlier this year a domestic violence and abuse leaflet was distributed to all employees.

Identifying Child Sexual Exploitation (CSE) remains a high priority for our organisation and during the year we have continued to deliver bespoke CSE training jointly with Barnardo's to our Emergency Department teams, paediatric ward staff, front line community nurses and allied health professionals. The training aims to raise the profile of CSE ensuring they are alert to the signs and triggers. We have good representation at Sandwell and Birmingham's CSE Health Groups from the paediatric areas including our Integrated Sexual Health Services, Safeguarding Team and ED.

We flag all children and young people who are known to Sandwell CSE Team as being at risk of CSE on our clinical systems. Audit has shown an improvement in ED practitioner response to a flag and in contacting Children's Social Care to share information on ED attendance and ensure appropriate support is in place.

The Child Protection Information Sharing (CP-IS) Project is embedded within our EDs and audit has shown that staff are reviewing systems to check for this information to inform their assessment. We currently manually flag our systems for Sandwell children where there is a child protection plan in place as the local authority are not currently live with CP-IS to ensure that this information is equally available.

We are currently developing systems in maternity services to ensure information in relation to female genital mutilation risk is available and are working closely with NHS England to implement Female Genital Mutilation Information Sharing system (FGM-IS).

Priorities for 2018/19 will continue to focus on CP-IS integration with our new electronic patient record (EPR), Unity, and implementation of the FGM-IS system across maternity services ensuring this information is integrated into Unity to inform risk. We will continue to maintain current compliance with mandatory safeguarding children training to ensure we have a skilled and knowledgeable workforce and focus on domestic violence and abuse with a view to secure substantive funding for our Advocacy project post June 2018.

Adult Safeguarding

We changed the adult safeguarding team during the year and now we have an Adult Safeguarding Lead Nurse and the appointment of a second Adult Safeguarding Nurse to provide visibility and operational support to frontline staff and patients.

Our dedicated Tissue Viability team includes a continence specialist nurse and we are excited to be recruiting a nurse dedicated to falls prevention. The adult safeguarding team are supported by other specialists such as learning disability, and dementia. Our new dementia, delirium and distress pathway aims to improve care for patients with cognitive impairment and promote least restrictive care. We have appointed two new activity co-ordinators and developed a training programme for volunteers who are attending the wards to provide therapeutic activity for patients with dementia, delirium and learning disabilities during their hospital admission.

We have focused on Deprivation of Liberty applications for those patients, with training for senior nurses, consultants, senior therapists and managers within the organisation. In addition a tool for assessing capacity and prompt for raising a Deprivation of Liberty application which reinforces the Mental Capacity Act (2005) has been created. Whilst it is recognised that this work is required to continue within the organisation to ensure it is fully embedded initial data is encouraging. We applied for more than double the Deprivation of Liberty safeguards during the year when compared with the previous year.

We continue to work closely with Sandwell and Birmingham multi-agency safeguarding board participating in work streams for both prevention and protection of shared strategies. We prioritise full cooperation with any identified cases meeting the criteria for public enquiries and we are committed to learning lessons and improving practices around patient safeguards. PREVENT duties within the Trust continue to develop with participation at multiagency meetings (Channel Panel) contributing to individual case management. We participate in PREVENT forums chaired by NHS England. All activities of the Safeguarding Nurse are recorded on a dashboard to ensure trends and themes can be identified to improve and maintain the safety of our patients.

Readmission rates

The table below details our readmission rates. This excludes deaths and stillbirths. The information is collected during a financial year period and we now measure readmission within 30 days (previously 28 days). Readmission reduction remains a priority for the Trust.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to monitor performance through group management meetings and group performance review meetings.

Age 0 – 15 years

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
2017/18	16145	934	5.8%
2016/17	16367	998	6.1%
2015/16	16015	1105	6.9%
2014/15	16058	1382	8.6%

Age 16 and over

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
2017/18	95113	8997	9.5%
2016/17	96427	8789	9.1%
2015/16	98232	9930	10.1%
2014/15	100662	9831	9.8%

All Ages

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
2017/18	111258	9931	8.9%
2016/17	112794	9787	8.7%
2015/16	114247	11035	9.7%
2014/15	116720	11213	9.6%

Quality Improvement Half Days (QIHDs)

2017/18 saw the continued development and expansion of Quality Improvement Half Days (QIHDs), our unique approach to staff involvement, with over 1,000 colleagues across the organisation regularly attending each time. The four hour QIHD sessions provide a chance for multi-disciplinary teams to take time away from their normal day-to-day duties to consider how to learn and develop new ideas.

April saw the introduction of 'ward' QIHDs, two hours of protected time for the team to spend together to consider how best to improve the quality of services provided to patients and staff on the wards. The use of this time has had mixed success with some wards finding it challenging to organise their QIHDs while others have embedded this into their routine so they have a known time when they can come together to talk about service improvements. A review has reconfirmed support for ward QIHDs so help is being provided to create the right environment for these sessions to succeed everywhere.

A new accreditation system was launched this year to allow teams to put themselves forward for recognition that their QIHDs are achieving quality improvement through staff involvement. Teams meeting the entry level can then put themselves forward for bronze, silver or gold status. The palliative care team led the way and impressed the awards panel and earned themselves a silver award. Imaging, health visiting, newborn hearing services, obstetrics and gynaecology, rheumatology, elderly care, stroke and neurology and governance celebrated too after their hard work on quality improvement gained them a bronze award. Moving forward the aim is to have all teams rated in 2018/19.

Learning from deaths

Mortality data is now extracted from the CHKS (Casper Healthcare Knowledge) System, which reports the Risk Adjusted Mortality Index (RAMI) as the principle measure of our organisation's mortality, and the HED (Healthcare Evaluation Data) System which reports the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI).

Hospital Standardised Mortality Ration (HSMR)

The HSMR is a method of comparing mortality levels in different years, or for different sub-populations in the same year, while taking account of differences in population structure. The ratio is of (observed) to (expected) deaths, multiplied conventionally by 100. Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100. This information is derived from the HED system, which is rebased monthly to providing the most up to-date-data.

Our HSMR is currently 122 (December 2017) for the Trust and outside statistical confidence limits. There is ongoing scrutiny and oversight of mortality statistics at the Mortality and Quality Alerts Committee (now the Learning from Deaths Committee). A report was commissioned with HED (Healthcare Evaluation Data), analytics provider which concluded Sandwell General Hospital is a statistically significant HSMR outlier and City Hospital remains within expected limits. A Trust-wide investigation of the following diagnoses groups was conducted:

- Pneumonia
- Pleurisy
- Respiratory failure; insufficiency; arrest (adult)

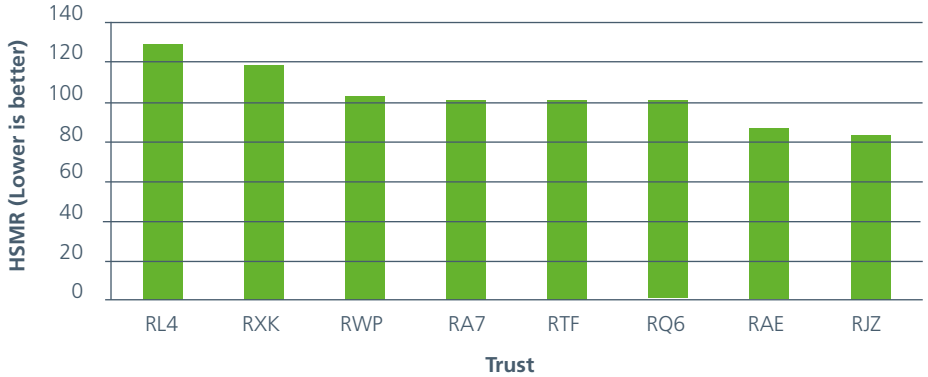
There were no significant quality of care issues identified. The broadening gap between HSMR for weekend and weekday admissions is subject to close monitoring at the monthly Learning from Deaths committee to identify actions to improve this position.

Changes in Palliative Care practice, i.e establishment of the Connected Palliative Care Hub and the coding of this change, look to be impacting on SWBH's HSMR. This is demonstrated by the HSMR model without palliative care. This is being addressed by:

- Reviewing the numbers of patients being seen in hospital by the palliative care team to ensure that HES coding accurately reflects practice.
- Ensuring that the appropriate distinction between supportive care and palliative care is being made during coding.

Further investigation and external audit was commissioned by the Trust information team which concluded that the coding practices at SWBH is robust and is inclusive of multiple co-morbidities in all spells of care. However there is ongoing close monitoring of Palliative Care coding practice to understand the reason for the reduction and establishing if this is consistent with the 'on the ground' view of patients seen at the Trust.

Hospital Standardised Mortality Ration (HSMR)



KEY

RL4 – The Royal Wolverhampton Trust
RXK – Sandwell and West Birmingham Hospitals NHS Trust
RWP – Worcestershire Acute Hospitals NHS Trust
RA7 – University Hospitals Bristol NHS Foundation trust
RTF – Northumberland Healthcare NHS Foundation Trust
RQ6 – Royal Liverpool and Broadgreen University Hospitals NHS Trust
RAE – Bradford Teaching Hospitals NHS Foundation Trust
RJZ – King's College Hospital NHS Foundation Trust

Risk Adjusted Mortality Index (RAMI)

This is a methodology developed by Caspe Healthcare Knowledge Systems (CHKS) to compute the risk of death for hospital patients on the basis of clinical and hospital characteristic data. It is a ratio of the observed number of deaths to the expected number of deaths that occur within a hospital. The Trust's RAMI for the most recent 12 month cumulative period (January 2018) is 109 and outside of statistical confidence limits. It is also above the National HES peer RAMI of 88. The aggregate RAMI for the City site is within statistical confidence limits with a RAMI of 98, and the Sandwell site with a RAMI of 116, which is outside of statistical confidence limits. Mortality rates for the weekday and weekend low risk diagnosis groups are within or beneath the statistical confidence limits.

Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days of discharge. Our SHMI score is currently 108 (November 2017) for SWBH Trust. This data is derived from HED (Healthcare Evaluation Database) for the Summary Hospital Level Mortality Indicator (SHMI).

Mortality comparisons using highest SHMI against national results: July 2016 June 2017

Indicator	Lowest	Highest	SWBH NHS Trust
Score (SHMI)	0.726	1.228	1,036
Observed	554	1291	2029
Expected	763	1052	1958

The data above compares our mortality figures against all other Trusts nationally. A Trust would only get a SHMI value of one if the number of patients who died following treatment was exactly the same as the expected number using the SHMI methodology.

The values for the Trust must be taken from two different periods as reported by NHS Digital, and include the lowest and highest value for other Trusts from the reporting period, by way of comparison.

The Trust also monitors its SHMI value taken from a national benchmark data provider (HED) site and includes this within its various mortality and performance monitoring reports. This data is available for a more recent period than is available from the NHS Digital website.

Trust Mortality Review System

For the year 2017/18 we set ourselves a target of reviewing 90 per cent of all hospital deaths within 42 days and 100 per cent of all hospital deaths within 60 days. By reviewing the care provided we can identify areas where learning can take place to improve outcomes for our patients. Mortality Review compliance has been set as a local Quality Standard for 2017/18. We have not been able to achieve this target due to a number of contributing factors. In the forthcoming year, new targets will be set as well as rolling out a new review method, Structured Judgemental Review methodology, recommended by Learning From Deaths Guidance March 2017.

2017/18

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD
Death	101	105	120	326	134	111	106	351	130	115	164	409	176	138	139	453	1539
Reviewed	51	50	67	168	63	45	46	154	44	45	74	163	79	55	39	173	658
% Reviewed	50	47	55	51	47	40	43	43	33	39	45	39	44	39	28	38	42
% Cumulative Reviewed	50	49	51	51	50	48	47	47	45	44	44	44	44	44	42	42	42

Data highlighted in red has not been finalised for year end.

Chief Executive Toby Lewis speaking with clinicians about our Trust's Safety Plan at a Listening into Action Event.

Sister, Lynne Hackett talks to patient, Sarah Meanley.

During 2017/18 Q1 to Q3, 1591 of SWBH NHS Trust's patients died in hospital. 347 deaths in Q1, 360 deaths in Q2, 421 deaths in Q3, 463 in Q4.

By 31st January 2018, 492 mortality case record reviews and 22 investigations have been carried out in relation to 25 of the deaths. In 22 cases a death was subject to both a case review and an investigation. The number of deaths in each quarter for which a case record review or investigation was carried out was 170 in the first quarter, 156 in the second quarter, 166 in the third quarter, data for Q4 is not yet available.

Nine patient deaths, representing 0.80% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of four patient deaths representing 0.35% of the patient deaths for the first quarter, two patient deaths representing 0.18% of the patient deaths for the second quarter, three patient deaths representing 0.27% of the patient deaths for the third quarter, data for Q4 is not yet available.

These numbers have been estimated using the SWBH NHS Trust Mortality Review System. The Mortality Review System (MRS) is based on the PRISM methodology. It is in place to ensure that there is a review of the management of a large proportion of patients who have died in our care. On notification of the death to the CARES office, the notes of the patient are scanned into the CDA and a notification is sent to the Clinical Director and a Consultant of the Directorate in which the death occurred. The electronic notification system has been set up to allocate the reviews to a consultant colleague within the Directorate, but not to a consultant who provided care to the patient. A comprehensive review of each case is performed (within 42 days of the death) using the scanned notes of the ultimate, and where appropriate, penultimate inpatient episode.

The MRS allows each case to be examined for excellence as well as errors or deficiencies in care and the death is categorised as expected or unexpected and whether the death was preventable. A MRS report is compiled monthly and scrutinised at the monthly Learning From Deaths committee and any actions arising are also monitored for completion. The purpose of the report is to identify the deaths that have been categorised with preventable codes.

We also use a 'trigger method' to identify the cases not categorised with a preventable code, but where there has been a negative response to a significant number of questions (three or more) relating to the clinical assessment or ongoing management. These are investigated further through the Learning From Deaths committee. The outcome and actions from these incidents are reviewed by the committee to identify quality improvement themes and opportunities. The MRS also provides a report of the lessons learnt where this is recorded for cases reviewed.

Data from the MRS is also used to investigate and respond to external mortality alerts for example CQC alerts and alerts in relation to specific diagnoses/procedure groups. The committee also reviews the outcome of HMC Inquest and from all these sources identifies learning and quality improvement opportunities.

The following areas have been identified as learning points from case record reviews and investigations conducted in relation to the deaths identified in 2017/18 through our MRS and from investigation of other internal and external mortality alerts.

- Compliance with the Sepsis Bundle notably delayed administration of antibiotics.
- Late recognition of AKI and delay in identifying and managing the end of life are some of the more common problems identified.
- Other areas noted for quality improvement are delayed intervention eg commencement of CPAP, suboptimal preoperative assessment, compliance with the head injury pathway, compliance with discharge criteria and delayed diagnosis of subarachnoid haemorrhage.

Examples of the quality improvement projects that have come from our work are:

- Development of the AKI guidelines and outreach acute renal services, supported by electronic flagging system to Nephrology team.
- Revision of the sepsis bundle and trust-wide sepsis audit supported by the sepsis team.
- End of Life Care and Specialist Palliative Care are now coordinated through a palliative care hub covering in and outpatient care.
- The Commissioning of a dedicated NIV unit on the respiratory ward.
- Updated head injury proforma.
- Focused education within ED.
- Participation in the TARN audit.
- Implementation of the NHSI enhanced discharge initiatives e.g. Red to Green and the SAFER flow Bundle.

Action in the reporting period by SWBH to achieve quality improvement in these areas has come through several pieces of work.

- We have implemented a medical examiner service as part of the Trust's Learning from Deaths programme to support accurate death certification and junior doctor training in this area. This team will triage all deaths and identify deaths where review, investigation, reporting to coroner or as incidents very soon after death is needed. The medical examiners will also support and engage relatives and carers to further identify cases for review and learning.

- The acquisition and implementation of the new structured judgemental review method and analysis tool and the participation by trust staff in SJR training internally and externally as tier one trainers.
- A defined trained pool of SJR reviewers is being identified.
- Participation in the National Learning Disability Mortality Review Programme (LeDeR) led by the University of Bristol and notification of Learning Disability Deaths to the LeDeR programme, which went live for submission in October 2018. The Trust also reports monthly in detail on learning disability patients who have died in the preceding month.
- We work accross Black Country Trusts and our mortality lead chairs the NHS England West Midlands Mortality Concordat to learn from regional good practice.
- Learning and news of QI projects are shared through monthly email Learning from deaths e-bulletin, DEATH Matters quarterly newsletter. Each group is represented at LfD committee and SJR reviewers are taken from every specialty.
- Corporate work streams identifying group and specialty quality improvement of end of life care and specialist palliative care are monitored regularly.
- When implemented our new EPR system will ensure reliable medical record review and support for full timely case review of cases identified for review.

Reporting requirements prescribe that a comparison of mortality data for the previous reporting period is included. At SWBH we have a process in place and have this data available for 2016/17, however this has not been mapped with the Learning from Deaths methodology, therefore comparison against previous years data will be reported in future quality accounts.

Our Connected Palliative Care team was rated 'Outstanding' by the CQC.

Deaths of patients with involvement from palliative care services

Diagnostic care coding = Z5.15. The table below provides information relating to the number of deaths at the Trust where there was a diagnosis of Palliative Care made. A Trusts Mortality data is affected by palliative care and specialist palliative coding as well as comorbidity coding. Changes in external mortality data calculation methods and rebasing, changes in palliative care provision (eg focusing on community care) and coding can affect our data and comparison with peer Trusts.

Mortality comparisons against national results: July 2016/17

Total number of Total number of deaths deaths	Palliative Care	Percentage (%)
2029	387	19.1

Venous Thromboembolism (VTE)

A Venous thrombo-embolism (VTE) is a blood clot that forms in a vein. A calf vein is the most common site for this to occur but occasionally pieces of the clot can break away and flow towards the lungs and become a pulmonary embolism (PE). The Department of Health requires all Trusts to assess patients who are admitted for their risk of having a VTE. This is to try and reduce some of preventable deaths that occur following a VTE while in hospital.

We report our achievements for VTE against the national target (95 per cent) and report this as a percentage. The calculation is based on the number of adults admitted to hospital as an inpatient and of that number, how many had a VTE assessment within 24 hours. Our year end position is 96.1%

Venous Thromboembolism (VTE) risk assessment (National Target 95%)	2016/17	2017-2018 (Apr – Dec)				
	SWBH		SWBH	National Average	Highest Trust	Lowest Trust
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	95.36%	Q1	96.1%	95.1%	100%	51.4%
		Q2	96.4%	95.2%	100%	71.9%
		Q3	96.5%	95.3%	100%	76.1%
		Q4	95.2%	TBC	TBC	TBC

The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website and SWBH data is consistent with Trust reported data.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to monitor compliance of VTE assessments on admission as part of the Trust's Safety Plan compliance. It is also monitored as part of our Integrated Performance Report which is monitored at our Quality and Safety committee and reported to the Trust Board monthly. We believe the introduction of our new electronic patient record system, Unity, will help us to improve our compliance.

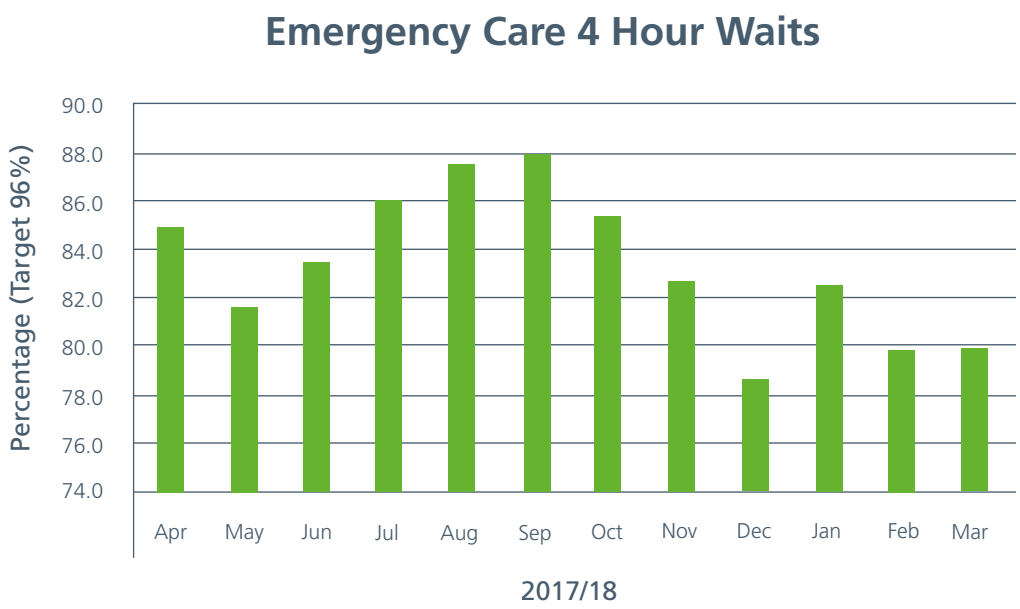
Our Connected Palliative Care team received positive feedback from the CQC.

Emergency four hour waits

In line with the national standard we aim to ensure that 95 per cent of patients will wait for no more than four hours within our Emergency Departments (ED). Although the majority of patients were seen in four hours on average we achieved 83.4% at year end.

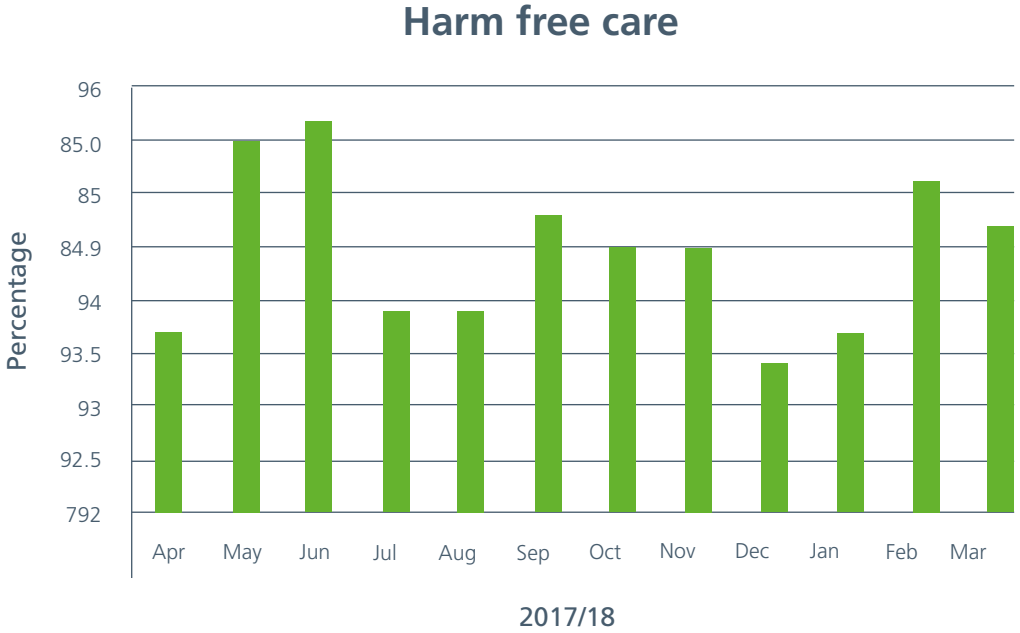
We continue to see good results in ambulance handover time, meaning that ambulance crews can get back on the road more quickly. We remain committed to improving our performance and have expanded our Rapid, Treatment and Assessment (RAT) this year which has shown an improvement in time to treatment.

Percentage of patients waiting four hours or less in Emergency Departments 2017/18
(Higher is better – target 95%)



Harm free care

We continue to undertake monthly prevalence audits looking at four harms – pressure ulcers, falls; catheter related urinary tract infections (UTI) and deep vein thrombosis (DVT). We review harms via the incident reporting framework with lessons learned shared locally and across the organisation.

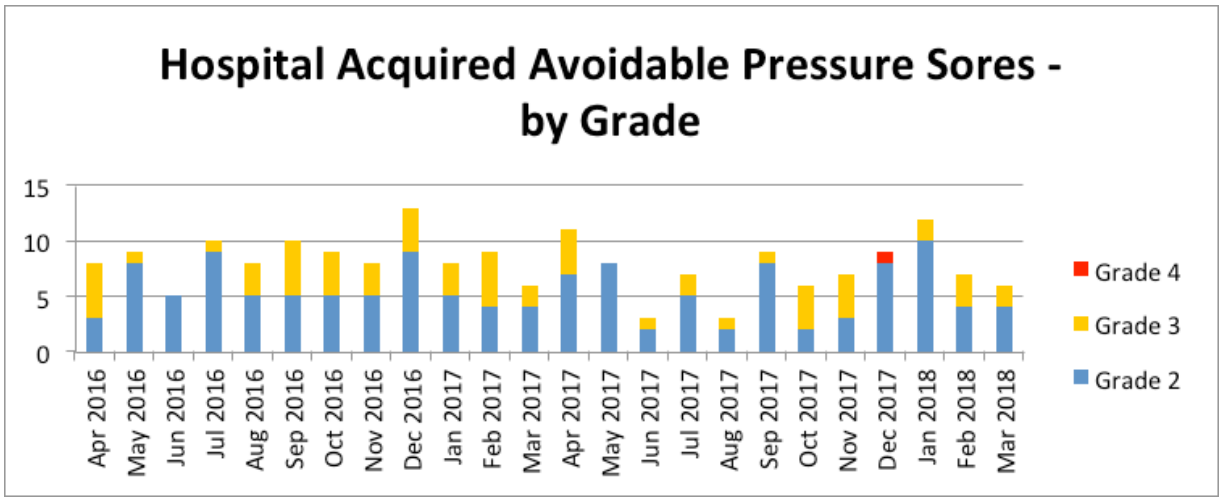


Pressure ulcers

Pressure ulcer prevention remains one of the key priorities in line with the Trust vision to provide patients with safe care. We continue to promote being open with the reporting of pressure damage incidences in order to learn and improve future care for patients.

Pressure ulcer prevention is one of the key parts of our Safety Plan for 2018 which focuses on ensuring consistency in identifying when our patients are at risk of developing pressure damage and ensuring they have all the preventative strategies in place to reduce the risk of pressure damage.

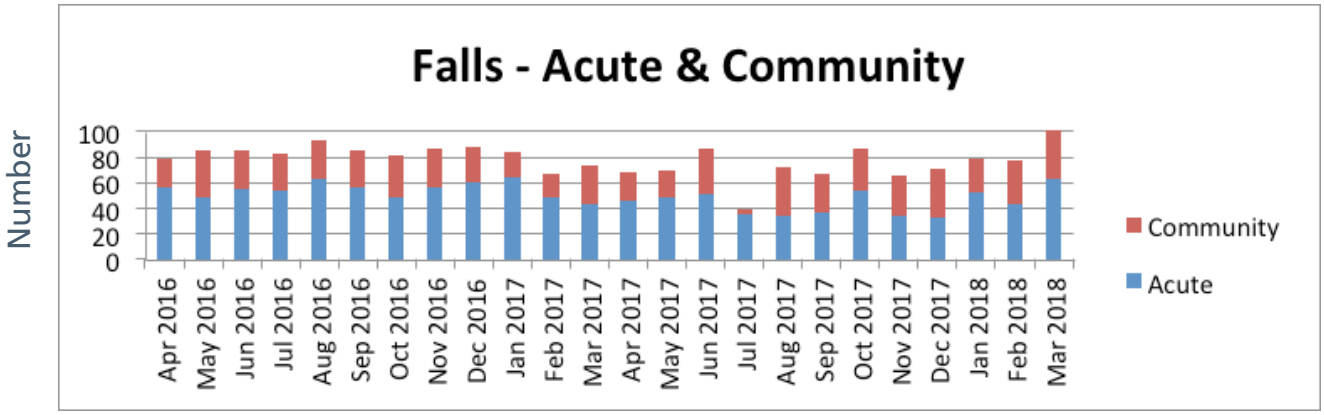
The Tissue Viability service is engaged in the National NHS Improvement 'Stop the Pressure' campaign to eliminate avoidable pressure ulcers within the Trust. The campaign focuses on the early identification of at risk patients and reacting quickly to the early warning signs and preventing pressure damage occurring. This initiative supports any areas in the Trust who are identified as reporting any increases of pressure damage occurring. The campaign has proven effective in a number of areas, supporting staff with education and training in pressure ulcer prevention and has reduced the incidence of reported pressure damage in these areas.



Falls

The number of falls for 2017/18 was 943 with 14 of the falls resulting in serious injury. This is a reduction of 51 falls compared with 2016/17 data. Falls resulting in serious harm have also reduced year on year from 24 to 14.

The Trust remains committed to patient safety and reducing harm occurring to our patients and we will continue to focus on falls prevention with a key emphasis on the assessment of patients and the implementation of preventative strategies to keep our patients safe.



Infection prevention and control

The aim of the Infection Prevention and Control Service (IPCS) is to develop, utilise and promote infection prevention and control practices that are cost effective, safe and efficient, minimising the risk of patients acquiring infections, during or as a result of their stay in hospital. Working in partnership with health care professionals across the health economy, the Trust is committed to a zero tolerance ambition to eliminate all avoidable HCAIs.

To comply with current legislation and meet the requirements from professional bodies such as: Department of Health, the Care Quality Commission and NHS Improvement [NHSI], we adopt a proactive approach to identification, management and monitoring of infections through education, training, surveillance, and monitoring of clinical and non-clinical practices in line with national standards such as National Institute for Health and Care Excellence [NICE] guidance, Patient Lead Assessment in the Clinical Environment [PLACE] and standards of cleaning, guidance and recommendations from professional bodies.

Organisational structures continue to work well both within our own organisation and across the wider healthcare economy. Partnership working with the Clinical Commissioning Groups (CCG), NHS Improvement [NHSI], Health Protection Unit (HPU) and Public Health England (PHE) through the Health Economy Groups for Infection Prevention and Control continues.

Target for 2017/18	Agreed target/ rate [year end]	Trust rate	Compliant	Comments	
MRSA bacteraemia	0 tolerance	0	Yes	**Pre 48hrs [laboratory identified]** 4	**Post 48hrs [laboratory identified]** nil
				All bacteraemias identified in the laboratory have had a post infection review as per PHE guidance to identify issues and lesson learnt. Of the cases identified 0 has been attributed to SWBH.	
***C.difficile* acquisition toxin positive**	30	28 attributed to SWBH	Yes	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged two or over during the reporting period is 12.85	
MRSA screening - elective [YTD]	85%	89.0%	Yes	Locally agreed target.	
MRSA screening - non elective [YTD]	85%	91.4%	Yes	Locally agreed target.	
Post 48hrs MSSA Bacteraemia *(rate per 100,000 bed days)*	N/A	10 (4.69 per 100,000 bed days)	NA	All post 48 hrs bacteraemias have a post infection review to identify issues and lesson learnt.	

Blood culture contamination rates

(Target = 3% by ward, dept. and site.)

Sit	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City	2.4%	0.9%	2.3%	1.2%	1.6%	1.9%	1.2%	1.9%	1.9%	1.4%	1.3%	2.6%
S.Well	2.5%	3.3%	2.5%	2.8%	2.3%	3.6%	2.9%	2.4%	3.7%	3.5%	5.4%	2.6%

Overall Trust rate 2.9%. It needs to be recognised that due to the clinical condition of some patients there is a risk of obtaining an unavoidable blood contaminant. However, any clinician identified as taking a contaminated blood culture is required to attend for further training to reiterate practices. In addition to this, since Aug 2014 the IPCS has introduced a training programme for all new doctors to the Trust. This is now managed by the clinical fellows.

We monitor incidences of infections so that we can identify and act on periods of increased incidents [PII]. This includes outbreaks of diarrhoea and vomiting, those attributed to a variety of micro-organisms including: Clostridium difficile [CDI], Extended Spectrum βeta lactamase organisms [ESBL], Carbapenamase resistant organisms [CRO]; Vancomycin resistant enterococci [VRE], MDR Acinetobacter. In all incidences strains have been typed to determine any outbreaks and post infection reviews undertaken and multi-disciplinary and agency meetings held to identify root causes and lessons learnt.

Site	Organism	2017-18 month	PII or outbreak	Ward or bay closure
Sandwell CCS	VRE	June 17	PII	NA
City D15	CDI	July 17	PII	NA
Sandwell P5	CDI	Sept17	PII	NA
Maternity NNU	ESBL	Oct	outbreak	NA
Sandwell P2	CDI	Oct17	PII	NA
Sandwell L4	Norovirus	Dec 17	outbreak	Bays
Rowley Regis	Norovirus	Dec17	outbreak	Bays
City D16	Flu	Dec 17	outbreak	Bays
Sandwell L4	Flu	Dec 17	outbreak	Bays
Maternity NNU	ESBL	Dec17	PII	NA
Sandwell L4	Flu	Feb 18	outbreak	Bay
Rowley Regis	Norovirus	Feb 18	outbreak	Bays
Sandwell P5	Norovirus	Mar 18	outbreak	bay

The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website and SWBH data is consistent with Trrust reported data.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continued commitment and compliance with infection prevention and control policies by clinical and non-clinical groups and clinicans. Audit and training continues to be prioritised as a means of monitoring and delivering continuous improvements.

Information Governance Toolkit (IGT) attainment levels

We are compliant across the Information Governance Toolkit requirements for 2017/18. The Trust Information Governance Assessment Report overall score for 2017/18 was 93 per cent and was graded GREEN. This means that a minimum Level 2 was achieved for all requirements (as required for the NHS standard contract). We will continue to build on this to strengthen our IG practices and processes and work towards achieving full mandatory compliance with the new data security and protection toolkit which replaces the information governance toolkit in April 2018.

Incident reporting

A positive safety culture remains essential for the delivery of high quality care. The Trust continues to submit its incident data to the National Reporting and Learning System (NRLS) which is publically available and provides comparative data with like-sized trusts. This data shows as at September 2017, we are in the middle 50 per cent of reporters of trusts with a reporting rate of 47.98 per 1000 bed days.

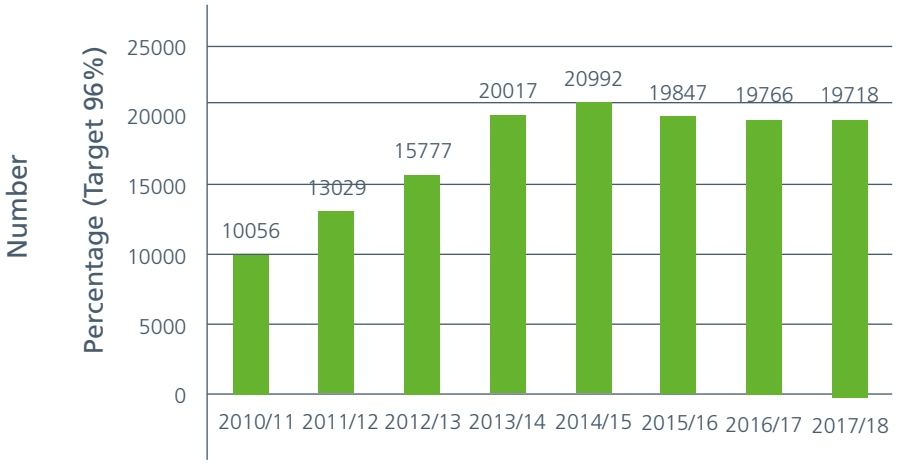
L– R Ward Manager, Tracy Weston and Staff Nurse, Anthea Forsythe complete the Ten out of Ten safety plan checklist.

District Nurse Clinical Lead for Tipton, Andy Churm (central) is leading on the mobile working project.

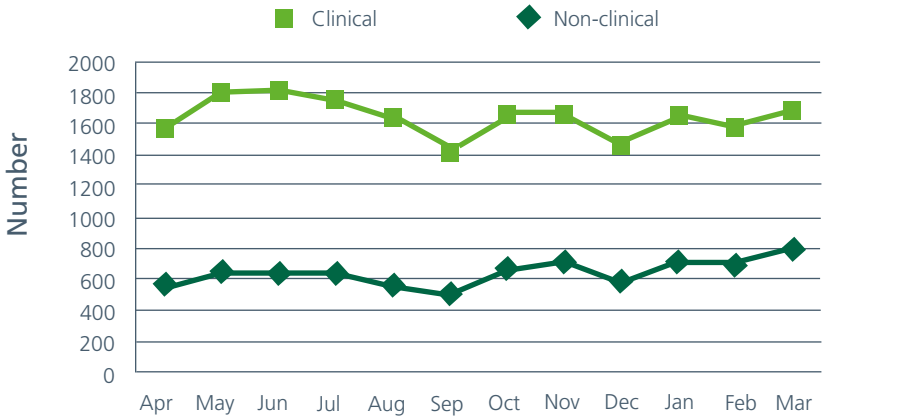
Date	Average rate of reporting per 100 admissions	Best reporter/ 100 admissions	Worst reporter/ 100 admissions	Number of incidents resulting in severe harm	Percentage of incidents resulting in severe harm	Number of incidents resulting in death	Percentage of incidents resulting in death
2011/12	6.29	9.82	2.34	86	1.15	14	0.2
2012/13	9.58	12.65	2.49	32	0.32	19	0.15
2013/14	11.67	12.46	1.72	24	0.2	16	0.1
Date	**Average rate of reporting per 1000 bed days**	**Best reporter/ 1000 bed days**	**Worst reporter/ 1000 bed days**	**Number of incidents resulting in severe harm**	**Percentage of incidents resulting in severe harm**	**Number of incidents resulting in death**	**Percentage of incidents resulting in death**
2014/15	56.19	84	7	28	0.32	7	0.1
2015/16	50.1	76	16.5	20	0.2	6	0.1
2016/17 (April 16 to Sep 16)	44.48	73	22	8	0.2	1	0.0
2016/17 (Oct 16 to Mar 17)	47.93	70	23	4	0.1	3	0.1
2017/18 (Apr 17 to Sep 17)	47.98	111.69	23.47	2	0.0	1	0.0

The latest data (April 17 - September 17) shows an overall position of reduced incidents resulting in severe harm or death.

Total incidents reported by financial year



Total incidents reported during 2017/18 split by Clinical and Non-clinical



Incidents are generally categorised into clinical (patient safety) and non-clinical and then further categorised dependant upon their causative factor. The chart on page 57 shows the data for the main types of incidents throughout the year, month on month. Serious incidents continue to be reported to the CCG. The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to facilitate investigations and learning through the corporate risk team. Patient safety incidents resulting in moderate harm or above that do not meet external reporting criteria are investigated at clinical group or corporate directorate level. The number of serious incidents reported in 2017/18 is shown in the following table. This does not include pressure sores, fractures from falls, ward closures, some infection control issues, personal data or health and safety incidents.

2017/18	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of SIs (by date reported as SI)	0	3	1	0	3	4	1	2	2	3	1	3

General Data Protection Regulation

The General Data Protection Regulation (GDPR) will replace the Data Protection Act (1998) from 25th May 2018.

Like all NHS trusts we are in a good position due to the work undertaken as part of the Information Governance toolkit. We have an action plan in place to review our information processes, particularly with regards to children's information and transfer to non EU countries.

Never Events

During 2017/18 three never events were reported. A never event is a serious untoward incident that has either caused or has the potential to cause serious harm that should never happen if robust controls are in place to prevent them from happening.

Never events reported in 2017/18

Specialty and Date	Type of Never Event	Root Causes	Changes made
T and O Theatres/ Anaesthetics	Wrong site block	Failure to complete WHO Safe Surgery "Sign In"	Mandatory sign in part of Safe Surgery Checklist use and responsibilities reinforced Mandatory stop before you block standard operating procedure and the SOP updated reinforced Stop before you block video has been circulated to all anaesthetists Process in place for practitioner performing a procedure is present for the whole process Reprinted stop before you block poster in A3 size
BMEC	Wrong eye lasered	Failure to follow the correct procedures	We have amended our standard operating procedure for the practice of consenting sequential procedures. We have introduced a modified WHO checklist for use in BMEC OPD procedures. We have produced a standard operating procedure requiring site marking and inclusion in the WHO surgical safety checklist.
Dermatology	Wrong patient biopsied	Failure to follow positive patient identity procedure	Our Positive Patient Identification (PPID) video has been recirculated to all staff as reminder of its importance. All staff in Dermatology have attended a training session on PPID and use of WHO checklists. We have introduced patient ID bracelets for those attending outpatient (OPD) theatre sessions in dermatology.

Duty of Candour

The Trust has a robust method, through use of the electronic incident reporting system, to identify those incidents which, by the nature of the degree of harm, trigger the statutory duty of candour.

When incidents are reported which identify that the level of harm to a patient is moderate, severe or they have died due to care issues clinicians are engaged in discussions to clarify that the outcome meets the recognised definitions to trigger this level of candour, recognising that being open and the professional duty of candour continues to happen at all or no level of harm.

The Incident reporting system allows for capture of the duty of candour conversations taking place. Since 1 April 2017 453 incidents have met the statutory requirements and of those 95 per cent (430) are evidenced as being complete. The remaining 23 are being reviewed.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 3850. Of these, in excess of 3400 were recruited into National Institute for Health Research (NIHR) portfolio studies whilst 450 were recruited into non-NIHR portfolio studies.

The numbers of patients involved in research at the Trust have increased year on year over the last four years, reflecting the Trust's ongoing commitment to support and develop research. Through this we continue to improve the quality of care offered to patients locally, ensure that our staff remain abreast of the latest treatment possibilities and make important contributions to the wider health environment.

There are over 385 research studies being undertaken across the Trust in various stages of activity, from actively recruiting participants into new studies to those in long term follow-up. In 2017/18, 60 new studies have been given Trust approval to commence (46 NIHR portfolio studies and 14 non NIHR portfolio studies). 104 NIHR portfolio studies have actively recruited research participants in 2017/18.

During 2017/18, patient recruitment was highest in cardiovascular disease, ophthalmology and rheumatology although research activity has taken place across a full range of disciplines including stroke, diabetes, gastroenterology, surgery, dermatology, maternity, obstetrics and gynaecology, paediatrics, respiratory, orthopaedics and physiotherapy and cancer (breast, lung, colorectal, and haematological, gynaecological, and urological malignancies).

Important new developments in 2017/18 include:

- Increasing the internationally recognised excellence of our research portfolio: We are for example a key partner in the new Arthritis Therapy Acceleration Programme (https://www.kennedy.ox.ac.uk/about/translational-research/atap) linking universities and hospitals in Oxford and Birmingham. Some of our leading researchers have secured major highly prestigious grants and awards including the NIHR Senior Investigator award to Prof Greg Lip.
- Increasing the breadth of our clinical research portfolio with new research initiatives in a range of areas including sickle cell disease, critical care, maternity and orthopaedics.
- Increasing the range of health care professionals contributing to our research portfolio: physiotherapists have made major contributions to our research, and we have seen important developments in the involvement of clinical nurse specialists and laboratory scientists in the development and delivery of research and innovation. We have created secondment opportunities to allow clinical nurses/midwives to gain exposure to research.
- Translating research into better and safer care: Our researchers have been involved with/led the development of national/international clinical guidelines for a range of diseases over the last 12 months including Systemic Lupus Erythematosus.
- We are actively working to enhance the quality of space for research and development activities at the Trust. Some of our team have recently moved into new space in theBirmingham treatment centre and we are in detailed discussion about the creation of enhanced space at the Sandwell site.

Participation in Clinical Audits

During 2017/18, Sandwell & West Birmingham NHS Hospitals Trust has participated in 53 national clinical audits and 3 national confidential enquiries covering NHS services which the Trust provides. The Trust has reviewed all the data available to them on the quality of care in these services.

The national clinical audits and national confidential enquiries that the Trust participated in and for which data collection was completed during 2017/18 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	Participated Yes /No	Percentage of eligible cases submitted (Provisional)
Women's & Child Health		
Maternal, Newborn and Infant Clinical Outcome Review Programme (CORPS) - Perinatal Mortality surveillance	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (CORPS) – Perinatal Mortality and Morbidity	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (CORPS) – Maternal Mortality Surveillance	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (CORPS) – Maternal Morbidity confidential enquiries	yes	100%
National Neonatal Audit Programme (NNAP)	yes	100%
British Thoracic Society: Paediatric Bronchiectasis	yes	100%
National Paediatric diabetes Audit	yes	100%
National Maternity and Perinatal Audit (NMPA)	yes	100%
National Pregnancy in Diabetes (NPID) Audit	yes	100%
Acute care		
Hip, knee and ankle replacements (National Joint Registry)	yes	100%
Severe trauma (Trauma Audit & Research Network)	yes	50%
Intensive National Care Audit (ICNARC)	yes	100%
Surgical Site infection Surveillance – Hip and Knee	yes	100%
Sentinel Stroke and Stroke Improvement – National Audit Programme	yes	>90%
Royal College of Emergency Medicine Audit – Sepsis	yes	100%
Royal College of Emergency Medicine Audit – Consultant Sign Off	yes	100%
Royal College of Emergency Medicine Audit – Asthma	yes	100%
National Emergency Laparotomy Audit	yes	100%
Long term conditions		
National Inpatient Diabetes Audit	yes	100%
National Pregnancy in diabetes	yes	100%
National COPD Audit (Pulmonary Rehabilitation)	yes	100%
National COPD Audit (Secondary Care Audit)	yes	100%
National COPD Registry (Secondary care Audit)	yes	100%
National Audit of Dementia	yes	100%
UK Parkinsons Audit	yes	100%
National Diabetic Footcare Audit	yes	100%
Inflammatory Bowel Disease (IBD Registry)*	no	
Cardiology		
Myocardial Infarction (MINAP)	yes	100%
National Heart Failure Audit	yes	77%
National Audit of Percutaneous Coronary Interventions	yes	100%
National Audit of Cardiac Rehabilitation	yes	100%
ICNARC NCAA – Cardiac arrest	yes	100%
Rhythm Management	yes	100%
Cancer		
Oesophago-gastric Cancer Audit (NAOGC)	yes	>90%
National Prostate Cancer Audit	yes	100%
National Audit of Breast Cancer in Older People (NABCOP)	yes	100%
Head and Neck Cancer Audit	yes	100%

National Audits	Participated Yes /No	Percentage of eligible cases submitted (Provisional)
National Lung Cancer Audit	yes	100%
(NBCP) Colorectal Cancer Audit	yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion: Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	yes	100%
National Comparative Audit of Blood Transfusion: 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	yes	79%
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP)	yes	100%
Falls and Fragility Fractures Audit Programme – Fracture Liaison Service Database	yes	100%
Falls and Fragility Fractures Audit Programme – Inpatient Falls	yes	100%
(BAUS) - Nephrectomy Audit - Percutaneous Nephrolithotomy - Stress Urinary Incontinence Audit - Urethroplasty Audit	 no yes yes no	 Procedure not currently performed 100% 100% Procedure not currently performed
Other		
Patient Reported Outcome Measures (PROMS) Varicose Vein - terminated September 2017	yes	75%
Patient Reported Outcome Measures (PROMS) Groin Surgery – terminated September 2017	yes	68%
Patient Reported Outcome Measures (PROMS) Hip and Knee Surgery	yes	76%
National Ophthalmology Audit	yes	81%
Endocrine and Thyroid National Audit	yes	on going
National Audit of Intermediate Care (NAIC)	yes	100%
National Confidential Enquiries (Patient Outcome Data)		
Chronic Neurodisability	yes	90%
Young People's Mental Health	yes	83%
Acute Heart Failure	yes	45%

*The IBD registry was not participated in due to difficulties with resourcing. Measures taken to improve compliance 2018-19 are; Recruitment of administration staff, support from the Clinical Effectiveness department and integration between the Unity EPR system and the Registry.

The Emergency Gynaecology Assessment Unit team achieved 100% safety checks for patients. L-R Kuldip Manak, CNS Emergency Gynaecology, Lis Hesk, Matron for Gynaecology and Annette Black, Cancer Nurse Specialist.

Healthcare Assistant Sandra Burton with patient Carol Potter.

Partner statements
Healthwatch Birmingham

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for Sandwell and West Birmingham NHS Trust. We are pleased to see that the Trust has taken on board some of our comments regarding the previous Quality Account. For example, the Trust has:

Given examples of patient experience and feedback, and how these are used to develop solutions that improve the quality of services.

- Demonstrated how the Trust learns from complaints and actions taken based on these lessons.
- Demonstrated how staff, patients and carers are involved in decision-making and activities within the Trust.

Patient and Public Involvement

It is positive to see that listening and learning from experience of patients in the Trust's care and their relatives or carers is a priority for 2018/19. We note the varied ways in which the Trust has engaged with patients and the public.

Firstly, by holding Facebook live events where members of the public can engage with clinicians on various subjects such as heart health care. This is an innovative way of sharing information with patients and the public that they might not have time to ask in a consultation. Equally, the Trust can use these events to understand patients' needs about what they expect from services based on their experiences.

Secondly, we welcome the establishment of a carers' group during the year that has informed the development of the Trust's carers' strategy. This is a good resource for understanding how best to support relatives and carers. We note that some action has already been taken in relation to carers, such as allowing people to stay in a bed alongside their relative and open visiting hours on all wards.

Thirdly, we note the initiatives of the Members Leadership Group. For instance, involvement in the Care Quality Commission inspections and improvement plans, and the supporting safety plan. We welcome that in 2018/19 the Trust intends to work closely with other partners to better join up the Trust's formal patient engagement activities.

Lastly, we welcome the work of the Local Interest Group to ensure inclusion within the workplace for all people who might otherwise be discriminated against. It is positive to see that the Local Interest Group (which is made up of leads from staff networks, chaplaincy service, and members of the public) works with the Trust to ensure that there is a coordinated approach to service improvement in order to meet the needs of those with protected characteristics and disadvantaged groups.

In our response to the 2016/17 Quality Accounts, we asked the Trust to consider developing a strategy for involving patients, carers and the public in decision-making. Our examination of the various initiatives around patient and public involvement, shows that the Trust has the foundation on which it can develop such a strategy. As we argued in our previous response, such a strategy should clearly outline how and why patients, the public and carers are to be engaged in order to improve health outcomes and reduce health inequality. This will ensure that there is commitment across the Trust to using patient and public insight, experience and involvement. To be effective, the strategy needs to be understood by all staff, promoted, and arrangements for collating feedback and experience should be clearly outlined.

In our response to the 2016/17 Quality Account, we asked the Trust to provide examples of changes or improvements to services and practice that have occurred as a result of that feedback. We also hoped to read how the Trust uses patient feedback and experiences to understand barriers different groups face. We are pleased to see examples of these in the 2017/18 Quality Account. We note the appointment of a diversity lead and implementation of awareness raising sessions on LGBT issues. In addition, the implementation of an 'infant feeding policy' that promotes zero separation from the mother when admitted in areas outside of maternity. Lastly, changes to templates for patient letters (e.g. making writing more visible; printing appointment letters on yellow paper) and deaf awareness training for staff.

We look forward to reading more about the impact of feedback, and we would like to read how the Trust communicates with patients about how they are using their feedback to make changes. At Healthwatch Birmingham, we believe that demonstrating to patients how their feedback is used to make changes or improvements shows service users and the public that they are valued in the decision-making process. Consequently, this has the potential to increase feedback as service users and the public will know that their views matter and lead to actual changes/improvement to services.

In our response to the Trust's 2016/17 Quality Accounts, we expressed concern that the number of formal complaints the Trust receives had increased from 871 in 2015/16 to 1026 in 2016/17. We are pleased to see that the number of formal complaints has reduced from 1026 (2016/17) to 825 (2017/18). We also note that complaints responded to within the target date has increased, from 81% (2016/17) to 92% (2017/18). However, the average number of days the Trust takes to respond to complaints steadily increased over the year. The most common themes of complaints has remained the same for the past three years. Complaints are mainly about clinical treatment, appointment delay or cancelations, communication and discharge and transfers. We note the lessons learnt from complaints and actions taken. However, we believe that the Trust needs to take innovative action in order to identify where the problems are, for instance in the discharge process, and understand and address these issues.

Staff and PPI (Patient and Public Involvement)
We note that the Trust did not meet its target to improve by 5% the percentage of staff responding to two of the three NHS staff survey. We welcome that the staff survey indicates improvement in the percentage of staff who believe that their role makes a difference to patients and service users.

It is positive to see the varied ways that the Trust is engaging staff. For instance, the Listening into Action events and Speak up Day, to ensure that staff feel heard and valued. We particularly welcome the 'Quality Improvement Half Days' that the Trust holds for staff to consider how to learn and develop new ideas. In addition the introduction of ward quality improvement days, where for two hours a team comes together to consider how best to improve the quality of services they provide within their wards. We would like to read in the 2018/19 Quality Accounts ideas from these meetings that have been taken up.

We believe that these Quality Improvement Days present an opportunity for staff delivering care to discuss issues around the effective use of patient feedback, and also as a means to communicate patient feedback to staff delivering care. Quality Improvement days can also be used to inform staff how feedback from patients/service users has been used to make informed decisions within their department/directorate. We believe that the basic approach of Healthwatch Birmingham's Quality Standard for PPI has some questions that might help the Trust to develop this further. The Quality Improvement Days can discuss whether:

- there is a clear strategic approach for PPI that staff understand across the Trust?
- staff understand what their responsibilities are in relation to PPI?
- they have set objectives for PPI that are regularly monitored?
- they understand how PPI informs decision-making in their service area to make improvement and address inequality? and,
- they understand that improvements or changes made as a result of feedback should be shared with patients and the public?

Trust Performance against standards and CQUIN
Similar to our response to the 2016/17, we are concerned that the Trust has failed to meet standards in a number of areas that have the potential to lead to variability in the quality of care leading to poor health outcomes. We note that there has been some improvement in falls, and falls with injuries, due to improvement in safety checks and assessments. However, there are other key areas where the Trust has failed or partially achieved its target. Such as:
Meeting the four hour A&E waiting times commitment to patients

- Cutting delayed transfers of care
- Implement the improvement plans to reduce avoidable mortality in surgery, cardiology, deaths due to sepsis and perinatal mortality
- The percentage of patients who met the criteria for sepsis screening, and were screened for sepsis, and the percentage of patients found to have sepsis following a screening and received IV antibiotics within one hour
- Creating a more engaged workforce
- Implementing an activation system for patients with long term conditions, such as HIV, to enable better outcomes (activate patients knowledge, skills and capacity to manage their own condition).

Regarding inspections, we note that the Trust was inspected in March 2017 by the CQC and a report published in October 2017. The Trust is still rated 'requires improvement'. We recognise that 70% of services are rated good or outstanding (i.e. end of life care is outstanding; imaging and surgery services is good; caring domain is outstanding). Equally, the safety domain has improved from inadequate to requires improvement. However, community inpatient wards have now been rated inadequate.

We note that the Trust has worked to address the actions detailed in the CQC report. Although the aim was to deliver actions by March 2018, we see that the Trust is facing problems with the following:

- Addressing the requirement for substantive middle grade staff overnight in A&E departments
- Working with other Trusts to implement Service Level Agreements (SLA) to provide paediatric ophthalmology cover out of hours and substantive posts in hours.

Healthwatch Birmingham is particularly concerned about the impact delays in the building of the Midland Metropolitan hospital is having on access and quality of services. For instance, failure to finalise Sandwell Treatment Centre locations and the seven day hospital service. More concerning is that failure to move to the new hospital means that high dependency patients cannot receive ongoing reviews by a consultant. Considering that the opening of the new hospital might be further delayed (reports says until 2022), the Trust needs to develop a plan to ensure that access to services and quality of care does not suffer. Alongside this, the Trust should ensure that they are prepared for the new hospital with the right staff skills mix and numbers.

We look forward to reading about improvement on these in the 2018/19 Quality Account, in addition to the missed targets above.

In our response to the 2016/17 Quality Account we were concerned that the Trust had only carried out 68.3% mortality reviews against a target of 90%. We argued that reviews are an important tool for ensuring that learning occurs and helps improve the quality of care. We note that mortality reviews have further decreased to 44% in 2017/18 from 61% in 2016/17 (against a target of 90%). We also note that there have been three never events against a target of zero, and mixed sex accommodation breaches have increased from 51 in 2016/17 to 314 in 2017/18.

We note the process the Trust takes when a death occurs, the learning points identified and actions taken. However, it is not clear how and when the Trust involves families and carers in the review or investigation process. We ask that the Trust demonstrates how it follows the NHS National Guidance on Learning from Deaths regarding family and friends. The guidance states: "Providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken"

Involving families and carers in case reviews and investigations offers a more rounded view and understanding of patient experience. We would like to read in the 2018/19 Quality Accounts, how families and patients have been involved in various stages of case reviews and investigations. In addition, how the Trust weights families' and patient's views, compared with how they weight the views of clinical staff.

The Trusts Priorities for 2018/19

Healthwatch Birmingham has taken note of the Trust's priorities for 2018/2019. We believe that a continued focus on improved outcomes for patients with signs and symptoms of sepsis; improving the consistency of care (correct documentation and risk assessments); and listening to patients experiences to help improve patient care are important. In particular, plans under the listening to patients priority, namely to listen and act on experiences heard through PALS, complaints and friends and family test. Including plans to complement this by introducing 'Purple Points' which are a phone based system accessible from all in-patient areas. This will enable patients and carers to raise concerns or compliments about the care or information provided to them at that time.

To conclude, Healthwatch Birmingham would like to commend the Trust for taking action in response to some of our comments on the 2016/17 Quality Accounts. It is positive to see examples of the use of feedback to make changes, learning from complaints and death, and actions taken in response. We would like to see further improvements in these areas in the 2018/19 Quality Account.

As per our role, Healthwatch Birmingham is running various projects to support providers in Birmingham to meet their statutory role of consulting/engaging with patients and the public. Consequently, ensuring that Trusts are using public and patient feedback to inform changes to services, improve the quality of services and understand inequality in access to services and health outcomes. We have worked with some Trusts to review their patient and public involvement process (PPI), identify areas of good PPI practice and recommend how PPI practice can be made more effective. We would welcome the opportunity to explore how we can support the Trust to improve in the year ahead.

Sandwell and West Birmingham CCG

This Quality Account, prepared by Sandwell and West Birmingham Hospitals Trust (SWBH), is a true reflection of the work undertaken by the trust during the 2017/18 contract year.

SWBH engages fully and openly with its CCG commissioners, providing opportunity for dialogue at both a contract and locality level, via CQRM, and CRM meetings.

SWBH has demonstrated its commitment to quality by the introduction of a number of quality improvement schemes during the year, including: The 'Purple Points' initiative, which improves the way patients and carers can raise issues or concerns about patient care; and the continuation of Quality Improvement Half Days (QIHDs), which provide opportunities for multi-disciplinary teams to develop innovations or improvements to service. The Trust has also seen a significantly reduction in the number of complaints it has received, and has also seen a significant improvement in PROMS (Patient Reported Outcome Measures).

During the 2017/18 contract year, the CCG wishes to acknowledge and congratulate SWBH on their continued reduction of patients experiencing pressure damage and pressure damage resulting in significant harm; their continued progress on reducing hospital acquired infections (with low numbers of C-Diff and MRSA infections acquired by patients in 2016/17; the Trust's success in achieving their strategic priorities in relation to: Implement the safety plan in all inpatient areas (including community wards) so that patients have all safety checks as standard; Deliver reductions in wait time and improved productivity through successful execution of our annual production plan for elective care; and Reduce agency spend by £10m during the year. The CCG also wish to acknowledge the Trust's moderate success in achievement against most National CQUIN schemes for 2017/18.

The CCG also wishes to recognise and acknowledge the challenges faced by SWBH to: improve Mortality Index scores; to achieve the emergency care 4 hour wait target; to continue to address workforce issues - notably sickness absence and numbers of agency staff; improving safety in relation to patient falls, and to improve average adjusted health gain scores against PROMs indicators. The CCG also wishes to acknowledge the challenges faced by the Trust due to the pause in construction work of the Midland Metropolitan Hospital and the impact this has had across the organisation. The CCG wishes to acknowledge the CQC inspection of March 2017, which led to an overall Trust rating of 'requires improvement', but recognises the significant improvements that have been made as well as the excellent rating awarded to the End of Life Care service, which received a score of 'Outstanding'.

Looking forward, the CCG welcome the Trust's Quality Plan Objectives for 2017-20, its aspiration to: reduce avoidable deaths in hospital so Trust is in the top 20% of comparable Trusts; deliver better quality outcomes, so that Trust is in top 20%; continue to improve Patient Reportable Outcome Measures so that the Trust falls within the top 20% of comparable organisations nationally; implement the electronic patient record; and ensure that work continues in relation to achieving 'Seven Day' hospital standards.

Trust response

We welcome the comments from our partners relating to our Quality Account. Understanding and improving the experience of our patients, their carers and families is really important to us. We look forward to working with our partners over the next 12 months as we work to continue to improve the services we provide for our patients through the delivery of our Safety Plan and our quality and safety priorities for 2018/19.

Independent Practitioner's Limited Assurance Report to the Board of Directors of Sandwell & West Birmingham NHS Trust on the Quality Account

We have been engaged by the Board of Directors of Sandwell & West Birmingham NHS Trust to perform an independent assurance engagement in respect of Sandwell & West Birmingham NHS Trust's Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the following indicators:

- rate of clostridium difficile infections;
- percentage of patient safety incidents resulting in severe harm or death

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health and NHS Improvement guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from commissioners dated 25/05/2018;
- feedback from local Healthwatch organisations dated 21/05/2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated Quarter 1 2017/18, Quarter 2 2017/18, Quarter 3 2017/18 and Quarter 4 2017/18;
- the national patient survey dated 2017;
- the national staff survey dated 2017;
- the local staff survey dated June 2017 and March 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 04/05/2018;
- the annual governance statement dated 25/05/2018; and
- any other information obtained during our limited assurance engagement.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Directors of Sandwell & West Birmingham NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Sandwell & West Birmingham NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;

- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sandwell & West Birmingham NHS Trust.

Our audit work on the financial statements of Sandwell & West Birmingham NHS Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Sandwell & West Birmingham NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Sandwell & West Birmingham NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Sandwell & West Birmingham NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Sandwell & West Birmingham NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Sandwell & West Birmingham NHS Trust and Sandwell & West Birmingham NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Birmingham

25 May 2018

Accountability Report

Corporate Governance Report

Director's Report

The Trust Board meets monthly. The Chair of the Board is Richard Samuda and the Vice-Chair is Olwen Dutton. Professor Thomas, a new Non-Executive Director was appointed from the University of Birmingham to the remaining vacancy.

Non-Executive Directors: Board and Committee attendance

	Trust Board	Remuneration and Terms of Service	Audit and Risk Management	Quality and Safety	Finance and Investment	Charitable Funds	People and Organisation Development	Major Projects Authority	Public Health, Equality and Community Development
Richard Samuda, Chair	11/12	1/1		4/12	9/13	5/5	3/4	4/7	2/5
Olwen Dutton, Vice-Chair	10/12	1/1	2/5	11/12					
Prof Kate Thomas, Non-Exec Director	6/10	1/1							5/5
Mike Hoare, Non-Exec Director	9/12	1/1		2/5	9/13			5/7	
Harjinder Kang, Non-Exec Director	10/12	1/1	3/5		8/13		4/4		
Waseem Zaffar, Non-Exec Director	10/12	1/1	4/5			5/5			2/5
Marie Perry, Non-Exec Director	10/12	1/1	5/5	6/8	7/13				

	Trust Board	Quality and Safety	Finance and Investment	Charitable Funds	People and Organisation Development	Major Projects Authority	Public Health, Equality and Community Development
Toby Lewis, Chief Executive	12/12				3/4	5/7	3/5
Rachel Barlow, Chief Operating Officer	12/12	11/12	10/13		3/4	5/7	
Kam Dhami, Director of Governance	11/12	10/12					
Raffaela Goodby, Director of People and OD	11/12		8/13		2/4	5/7	4/5
Elaine Newell, Chief Nurse	9/12	11/12		4/5	3/4		2/5
Tony Waite, Director of Finance	12/12	7/12	13/13	3/5		6/7	
Dr Roger Stedman, Medical Director*	7/7	6/7		1/5		3/7	2/5
Dr David Carruthers, Medical Director**	3/3	1/3				1/2	

KEY	
*	Stepped down from position as Medical Director in November 2017
**	Appointed as Medical Director from January 2018

The Trust Executive Group (at 1st April 2018) is:

- Toby Lewis, Chief Executive Officer (Board Member)
- Rachel Barlow, Chief Operating Officer (Board Member)
- Dr David Carruthers, Medical Director (Board Member)
- Tony Waite, Finance Director (Board Member)
- Raffaela Goodby, Director of Organisational Development (Board Member)
- Kam Dhami, Director of Governance (Board Member)
- Paula Gardner, Chief Nurse (Board Member)
- Ruth Wilkin, Director of Communications
- Alan Kenny, Director of Estates and New Hospital Project
- Mark Reynolds, Chief Informatics Officer
- Dave Baker, Director of Partnerships and Innovation

The members of the Audit and Risk Management Committee at 31 March 2018 were Marie Perry (Chair), Olwen Dutton, Harjinder Kang and Waseem Zaffar.

Committee	Purpose
Trust Board	The Trust is led strategically by the Board with Non-Executive Directors and the Executive Team working collectively to drive the strategic direction of the Trust and ensure high quality patient care, safe services and sustainable financial management over the medium/long term. The Board meets monthly.
Audit and Risk Management Committee	The Committee provides oversight and assurance in respect of all aspects of governance, risk management, information governance and internal controls across Trust activities. The committee meets five times a year.
Quality and Safety Committee	The Committee provides oversight and assurance in respect of all aspects of quality and safety relating to the provision of care and services to patients, staff and visitors. During this year the Committee has contributed to the development of the Trust's Quality and Safety Plans which form core pillars of the Trust's strategic direction. The Committee meets monthly.
Finance and Investment Committee	The Committee provides oversight and assurance in respect of the Trust's financial plans, investment policy and the robustness of major investment decisions. The Committee has retained a sharp focus on the Trust's delivery against its Long Term Financial Model. The Committee meets monthly.
Charitable Funds	The Committee provides oversight and assurance in respect of how the Trust's Charitable Funds are invested to the benefit of patients in accordance with the wishes of donors. The Committee meets quarterly.
People and OD	The Committee provides oversight and assurance of delivery against the Trust's workforce and OD strategies, including the programme of workforce transformation, recruitment and retention and sickness absence management. The Committee meets quarterly.
Major Projects Authority	The Committee provides the Board with assurance concerning the strategic direction of the Trust. Specifically implementation of the Electronic Patient Record system "Unity" and to support the project to establish the Midland Metropolitan Hospital (MMH). MPA ensures that programmes of work/reconfigurations are consistent with the long term direction towards the new hospital. The committee meets bi-monthly.
Public Health, Community Development and Equality Committee	The Committee provides oversight and assurance regarding plans to drive holistic public health interventions and the Trust's equality ambitions. The Committee meets quarterly.
Remuneration Committee	The Committee advises on the terms and conditions of employment and remuneration packages for the Chief Executive and Executive Directors. The Committee meets as and when required. The Remuneration Committee met once in 2017/18.

REGISTER OF INTERESTS 2017/18

Name/Title	Purpose
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 and 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 and Procurement - Consumer Council for Water
Waseem Zaffar	• Elected Councillor – Lozells & East Handsworth Ward (Birmingham City Council) • School Governor at Heathfield Primary School. • Member of 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 Review – University of Keele • Trustee - Medical Schools Council Assessment Alliance
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 and 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
Executive Directors	
Mark Reynolds (Chief Information Officer)	None
Alan Kenny (Director of Estates and New Hospital)	None
Ruth Wilkin (Director of Communications)	None
Dave Baker (Director of Partnerships and Innovation)	None

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Toby Lewis
Chief Executive
25/05/2018

Annual Governance Statement 2017/18

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sandwell and West Birmingham Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sandwell and West Birmingham Hospitals NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

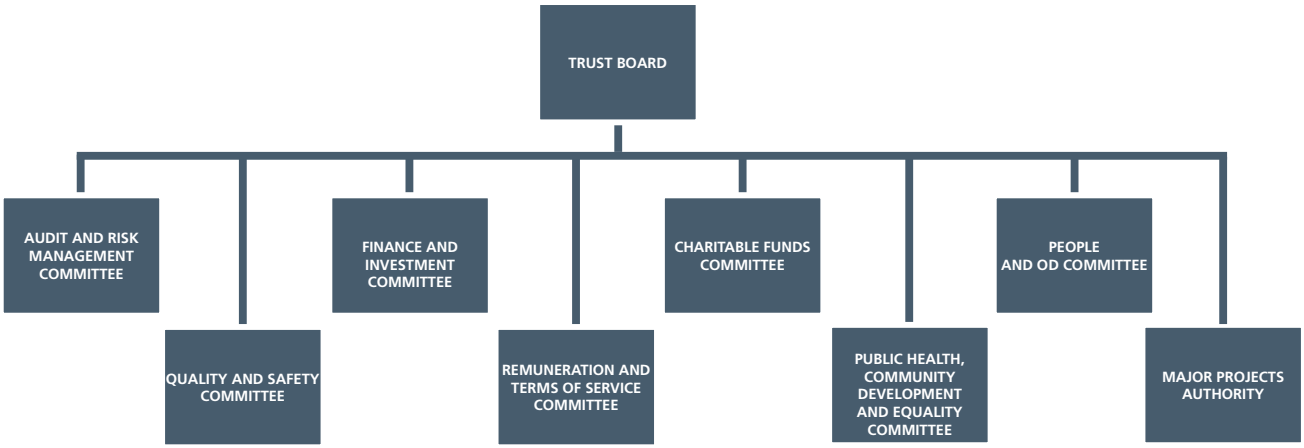
Assessment of effective governance framework

2017/18 saw continued collaborative working through the Black Country Provider Partnership with counterparts in Dudley, Wolverhampton and Walsall and through the Black Country (and West Birmingham) STP. I continue to meet on a regular basis with the CCG Accountable Officer and representatives of the two local authorities to drive forward joint working through which health and social care services are more closely integrated to ensure timely and effective care pathways that meet the collective needs of the users of our services and their families and carers. To a much greater degree than in prior years we have held structured review meeting with primary care partners, which have given rise to changes and projects, including a memorandum of understanding with the Modality GP partnership, which we are in process of expanding across willing general practice colleagues in western Birmingham.

The structure of our governance working alongside Cerner and with the Hospital Company is understandably in focus, given delays with both deployment of Unity and the opening of Midland Met. The formal liaison committee for the latter development has met on numerous occasions, and the Trust has routinely attended as of right the board meetings of the SPV. A single Board committee, the major projects authority, oversees both developments, among other roles, and that committee has now moved to a monthly rather than bi-monthly footing.

The Trust is led strategically by the Trust Board. The Board sets out the strategic direction of the Trust. Below the Board there are 8 Board committees (figure 1) which serve an overview function against our 2020 Vision, and supporting plans. This structure is designed to ensure open and frank challenge from across the Board on progress against our agreed ambitions as a Trust.

Figure 1



One new Non-Executive Director joined the Trust Board in 2017, Professor Kate Thomas. Kate is the Vice Dean and Programme Director for the MB ChB medical degree programme at the University of Birmingham. Kate is now Chair of the Public Health, Community Development and Equality Committee. Dr David Carruthers joined the Trust Board as Medical Director in January 2018. The full membership and attendances at Trust Board and its committees for the year are outlined on page 68.

The Board's governance model continues to evolve in a planned and structured way to ensure focus and deliver against the Trust's key priorities. In addition we spend considerable time as a Board on informal learning and visit and view time with clinical services. At Board development sessions we have focussed on the membership and efficiency of our Trust Board and Committees, and as part of this work aligned our Non-Executive members to ensure maximum effectiveness/benefit (challenge and assurance) across our governance structure. All Board meetings include patient feedback, typically through a specific story of relevance to the work of the organisation or its partners.

The committees provided effective governance reporting to the Trust Board throughout 2017/18.

- The Quality and Safety Committee has retained a strong focus on safe staffing and the quality of care. During this year the Trust has monitored implementation of the Safety Plan and CQC Improvement Plan, and will focus in 2018-19 on our quality plan.

- The Finance and Investment Committee retains a focus on the Trust's financial position and the measures being taken to ensure the Trust manages the financial challenges that continue to face the NHS locally and nationally. This includes the wider system challenge set out in the "GE Report" which reviewed delivery of the full business case.

- The People and OD Committee has oversight of the Trust's People Plan. The committee also has oversight of the actions being taken to address skill shortages in areas for which there is a national as well as local shortage. It also takes delegated responsibility for education and the doctors' hours guardian's work.
- The Charitable Funds Committee has oversight of the work underway to develop a more streamlined fund, and monitoring the Midland Met appeal.
- The Public Health, Equality and Community Development Committee has focussed on volunteering, equality and diversity objectives and oversight of progress against the Public Health Plan.
- The Audit and Risk Committee has retained a focus of issues including business continuity planning, information governance, the Board Assurance Framework (BAF), key accounting judgements, a review of Standing Orders and Schemes of Delegation and overseeing both internal and clinical audit programmes.
- The Major Projects Authority played an important role in oversight of the build for the Midland Metropolitan Hospital and oversight of key transformation projects such as the implementation of the Electronic Patient Record system "Unity".

The pivotal decision making role of the Clinical Leadership Executive (CLE) continues to evolve, and become both more visible and increasingly interactive. Operationally the Trust delivers care through seven Clinical Groups, each then sub-divided into directorates. The corporate group is our eighth and comprises seven directorates. Clinical services report to the Board through the Chief Operating Officer, who is supported by our Chief Nurse and Medical Director as an executive triumvirate. Since February 2018, the six Group directors have attended the private sessions of the Board – a measure designed to ensure full clinical engagement with the commercial challenges faced by the Trust.

Capacity to handle risk

The Risk Register is reported to the public Trust Board every month as well as the Audit and Risk Management Committee on a quarterly basis. The Risk Register is considered alongside the Trust's Integrated Quality and Performance Report providing a rounded assessment and challenge to Trust performance and progress against key objectives. We continue to devote time at public Board meetings on pre mitigated red risks to test whether mitigation plans are sufficiently robust to provide assurance around the direction of travel on an issue. These risks have been previously examined through the executive Risk Management Committee, and assessed collectively at the CLE.

As of 31st March 2018 the Risk Register had 19 key risks which were reported against monthly at Board level, 8 these had red residual risk scores after mitigation. These related to:

- Unfunded beds with inconsistent nursing and medical rotas, and spend relating to unfunded beds;
- The Trust's recent financial performance has significantly eroded cash balances and which were underpinning future investment plans;
- Financial implications to the Trust if the pay cost improvement programme is delayed or not delivered.
- Children-Young people with mental health conditions are being admitted to the paediatric ward due to lack of Tier 4 bed facilities;

The first three now have credible immediate action plans. As in prior and recent years, the Trust is unable to convincingly provide services to young people with complex psychiatric conditions attending our services for triage, but with no obvious onward ward plan.

Headline mitigating actions are reported and challenged at the Board and the Audit and Risk Management Committee. This reporting has led to focused challenge by the Board around sickness absence, financial performance and service delivery quality which means I am satisfied that this reporting is generating robust challenge over our performance on a regular basis.

New risks escalated to the Board in year included risks in respect of:

- Lack of results acknowledgement;
- Spend relating to unfunded beds.

Risks that have been the subject of repeated challenge by the Board have included:

- Trust wide implementation of a new Electronic Patient Record;
- Unfunded beds with inconsistent nursing and medical rotas;
- 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;

Risks that have been managed down during 2017/18 and which are now being managed by the Groups include:

- Reduced ability to provide an Interventional Radiology service as a result of difficulties in recruiting Interventional Radiology consultants;
- Differential and extended chemotherapy wait times between sites due to staff vacancies results in inequality of service for patients.

The Trust continues to use an electronic risk system. This enables clinical groups and corporate directorates to import their risk registers and update mitigating actions directly on to the system. There remains more work to do to make that process interactive with front line staff.

The Trust Board receives our two year Strategic Board Assurance Framework at our meetings held in public. These high level organisation-wide risks are discussed at our Board sub-committees where Executive leads provide regular updates on actions/mitigation to address our strategic risks.

Risk and control framework

Cyber Security

The Trust completed its annual cyber security inspection undertaken by an external firm and an action plan to address issues raised during the inspection will be implemented during 2018/19. The report was more adverse than expected, and the Major Projects Authority will oversee in some detail the work being done by the Chief Information Officer in Q1 on this matter.

Counter-fraud and probity

The Trust is supported through its Internal Audit function by a Counter Fraud service that reports routinely to the Audit & Risk Management Committee. The Trust continues to successfully prosecute former Trust employees who have found to have committed fraud. The Trust Board and Clinical Leadership Executive have all completed their annual declarations of interest for 2017/18.

Whistleblowing and duty of candour

The Trust continues to invest in an independent reporting system which enables staff to raise whistleblowing concerns. Matters that are raised as whistleblowing concerns have been considered and addressed, and anonymised survey data from staff shows high levels of confidence in our system, responsiveness and integrity. Our Speak Up day brand is designed to amplify that confidence further, and in Q3 2017/18 we undertook a detailed look back exercise, reporting in full at the Board, of prior concerns expressed by staff and flagged by them as still "unresolved".

Eight Freedom to Speak Up guardians have been appointed across the Trust. These nationally mandated roles are scaled to provide a peer group, bandwith, and crucially a guardian in each Group – tackling the key challenge, which is responsiveness to concerns 'in the middle' of our Trust. Our reporting to the national Freedom to Speak Up Guardian process has been weak in the early part of the fiscal year, but the process is now resolved.

I am confident that as a Trust we continue to meet the requirements in respect of the duty of candour.

Coroner Regulation 28 Reports

Deeply regrettably in the last fiscal year we have had two regulation 28 reports from the Coroner.

One case related to care provided by the Trauma and Orthopaedic Team in relation to a failure to consent the patient and complete pathway documentation. A Safety Summit, which I chaired, took ownership of a plan of changed practice, which has been reported routinely since to the Board's quality and safety committee. Progress has been strong.

The other case related to a failure to follow the head injury pathway in the Emergency Department, due to a delay in undertaking a CT scan of the head and a delay in providing a neck collar. This is the second such case in two years, and the fourth such serious incident. This report was received at the end of March 2018 and a formal response and action plan will be in place in Q1 of 2018/19. The medical director will take personal responsibility for ensuring that the agreed plan is implemented in full and the clinical audit function will undertake a review of compliance during Q2.

Ombudsman Investigations
In 2017/18 the Parliamentary and Health Services Ombudsman (PHSO) opened 12 investigations on complaints made previously to the Trust (of which we have around 1000 each year). Five cases each in Medicine and Emergency Care and Surgical Services, with one each for Women & Child Health and Corporate Nursing.

During the same period, 8 PHSO cases were concluded, with four being found in favour of the Trust's extant response. Of the others, one required an apology, and the other 3 required remedial action to be taken as a result of the failings found, which included financial remedy. The tracking of action plans from PHSO cases will be a specific matter for the Executive Quality Committee which meets monthly.

Health and Safety Executive Review
There have been no Health and Safety Executive on-site reviews in 2017/18. Further information was requested in December 2017 regarding a splash incident.

Safeguarding and Deprivation Of Liberty
We note the comments made by the Care Quality Commission in their report of 2017. Our own reviews prior to that inspection and since have found a more positive perspective, both on staff awareness and implementation of the policies we have, which reflect the law as it has emerged. The Board continues, through its visits, and audit review, to take a keen interest in this area, and to review quantitative and qualitative data. We have also reviewed our registration arrangements in respect of mental health patients and are progressing adjustments to ensure that we have in place what is required for our evolving role.

Equality and diversity
Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust has made considerable progress in work to support staff and patients with protected characteristics. We have completed on time our WRES and Equality Act annual reports, as well as responding to the Pay Gap review. These are all matters considered by both a board and an executive committee. We have invested in infrastructure not only to advance our management plans in this area, but also to support our three (soon to be four) employee networks.

Information governance

Information security and data protection
There are clear arrangements for information security within the Trust, including distinct roles for our Senior Information Risk Owner (SIRO), the Director of Governance and Caldicott Guardian, the Medial Director. Breaches and near miss issues are identified, acted upon and drawn as required to the attention of the relevant Board committee. The Trust's risk register process includes assessment of information security and data protection issues.

I can confirm that no level 3 incidents were reported to the Information Commissioner's Office in 2017/18.

The Trust's latest Information Governance Toolkit self-assessment declaration has led to an improvement on the previous year's score with the self-assessment score now at 93%. I am satisfied that sustained improvement has been achieved. That said, we will track in detail the opportunities and risks associated with GDPR.

The Trust has undertaken an assessment of the changes in General Data Protection Regulation (GDPR) and an action plan is in place to review our information processes and to work towards compliance as detailed in the Information Commissioner's Office (ICO) paper '12 Steps to Preparing for GDPR' which compliance will be reported on as part of the next Annual Governance Statement (2018/19 Annual Report).

Data Quality
The Trust 'Performance Indicator Assessment process, the Data Quality Kitemark' provides assurance on underlying data quality and performance assessment. Each indicator is assessed against seven data quality domains to provide an overall data quality assurance rating which is included in the Integrated Quality & Performance Report.

The Trust is in the process of developing a data quality improvement plan to ensure continuous improvement in performance information, this will be in place during Q2 of 2018/19. The continued development of the Integrated Quality & Performance dashboard provides assurance of accuracy and risks of data reporting from patient (including elective waiting times) and staff level to Trust position. The Trust audit plan includes a rolling programme of audit against all performance and quality indicators.

Data quality continues to be the focus of Board time in providing effective oversight and challenge. One of the key areas of assurance reporting to the Board is the safe staffing levels across the Trust provided through a report to each Board meeting with the matter subject to challenge at every public Board meeting. The move to a focus on care hours will make this work increasingly relevant to the quality of care experience that we are able to offer.

Annual accounts, including quality account
As in prior years, under the Health Act 2009 and the National Health Service (Quality Accounts) Regulation 2010, we have a clear and well understood process for settling our financial and quality accounts. We would expect to receive an unqualified opinion, notwithstanding material judgements to be made about the value placed on the stalled Midland Met development. Assurance has been provided to the Trust Board that the Quality Account presents a balanced view and appropriate controls are in place to ensure the accuracy of data.

Review of economy, efficiency and effectiveness of the use of resources

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit and Risk Management Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

There have been 3 Never Events in 2017/18. Our governance arrangements, which had been agreed with regulators early in 2017 after external review, were again revised. Our Serious Incident process was amended at the start of 2017/18, and the effectiveness of those changes will be tested by the Board in Q1 of 2018/19, with the help of a slightly delayed external review. I would expect that to suggest improvement opportunities in how we track and respond to amber incidents, and we have in mind changed arrangements which we can implement in the first half of 2018/19, after good work to resolve incident reporting investigation backlogs against our 21-day standard. We continue to see all incidents reported in SWBH circulated each morning across the whole senior leadership of the Trust, providing an absolute focus on the importance of incidents as an insight into both care and staff experience.

More generally, or rather applying rigour to more episodes of care, we have implemented our bed-wide Safety Plan metrics with considerable, and increasing, success in year. The vast majority of inpatient care now benefits from these standards, and the 'chasing down' of missed checks testifies to a belt and braces approach. The implementation of Unity will strengthen that approach. Meanwhile, our work on patient documentation through our Consistency of Care work and the work being done to meet all of our District Nursing Key Performance Indicators confirms a continued focus on the important basics of patient care.

I can confirm that the Trust is fully compliant with the registration requirements of the Care Quality Commission.

Our overall Care Quality Commission (CQC) rating was Requires Improvement. 70% of Trust services are rated good or outstanding. Within that, we improved in three of five categories, achieving outstanding for caring, and, of relevance to the annual governance statement, a good rating for the well-led measure. As at March 2018, 106 of the recommendations and issues arising from the CQC report have been delivered with the issues addressed. In 23 areas improvements/ changes have been implemented but further evidence is needed around the impact of these changes for patients.
There remain two areas where further work or a different approach may be required to succeed; providing out of hours Paediatric Ophthalmology cover and substantive recruitment of middle grades in our Emergency Departments.

There has been robust enforcement of the use of bank and agency staff, along with requests for substantive posts being signed off by myself as Accountable Officer through a vacancy assessment process. These are is enforced whilst always ensuring patient safety, in particular through the use of rolling adverts for key high risk roles (a register of which is reported monthly to the Board). There has been a significant reduction in the overall expenditure on bank and agency staff during the year – more than halving our position against 16/17 outturn, and a similar rate of improvement is needed in 18/19. The Trust's compliance against the agency framework cap is reported routinely to the Board's Quality and Safety Committee. Systemic action has been taken to remove payments that are above the framework cap, which also require authorisation from myself as Accountable Officer.

Our ability to exercise centrally, and localise intelligently, financial controls will be enhanced, we hope, by the implementation of our new financial system. This will permit routine reporting on compliance with our SFIs by requisitioner. This will address the non-pay control concerns that I reported in our 2016/17 Annual Governance Statement. Beyond this our payment compliance arrangements, for both contracts and employees, are strong. Any transition to shared service models over the coming year must maintain that grip.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

The trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Finally, looking into 2018/19, and based on weaknesses evident in 2017/18, I would highlight three residual areas of control concerns:

- The liquidation of Carillion Construction on 15th January 2018 has resulted in a significant impact/delay to the completion of the Midland Metropolitan Hospital. A substantial amount of remedial and negotiation work has taken place between the Trust, several Government Agencies, Legal Advisors and the Hospital Company Ltd to put in place a new contractor in adherence to procurement legislation, and timeline for completion of the new hospital within an agreed budget. This has been reported regularly to the Trust Board and will continue to be our most significant focus for the Trust in 2018/19. The considerable and ongoing delay in reaching agreement creates a series of risks to safety, finance and estate for the Trust which we had previously considered mitigated through the FBC. It makes it probable that we will inherit direct control for a period of a part built site and will need to develop a control regime sufficient to maintain that site and keep it ready for completion.

- The sufficiency and remedy of our IT infrastructure dominates day to day life inside the organisation. Identified by the Board in 2014-15 and fully funded since the underlying position is much improved. However, the operational impact of ageing architecture and botched prior remedy is if anything worsening in its impact on the patient, and mainly the staff, experience. A regime to track and pre-identify issues is in place but it will take the whole of 2018/19 to address in full the currently identified amber issues. Deploying Unity may surface new or additional issues and the non-retained estate vacation delay creates further risk.

- We are seeking to build up budgets at an ever more accurate and ever more local level, holding risk centrally only where that is truly unavoidable. This moves us away from a long term tradition of corporate reserves deployed throughout the year into positions as adjustments. This transition creates unanticipated effects and demands new actions and behaviours. We will spend the year working that through, against a promise to adjust budgets very rarely 'in flight'. The change will demand ever more accurate real time data, and will be accompanied by changes to how and what we code, made possible through Unity. It will be important to construct this more directorate based system without losing control.

Conclusion

I have set out some specific control issues that are a focus currently and for the coming year. On that basis I am able to confirm that there are effective systems in place for the discharge of statutory functions with these having been checked for irregularities and to ensure they are legally compliant. These systems of internal control underpin our work to continue to enhance the quality of care we deliver to the communities of Sandwell and West Birmingham.

I confirm that, as far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the trust's auditors are aware of that information. I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed

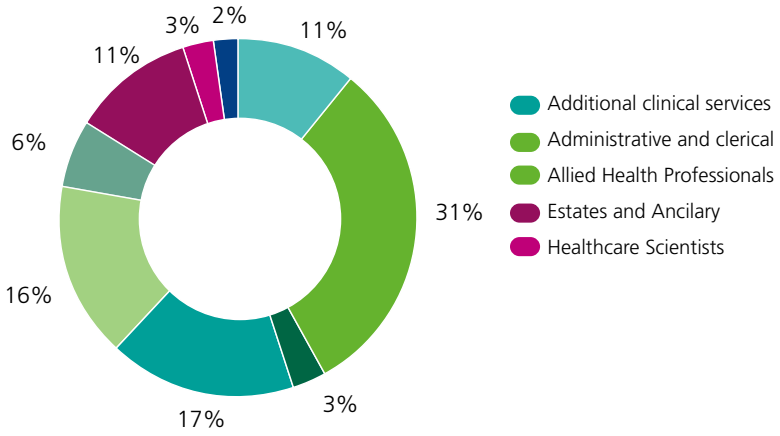
Toby Lewis Chief Executive (On behalf of the Board)

Our workforce

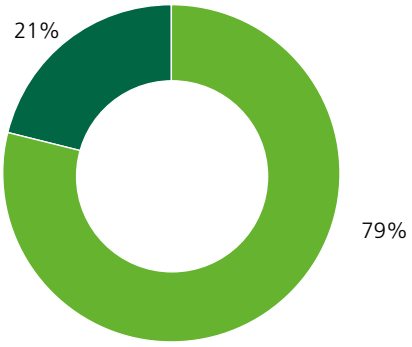
Our workforce are our biggest assets and we invest heavily in education, development and health and wellbeing services for all colleagues.

About our workforce

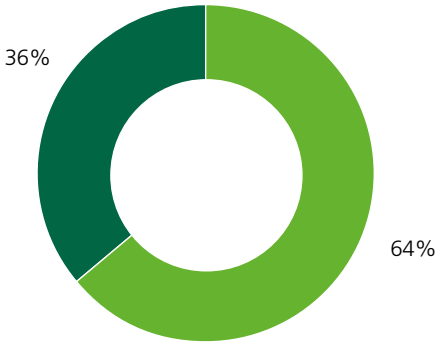
Workforce profile 2017/18



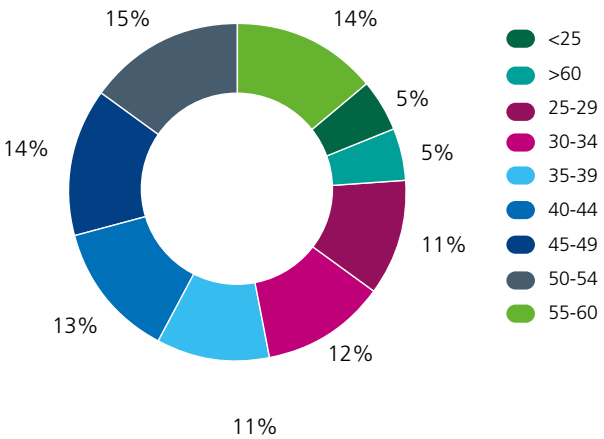
All employees gender profile 2017/18



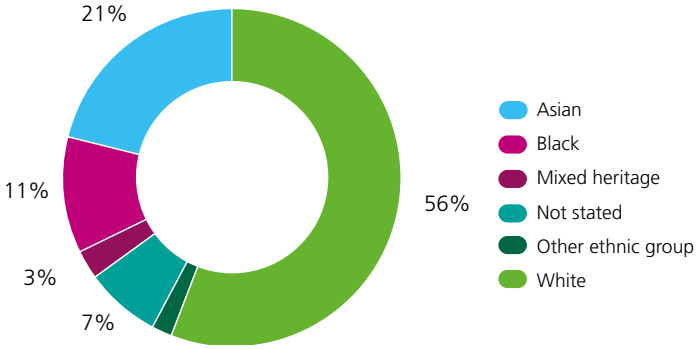
Directors gender profile 2017/18



Age profile 2017/18



Ethnicity profile 2017/18



Consistency of Care

Susan Grantham, Senior Sister on Priory 4, said: "Our main aim was to make the achievements set out in the Safety Plan, which focused on patient safety throughout their journey within our hospital."

Managers and Senior Managers

Band	Number
Band 7	31
Band 8 - Range A	35
Band 8 - Range B	25
Band 8 - Range C	20
Band 8 - Range D	12
Band 9	10
Directors and Chief Executive	8
Chair	1

Gender pay gap

The aim of publishing the Gender Pay Gap report is to reduce any pay gap and achieve parity between males and females in the workforce. The gender pay report legislation requires all employers with 250 or more employees from April 2017 to publish statutory calculations every year showing how large the pay gap (if any) is between male and female employees within their organisations. A snapshot of data was taken using the NHS Electronic Staff Records system, a specific update was completed in December 2017 to allow

trusts to produce the data required by the legislation. To see the full report go to: https://www.swbh.nhs.uk/about-us/equality-and-diversity-2/meeting-our-legal-requirements.

At the time of the snap shot was taken SWBH had 7,167 employees, the gender split within the overall workforce at that time consisted of 1,571 (22 per cent) male colleagues and 5,596 (78 per cent) female colleagues.

All staff	Median Hourly Rate	Pay Gap
Female	11.46	15.67%
Male	13.59	

AfC	Median Hourly Rate	Pay Gap
Female	11.32	1.03%
Male	11.20	

Medical staff	Median Hourly Rate	Pay Gap
Female	11.46	21.17%
Male	13.59	

Medical staff	Median Hourly Rate	Pay Gap
Female	55.13	11.38%
Male	62.20	

Engaging with our colleagues

Your Voice results show confidence in the care we provide

6,389 colleagues were sent the Your Voice questionnaires in May 2017. Out of these we received 1,203 responses giving an overall response rate of 18.8 per cent - a three per cent rise on the previous survey.

Overall the results are positive with 66 per cent of responders indicating confidence in areas such as:

- The care we provide
- Ability to make suggestions to make improvements within their team
- Looking forward to coming to work

Staff engagement increased by 1.2 percent on the previous survey with 66 per cent of colleagues saying they felt engaged. 67 per cent of colleagues who took part in the survey stated they felt involved and motivated within their teams.

Your Voice helps give an overview of how engaged our teams are and also allows the organisation to respond to concerns in a timely manner. Our clinical groups and directorates ensure teams take part in briefings at which the results are discussed and actions taken forward. For the first time this year we ran a 'You Said We Did' campaign which addressed some of the recurring themes in the feedback from colleagues.

NHS staff survey reveals rise in enthusiasm about working for the Trust

Results for the 2017 NHS staff survey showed an increase in enthusiasm about the work colleagues are doing.

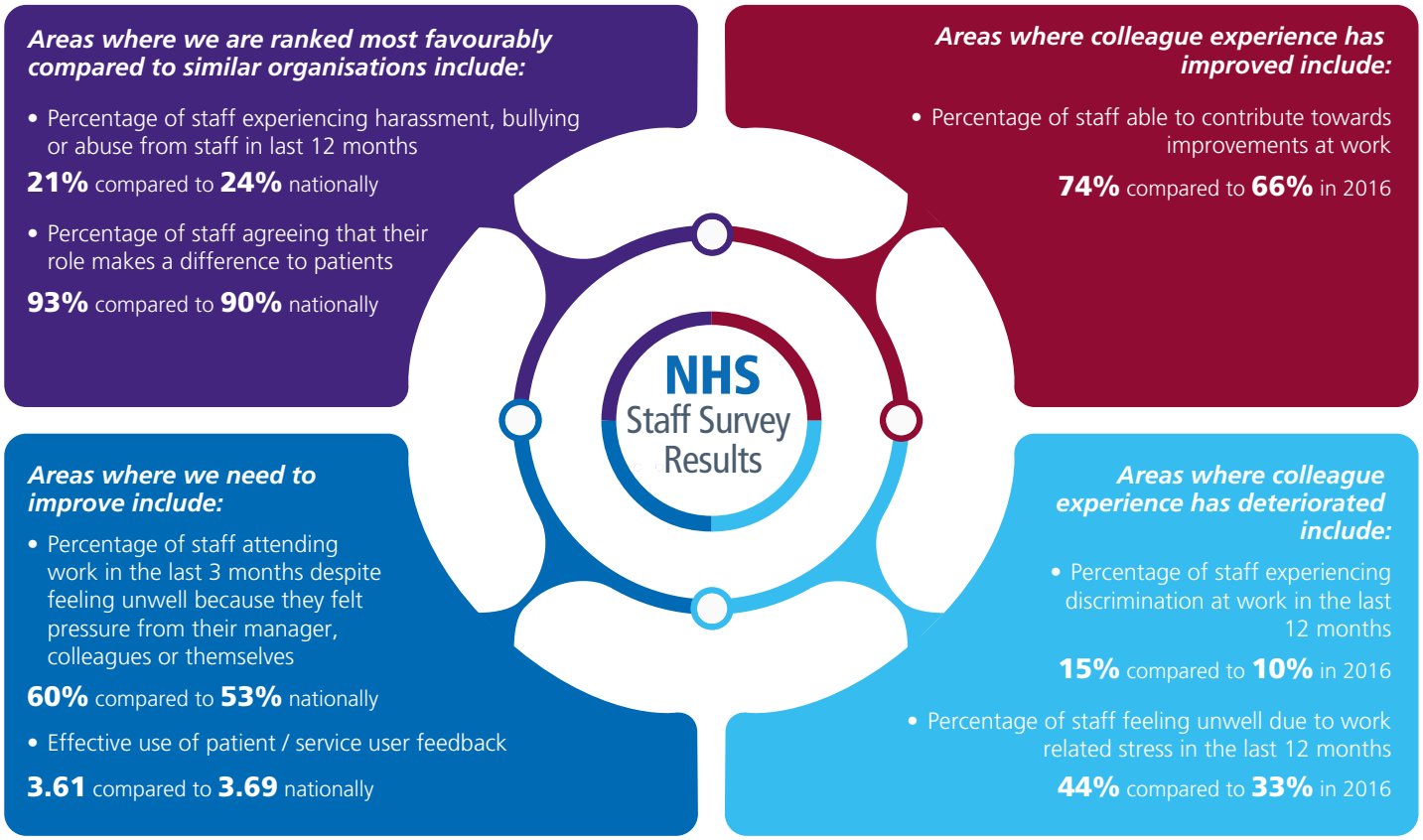
The number of colleagues agreeing that their role makes a difference to patients is 93 per cent which is above the national average.

Our overall indicator for staff engagement remains below average compared to trusts of a similar type. Our score was 3.74 compared to 3.78 nationally. However our engagement score is up from 3.71 in 2016. The engagement score includes:

- Perceived ability to contribute to improvements at work
- Willingness to recommend the Trust as a place to work or receive treatment
- The extent to which colleagues feel motivated and engaged with their work

1,250 colleagues were asked to give their feedback and 341 responded to the survey.

Summary of the findings:



Consistency of Care

Dilly Oakes, Ward Sister D15 and D16, said: "We've seen a real improvement since we've introduced this Consistency of Care plan, especially in our documentation. We've had a nurse in charge on each shift, and we have also carried out spot checks on documentation throughout the day to make sure everything is up-to-date. We've seen a massive improvement in monthly auditing."

Reward and recognition – Compassion in Care Awards
Compassion in Care is an award scheme which celebrates clinical and non-clinical colleagues who excel at consistently upholding the Trust's nine care promises. Colleagues nominate each other for going beyond the call of duty to provide excellent compassionate care.
Each month, a worthy winner is chosen who upholds our nine care promises:

- I will make you feel welcome
- I will make time to listen to you
- I will be polite, courteous and respectful
- I will keep you informed and explain what is happening
- I will admit to mistakes and do all I/we can to put them right
- I value your point of view
- I will be caring and kind
- I will keep you involved
- I will go the extra mile

Between April 2017 and April 2018, we received 68 nominations for the Compassion in Care awards. Winners were presented with a certificate, rewarded with £50 of high street vouchers and were also featured in Heartbeat (our internal magazine). Winners were also put forward as nominees for the annual Star Awards.

Colleagues shine at the Star Awards 2017
2017 saw our biggest ever Star Awards. Over 300 colleagues attended the annual event on 13 October last year. There were 18 award categories including Employee of the Year, Clinical Team of the Year (adults), Clinical Team of the Year (children) and Non-clinical Team of the Year. For the first time, we recognised the work carried out on a daily basis by our hardworking volunteers, by introducing a Volunteer of the Year category.

We had the highest number of nominations in the history of the awards with nearly 500 nominations received. Of these, 117 were from patients, carers and visitors, the highest number ever received for the Quality of Care award which honours colleagues who have improved the outcome of our patients and upheld and demonstrated our nine Care Promises. The award winners were chosen in a selection process involving Healthwatch Sandwell and Healthwatch Birmingham.

We were greatly encouraged to see support from businesses and organisations who helped us raised over £45,000 to help us stage a motivational event that praised and recognised the hard work and dedication of all our teams. One of the teams that attended the awards night were so appreciative they wrote to our chief executive to say: "From all of our team members we would like to thank you for a wonderful evening. Sadly we were not winners, but what a lovely way to boost morale."

SWBH benefits goes saves colleagues money and aids retention of key skills
Following its launch in October 2016 SWBH Benefits now has over 3'000 members in the Trust. The innovative employee benefits programme offers a unique platform that brings all of the benefits of working for SWBH in to one place. Colleagues access discounts at over 6'500 national and regional retailers, with the opportunity to save up to £600 a year. The offer includes all of the our health and well being offers, including smoking cessation, alcohol support, exercise classes, eye tests, access to debt advice and financial well being support, weight management, free yoga and Pilates classes, retirement planning, staff lottery and library services. The scheme also offers salary benefit schemes for cycle to work, car leave, childcare vouchers and smart phones and technology. SWBH Benefits hosts many events throughout the year, and generates sponsorship for the staff awards and local recognition schemes. The scheme has won two national awards and a finalist for three more, with other trusts learning from and adopting this approach.

Promoting mutual respect and tolerance through a focus on inclusion

We launched three employee networks in October 2016 to complement our approach to mutual respect and tolerance. This guidance clearly sets out the values of SWBH in how we treat each other, and expect to treat and be treated by our patients regardless of our beliefs, faith, ethnicity, orientation or any of the protected characteristics. We have supported three staff networks throughout the year by raising awareness, hosting events for staff and patients including marching at Birmingham PRIDE and hosting a recruitment stand, hosting a recruitment stand at Birmingham's Jamaica in the Square and FIESTA event. We have attended inclusion and diversity conferences and host the regional STP equality and diversity group in the Sandwell Education Centre.

During the year we launched a Disability and Long Term Conditions network, for colleagues and for our patients. There are a wide ranging set of pledges to achieve, agreed the board and sponsored by an executive, that will improve the experience of people with a seen or unseen disability or long term condition.

We hosted the first regional 'Stepping Up' Leadership Programme in partnership with the NHS Leadership Academy, and 100 colleagues from the four acute Black Country Trusts are attending a leadership programme to develop their skills. We implemented a policy to have a BME colleague on all interview panels, ensuring that panels are inclusive and reflect our staff and patient community. We have responded to the Workforce Race Equality Standard (WRES) for the second year, and published a Gender Pay Gap Report for the first time.

We celebrated LGBT History Month and Black History Month for the first time ever, celebrating colleagues as well as national and international role models. We have supported the Muslim Liaison Group (MLG) to raise awareness of Islam and the needs of Muslim patients and colleagues, and hosted an awareness raising day to engage and inform colleagues. Over 200 people visited the event and specific support for Ramadan and Eid is planned in partnership with the group.
We won three national awards for our work on Inclusion and Diversity and continues to give executive and non executive support to all employee networks, and plan to launch an Eastern European Network in early 2018.

Our work on Inclusion and Diversity is supported by our valued Patient Local Interest Group (LIG) which is chaired by a patient representative. The group meets on a quarterly basis to examine and scrutinise the work the Trust is doing, and offer challenge and ideas on how the Trust can be more inclusive.

Disability staff network

We value our disabled staff and support a Trust disability network that is focussed on awareness, wellbeing and career development. During the year we appointed a Head of Inclusion and Diversity, whose role is to ensure all our staff networks are supported to achieve their aims.

Application process

We treat all applications for employment equally. Shortlisting is done on skills and experience required for the role and without knowledge of any personal details. At interview stage every panel has representation from our BME workforce.

Counter-fraud and probity

The Trust is supported through its Internal Audit function by a Counter Fraud service that reports routinely to the Audit & Risk Management Committee and supports the implementation of the Counter-Fraud, Bribery and Corruption Policy. The Trust continues to successfully prosecute former Trust employees who have found to have committed fraud. The Trust Board and Clinical Leadership Executive have all completed their annual declarations of interest for 2017/18.

Aspiring for Excellence - New performance development review (PDR) process

We launched a new performance and development review, for all of the workforce, which will ensure that all colleagues have a set of objectives for the year ahead, agreed with their line manager, that they can work towards to aspire for and achieve brilliant patient care. The PDR also measures behaviours of every employee in how they display the Trust's nine promises. These are promises to our patients and promises

Pictured following their participation in our 'Stepping Up' leadership programme from left to right are Nashili Mann, Service Manager, Janice Barrett, Senior Sister, Karen Sylvester, Best Start Nurse Practitioner, Kuldip Bal, Best Start Nurse Practitioner, Janice Nelson, Project Manager, Stuart Young, Head of Diversity & Inclusion, Donna Mighty, Assistant Primary Care Liaison Manager, Aleha Khan, Senior Clinical Scientist.

to each other. The PDR will involve a conversation about development, learning and training needed for the year ahead. During the past year over 750 managers have been trained in how to run the PDR conversation, and all employees have been trained in their role and the importance of the PDR. For the first time ever, all professions within the Trust will undergo the same, rigorous performance assessment, with a score being given for performance (1-4) and potential (A-D). These scores will inform the training needs analysis, workforce plan, clinical service plans and enable us to identify key talent and retain skilled individuals. There are training videos and toolkits available on our intranet and through managers and Staffside colleagues.

New accredited manager programme

The People Plan, theme 4, sets out the Trust's ambition to develop line managers in to high performing individuals who coach and stretch their teams and deliver the best patient care they possibly can. We know that skilled line managers are able to get the best of their teams, enable them to be productive, at work, manage sickness well, recruit great people and govern and manage the money. This is the basis of our Accredited Line Manager programme, which has brought 770 line managers together to undertake five mandatory training modules to develop excellence in people management. The managers were trained in large groups, sharing their experiences and examples of line management, to learn and understand the basics of excellent line management, and their role and responsibility within the Trust. The five modules are

- Aspiring to Excellence - Performance and Development Review
- Recruitment and Retention
- Improving well being and decreasing sickness absence
- Good Financial management
- Governance process and procedure

It is envisaged that equipping line managers with the skills and knowledge to undertake their role well, it will improve the performance and productivity of the workforce and influence the key metrics within the People Plan. The programme has been developed and delivered internally by our own teams.

Consistency of Care

Jini Baiju, sister on Newton 4, said: "On our ward we have been highlighted for our excellent patient care from the Care Quality Commission inspection. However, we did find that our documentation was inconsistent. As a result we have put a number of measures in place to improve this issue. We have introduced audits in every shift, which has improved our documentation."

The Trade Union (Facility Time Publication Requirements) Regulations 2017 took effect on 1 April, meaning that as NHS employers we are now required to publish certain information on trade union officials and facility time.

Facility time covers duties carried out for the trade union or as a union learning representative, for example, accompanying an employee to disciplinary or grievance hearing. It also covers training received and duties carried out under the Health and Safety at Work Act 1974. We have eight (7.48 FTE) employees recorded as taking time off for Union Activities out of a workforce of 6127.11, but recognise that the figure is under reporting true activity levels, so we will be working over the course of this year to improve recording.

TU Official	% Time TU Activities	% Pay Bill TU Activities
Employee 1	0.95%	0.80%
Employee 2	3.15%	2.66%
Employee 3	0.18%	0.15%
Employee 4	7.64%	6.44%
Employee 5	2.67%	2.25%
Employee 6	0.19%	0.16%
Employee 7	1.00%	0.84%
Employee 8	0.08%	0.06%

Modern slavery and human trafficking

We fully support the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it, and supporting victims. In particular, we are strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to date include:

- We confirm the identities of all new employees and their right to work in the United Kingdom, and pay all our employees above the National Living Wage. Our Dignity at Work, Grievance & Disputes and Whistleblowing policies additionally give a platform for our employees to raise concerns about poor working practices.
- We provide training on safeguarding in respect of adults and children which includes reference to modern slavery as a form of abuse. The Trust policy on safeguarding adults provides advice and guidance to front line practitioners to ensure they are aware of and able to respond to incidents of modern slavery within care settings.

Our procurement approach follows the Crown Commercial Service standard and includes a mandatory exclusion question regarding the Modern Slavery Act 2015. When procuring goods and services, we additionally apply NHS Terms and Conditions (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation. Procurement staff receive training on ethical and labour issues in procurement.

Review of effectiveness

We intend to take further steps to identify, assess and monitor potential risk areas in terms of modern slavery and human trafficking, particularly in our supply chains.

In 2018/19, our anti-slavery programme will also:

- continue to provide mandatory training to all staff, both clinical and non-clinical on safeguarding issues including modern slavery;
- continue to provide professional development to staff involved in procurement matters which makes reference to modern slavery;
- continue to ensure that the terms and conditions of supply to the Trust preclude modern slavery practices in the Trust's supply chain.

Data related incidents

During the year there were two incidents reported to the Information Commissioner's Office (ICO) which both required no further action. The first involved a request for a Caldicott approval form to be sent to the Caldicott Guardian by a data quality staff member. Both the Caldicott Guardian's personal assistant and an Information Governance manager were copied into the email. The information contained a spreadsheet of the associated patient data, which was deemed excessive for the purpose resulting in a confidentiality breach. The second incident involved a staff member emailing patient data to the wrong address.

Emergency Preparedness, Resilience and Response (EPRR) Statement of Compliance

As a Category one responder under the Civil Contingency Act 2004 the Trust is required to be ready to respond to any critical or major incidents. As part of the national NHS assurance process, acute health providers alongside other responding organisations need to submit a self-assessment.

Our continued commitment to ensure we can respond to an incident means this year we were fully compliant against the NHS England Core Emergency Preparedness Response and Recovery (EPRR) standards. Our work program over the last 12 months has addressed the six areas that we were not compliant with in last year's Core Standards and progressed the categories we previously met. In February we successfully held the Trusts Live Exercise, observers from NHS EPRR teams and other Emergency Planners supported the trust galvanised development plans on the areas that we need some focus for the forthcoming coming year.

The introduction of a series of committees in a governance structure that ensure developments and changes are reported to the Trust Board as appropriate. We confirm that our level of compliance with the EPRR core standards 2017/18 has been confirmed to Sandwell and West Birmingham Hospitals NHS Trust's Board of Directors.

Remuneration and staff report

Remuneration Report

The Trust has a Remuneration and Terms of Service Committee, whose role is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors. The Committee meets as required.

Membership of the Committee is comprised of the Trust's Chair and all Non-Executive Directors. At 31 March 2018, these were:

- Richard Samuda (Chair)
- Olwen Dutton (Vice Chair)
- Harjinder Kang
- Cathryn Thomas
- Waseem Zafaar
- Marie Perry
- Michael Hoare

During 2017/18, the composition of the Committee changed, Cathryn Thomas commenced on 1st June 2017 replacing the position vacated by Paramjit Gill on 28th February 2017 Remuneration for the Trust's Executive Directors is set by reference to job scope, personal responsibility and performance, and taking into account comparison with remuneration levels for similar posts, both within the National Health Service and the local economy. Whilst performance is taken into account in setting and reviewing remuneration, there are no arrangements in place for 'performance related pay'. The granting of annual inflationary increases are considered and determined by the remuneration committee on an annual basis. In 2017-2018 no inflationary rises were approved.

It is not the Trust's policy to employ Executive Directors on 'rolling' or 'fixed term' contracts; all Executive Directors' contracts conform to NHS Standards for Directors, with arrangements for termination in normal circumstances by either party with written notice of 6 months. The salaries and allowances of senior managers cover both pensionable and non-pensionable amounts.

Items contained within the tables Salaries and Allowances of Senior Managers and Pension Benefits and the section on pay multiples are auditable and are referred to in the audit opinion.

SALARIES AND ALLOWANCES OF SENIOR MANAGERS

Name and Title	2017-18				2016-17			
	(a) Salary (bands of £5,000) £000	(b) Expenses payments (taxable) to nearest £000	(c) All pension related benefits (bands of £2,500) £000	(d) Total all payments and benefits (bands of £5,000) £000	(a) Salary (bands of £5,000) £000	(b) Expenses payments (taxable) to nearest £000	(c) All pension related benefits (bands of £2,500) £000	(d) Total all payments and benefits (bands of £5,000) £000
Richard Samuda, Chair	20-25.	29	0	25-30.	20-25	1	0	25-30
Olwen Dutton, Non-Executive Director (Vice Chair)	5-10.	0	0	5-10.	5-10	0	0	5-10
Cathyrn Thomas, Non-Executive Director (from 1/6/17)	5-10.	0	0	5-10.	0	0	0	0
Marie Perry, Non-Executive Director (from 1/10/16)	5-10.	8	0	5-10.	0-5	0	0	0-5
Waseem Zaffar, Associate Non-Executive Director (from 1/6/15)	5-10.	0	0	5-10.	5-10	0	0	5-10
Harjinder Kang, Non-Executive Director	5-10.	0	0	5-10.	5-10	0	0	5-10
Michael Hoare, Non-Executive Director Designate	5-10.	0	0	5-10.	5-10	0	0	5-10
Robin Russell, Non-Executive Director (1/6/15 to 31/8/16)	0	0	0	0	0-5	0	0	0-5
Paramjit Gill Non-Executive Director (to 28/2/17)	0	0	0	0	5-10	0	0	5-10
Toby Lewis, Chief Executive	190-195	0	42.5-45	235-240	190-195	2	72.5-75	265-270
Antony Waite, Director of Finance & Performance Management	140-145	2	0	140-145	150-155	0	120.0-122.5	270-275
Elaine Newell, Chief Nurse (from 19/12/16)	110-115	0	250-252.5	365-370	35-40	0	60.0-62.5	95-100
Roger Stedman, Medical Director (to 31/12/18)	125-130	0	0	125-130	170-175		137.5-140.0	305-310
David Carruthers, Medical Director (from 1/1/18)	20-25	0	15-17.5	40-45	0	0	0	0
Rachel Barlow, Chief Operating Officer	125-130	0	20-22.5	145-150	125-130	0	125.0-127.5	250-255
Kam Dhami, Director of Governance	95-100.	0	15-17.5	115-120	95-100	0	22.5-25.0	120-125
Raffaela Goodby Director of Organisation Development	95-100.	0	22.5-25	120-125	95-100	0	22.5-25.0	120-125

Notes to Salaries and Allowances of Senior Managers

1. 1. Elaine Newell was Acting Chief Nurse from 19/12/16 to 28/2/17. From 1/3/17 the appointment was on a substantive basis
2. 2. Non-Executive Directors - do not receive pensionable remuneration and therefore do not accrue any pension related benefits.
3. 3. Pension Related Benefits are a nationally determined calculation designed to show the in year increase in notional pension benefits, excluding employee contributions, which have accrued to the individual. Changes in benefits will be dependent on the particular circumstances of each individual.

Pensions

The pension information in the table below contains entries for Executive Directors only as Non-Executive Directors do not receive pensionable remuneration.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pensions payable from the scheme. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

PENSION BENEFITS								
Name and Title	2017-18				2016-17			
	Real increase in pension at age 60	Real increase in Lump sum at pension age	Total accrued pension at pension age at 31st March 2018	Lump sum at pension age related to accrued pension at 31st March 2018	Cash Equivalent Transfer Value at 31st March 2018	Cash Equivalent Transfer Value at 31st March 2017	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £'000	(bands of £2500) £'000	(bands of £5000) £'000	(bands of £5000) £'000	£'000	£'000	£'000	To nearest £'000
Toby Lewis, Chief Executive	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£0
Antony Waite, Director of Finance & Performance Management	0	0	0	135-140	953	951	0	0
Elaine Newell , Chief Nurse (from 19/12/16)	10.0-12.5	32.5-35.0	250-252.50	135-140	921	640	274	0
David Carruthers, Medical Director	0-2.5	0	50-55	150-155	1044	982	0	0
Rachel Barlow, Chief Operating Officer	0-2.5	0	20.0-22.5	100-105.	657	593	58	0
Kam Dhami, Director of Governance	0-2.5	0	15.0-17.5	95-100.	619	563	51	0
Raffaela Goodby Director of Organisation Development (from 11/2/15)	0-2.5	0	22.5-25.0		33	18	15	0

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/ Member in their organisation and the median remuneration of the organisation's workforce.

The midpoint banded remuneration of the highest paid director/Member in the Trust in the financial year 2017-18 was £192,500 (2016-17, £192,500). This was 7 times (2016-17,7) the median remuneration of the workforce, which was £26,565 (2016-17, £26,302).

In 2017-18, 4 (2016-17, 3) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £195,000 to £230,000 (2016-17 £195,000-£275,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions

The Trust's average workforce numbers totalled 6048, and the change in average number of WTE employed across year was an increase of 27. The change in WTE employed from March 2017 to March 2018 was a decrease of 13. This has not resulted in any material changes to the composition of the workforce.

The basic pay of the Trust's most highly paid individual has reduced between 2016-17 and 2017-18 by 13% (from £262,594 to £227,894,). However, this includes elements of pay that are wholly variable and may change significantly from one year to another for this and any other individuals in receipt of them.

The vast majority of Trust employees are subject to national pay settlements and have, in accordance with those national settlements, received a consolidated inflationary increase in pay in 2017-18 of 1%. Where applicable, employees have continued to make incremental progression within existing pay scales. Pay settlements have not had a material effect on the calculation of the pay multiple above.

Staff Report

Staff Numbers - average Number of Employees under contract of service

	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	760	104	**864**	821
Administration and estates	1,103	162	**1,265**	1,302
Healthcare assistants and other support staff	1,562	250	**1,812**	1,788
Nursing, midwifery and health visiting staff	1,928	306	**2,234**	2,248
Scientific, therapeutic and technical staff	664	41	**705**	737
Healthcare science staff	32	-	**32**	-
Total average numbers	**6,049**	**863**	**6,912**	**6,896**
Of which:				
Number of employees (WTE) engaged on capital projects	94	8	**102**	96

Staff Costs - Cost of Employees under contract of service

	Permanent £000	Other £000	2017/18 Total £000	2016/17 Total £000
Salaries and wages	247,353	-	**247,353**	238,645
Social security costs	24,260	-	**24,260**	23,743
Apprenticeship levy	1,180	-	**1,180**	-
Employer's contributions to NHS pensions	27,659	-	**27,659**	27,185
Termination benefits	919	-	**919**	-
Temporary staff		15,821	**15,821**	24,167
Total gross staff costs	**301,371**	**15,821**	**317,192**	**313,740**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**301,371**	**15,821**	**317,192**	**313,740**
Of which				
Costs capitalised as part of assets	2,679	-	**2,679**	2,697

Staff Sickness absence and ill health retirements

Staff Sickness

	2017-18 * Number	2016-17 Number
Total Days Lost	61,914	63,069
Total Staff Years	6,088	6,140
Average working Days Lost	10.17	10.27

*The data presented above represents information for the 2016 calendar year which the Trust considers to be a reasonable proxy for financial year equivalents.

Ill Health Retirements

	2017-18 Number	2016-17 Number
Number of persons retired early on ill health grounds	**6**	9
	£000s	£000s
Total additional pensions liabilities accrued in the year	**305**	323

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Exit Packages

Reporting of compensation schemes - exit packages 2017/18

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	4	-	**4**
£10,001 - £25,000	3	-	**3**
£25,001 - 50,000	2	-	**2**
£50,001 - £100,000	2	-	**2**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**11**	**-**	**11**
Total resource cost (£)	£251,846	£0	**£251,846**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Single exit packages can be made up of several components each of which will be counted separately in this note.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report

Off Payroll Engagements

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as at 31 March 2018	7
Of which, the number that have existed:	
for less than 1 year at the time of reporting	1
for between 1 and 2 years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for greater than 3 years	5

Off payroll engagements are subject to risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where appropriate, that assurance has been sought and received.

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months there are no new engagements between 01 April 2017 and 31 March 2018.

There are no off payroll engagements of Board members or senior officials with significant financial responsibility between 01 April 2017 and 31 March 2018.

Consultancy Services

During 2015-16 the NHS Trust Development Authority introduced controls over expenditure on consultancy services which included the requirement for NHS Bodies to seek approval before signing contracts for consultancy projects over £50,000.

During 2017-18 the Trust complied with these controls and engaged with suppliers for Consultancy Services (as defined in Chapter 5, Annex 1 of the Department of Health Group Accounting Manual 2016-17), the total expenditure incurred was £0.425m (2016/17 £0.930m).

Sustainability Report

Our Trust is committed to environmental and social sustainability and has been working over the last few years to improve our performance. We recognise the importance of embedding sustainability into the heart of the organisation and that using resources, for example energy and water, efficiently will reduce wastage and help save costs.

Our overarching aim is to deliver high quality care without exhausting resources or causing environmental damage. We believe that investing in infrastructure to improve energy and water efficiency will bring about positive environmental impacts and cost savings. We also want to engage our colleagues - reducing energy and water wastage, generating less waste, and travelling actively and sustainably will benefit the environment and improve the wellbeing of our staff and patients.

Energy and water use in our buildings

We spend around £4 million every year heading and lighting our buildings. We remain committed to stabilising and then reducing our energy consumption. Overall energy usage has remained similar to 2016/17 and we have continued work on energy efficiency schemes, including boiler replacements, upgrade of lighting to LED, solar PV at City Hospital and Rowley Regis Hospital, chiller replacements, optimisation of heating controls, and staff engagement. Our carbon emissions generated from energy consumption for 2016/17 were 20,275 tonnes of CO2e compared with 20,297 tonnes of CO2e for 2017/18.

Our water consumption for 2017/18 is 210,538 m3*, a 9 per cent reduction from the previous financial year. Water is essential in maintaining high levels of hygiene but through on-going improvements it is hoped that water consumption will stabilise.

*Some of the data has been estimated as at the time of compiling this report the data was not available from suppliers.

Waste

The Trust is passionate about reducing the amount of waste we generate and disposing of waste in the most environmentally sustainable way. Through engaging with staff, moving to paperless/paper light working, and liaising with our waste contractor, we have significantly reduced the amount of general waste sent to landfill (100 per cent of our general waste is recycled or reprocessed at a local facility). Clinical waste is sent for incineration with energy recovery. The trust generated around 319* tonnes of confidential waste which is recycled.

Transport and Travel

The Trust supports and facilitates access to our sites via sustainable and active modes of travel. We are working to reduce the number if journeys taken by single occupancy vehicles. In enable this, we have a cycle to work scheme, free bike checks for staff, free pool bike hire for staff, cycle storage facilities, dedicated cycle lanes, travel information kiosks, lunchtime walks, discounts on public transport, and much more.

We have recently installed six 7KW electric vehicle charge points across three sites for staff, patients and visitors to use to incentivise low emission vehicles. The Trust is also working to ensure that our new Midland Metropolitan Hospital is energy efficient and easily accessible by sustainable modes of travel.

Wider Sustainability Plans

As part of the Trust's Public Health Plan, we are setting targets to stabilise energy consumption, reduce the amount we spend on waste disposal costs, and encourage travel to sites by walking, cycling, public transport and low emission vehicles.

We are pleased to have won the Birmingham Connected Sustainable Travel Award, Best Energy Efficiency Scheme, Best Greener and Healthier Lifestyles (Food) Scheme and Overall Winner at the Making Birmingham Greener and Healthier Awards (2017). The Trust has also been awarded a Platinum Top Active Travel Location for our work on sustainable and active travel. We are also proud to be shortlisted for the HSJ Awards 2017 category of 'Improving Social and Environmental Sustainabilty' and have most recently been shortlisted for the 'NHS Sustainability Day Awards' under the energy, travel and healthy food categories.

4 Financial Statements

Our finances and investments
Directors' Report

The Trust reported a headline deficit for 2016/17 of (£6.996m), having experienced a particularly challenging winter period, not managing to close additional capacity beds as it had planned to due to increased demand, particularly at the front door. Those environmental factors had continued to contribute to the growth of the underlying deficit brought forward from previous years, manifested by increased acuity and attendances at A&E, high levels of beds occupied by people medically fit for discharge as well as difficulties in the recruitment of certain staff groups. The underlying deficit brought forward into the 2017/18 financial year therefore stood in excess of circa £20m.

The Trust therefore entered 2017/18 with an ambitious financial plan that expected to carry on addressing the operational challenges outlined above and that accepted the NHSI Control Total offer, being a deficit of £0.550m, before Sustainability and Transformation Funding of £10.483m, therefore planning for a headline surplus of £9.933m.

The plan was in line with the long term strategy from the Trust to generate underlying, cash backed surpluses in order to support the necessary investment programme. The purpose therefore for 2017/18 was to address the underlying deficit and while securing the performance levels required for the Midland Met project. There was a high degree of risk associated with this outcome, as it meant that the disruption seen to capacity to deliver planned care during 2016/17 was addressed, as well as efficiency savings of circa £33m, representing nearly 8% of patient related income. The Trust was also continuing to address CQC actions, deliver the Midland Met project and continue with EPR implementation. The performance of NHS trusts is measured against four primary financial duties:

- The delivery of an Income and Expenditure (I&E) position consistent with the target set by the Department of Health (DH) (the breakeven target);
- Not exceeding its Capital Resource Limit (CRL);
- Not exceeding its External Financing Limit (EFL);
- Delivering a Capital Cost Absorption Rate of 3.5%.

These duties are further explained as follows:

Breakeven Duty

For 2017/18 the Trust agreed an income and expenditure target surplus with NHS Improvement of £9.933m. This reflected acceptance of the control total of a deficit of £0.55m, and STF of £10.483m. This target more than meets the breakeven duty required of the Trust. Due to the ongoing environmental factors and inherent risk in the plan outlined above, achieving the target was challenging. At Month 6, the Trust conducted an internal review of its year to date performance and reforecast, identifying a potential risk to delivery of the control total. The Trust initiated a financial recovery plan with a core aim of both remediating back to control total for 2017.18 and addressing the underlying deficit, which was assessed at remaining stable at around £20m. Over the winter period, the Trust received Taper Relief funding of £7m from NHS England in support of double running costs during Midland Met construction, and was in receipt of circa £2m of additional funding from NHS Improvement to fund the additional costs of the winter period and to mitigate the risks to the financial plan in respect of this extraordinary pressure that was felt nationwide. The finance team also created a list of specific risks and opportunities to the outturn, with a specific risk management plan.

The outcome of this focused work, alongside tremendous efforts by operational and clinical colleagues to keep the show on the road and continue to meet patient need during such an operationally challenging time, was that by the year end the Trust had managed the risk to forecast outturn and was in an opportunity to consider whether it could take advantage of the STF "bonus" scheme, where improvement over and above control total is rewarded with a cash incentive. This would be absolutely in line with the Trust's strategy to deliver cash backed surpluses to fund its investment plans.

The Trust therefore ended the year with a surplus before STF of £6.352m, compared with a deficit of (£17.230m) the year before. Although this performance was assisted by a land sale at the City site during the year which generated a £16.3m profit, this still represents a significant improvement on the year before, under sustained challenge.

This overperformance led to additional STF cash bonus of £10.2m, on top of the £7.6m earned from the core scheme. For the purpose of measuring statutory accounts performance, the Trust generated a surplus in year of £32.538m, and this is shown below in figure 6.1.

As has been the case in previous years, the presentation of financial results requires additional explanation owing to adjustments generated by valuation updates to the Trust's assets as well as changes to the accounting treatment for donated and government grant funded capital assets. These technicalities are explained in the detailed notes to the Trust's published 2017/18 Statutory Accounts (separate document). Figure 6.1 shows how the Trust's reported performance is calculated. The surplus in the published Statutory Accounts is subject to technical adjustment and does not affect the assessment of the Trust's performance against the duties summarised above (ie I&E breakeven, CRL, EFL, capital cost absorption).

Figure 6.1

Income and Expenditure Performance	2017/18	2016/17
	£000's	£000's
Income for Patient Activities	420,702	416,916
Income for Education, Training, Research and Other Income	73,456	43,281
Total Income	494,158	460,197
Pay Expenditure	(314,512)	(311,043)
Non Pay Expenditure including Interest Payable and Receivable	(140,245)	(151,033)
Public Dividend Capital (PDC) - Payment	(6,863)	(5,117)
Total Expenditure (Including Impairments and Reversals)	(461,620)	(467,193)
Surplus/(Deficit) per Statutory Accounts	32,538	(6,996)
Exclude Sustainability and Transformation Fund	(17,813)	(5,297)
Exclude Impairments and Reversals	(8,435)	(5,161)
Adjustment for elimination of Donated and Government Grant Reserves	63	224
Surplus/(Deficit) per DH Target	6,352	(17,230)

Although impairments and reversals are not counted towards measuring I&E performance, they must be included in the Statutory Accounts and on the face of the Statement of Comprehensive Income (SOCI). Impairments and reversals transactions are non-cash in nature and do not affect patient care budgets. However, it is important that the Trust's assets are carried at their true values so that users of its financial statements receive a fair and true view of the Statement of Financial Position (Balance Sheet). DH holds allocations centrally for the impact of impairments and reversals.

Although the reported performance, both per the Statutory Accounts and I&E was a huge success for the Trust and its patients, and the health economy of Sandwell and West Birmingham, the underlying deficit did neither improve nor deteriorate over the period, and therefore remains at just over £20m. As part of its in year 2017/18 financial recovery plan, this was addressed in the setting of the financial plan for 2018/19 and as at the date of this report the Trust had identified 75% of the financial challenge arising from addressing the deficit, and continues to work at pace on the balance.

CRL

Further detailed information on capital spend is shown below at Figure 6.5. The CRL sets a maximum amount of capital expenditure a trust may incur in a financial year (April to March). Trusts are not permitted to overshoot the CRL although the Trust may undershoot. Against its CRL of £23.212m for 2017/18, the Trust's relevant expenditure was £22.982m, thereby undershooting by £0.230m and achieving this financial duty.

EFL

The EFL is a control on the amount a trust may borrow and also determines the amount of cash which must be held at the end of the financial year. Trusts are not allowed to overshoot the EFL although the trust is permitted to undershoot. Against its EFL of £36.838m, the Trust's cash flow financing requirement was £34.826m, thereby undershooting by £2.012m and achieving this financial duty.

Capital Cost Absorption Rate

The capital cost absorption rate is a rate of return on the capital employed by the Trust which is set nationally at 3.5%. The value of this rate of return is reflected in the SOCI as PDC dividend (as shown in Figure 6.1), an amount which trusts pay back to DH to reflect a 3.5% return. The value of the dividend/rate of return is calculated at the end of the year on actual capital employed being set automatically at 3.5% and accordingly the Trust has achieved this financial duty.

Income from Commissioners and other sources

The main components of the Trust's income £494.158m in 2017/18 are shown below in Figure 6.2 which shows an overall increase of £33.961m, 7.38%.

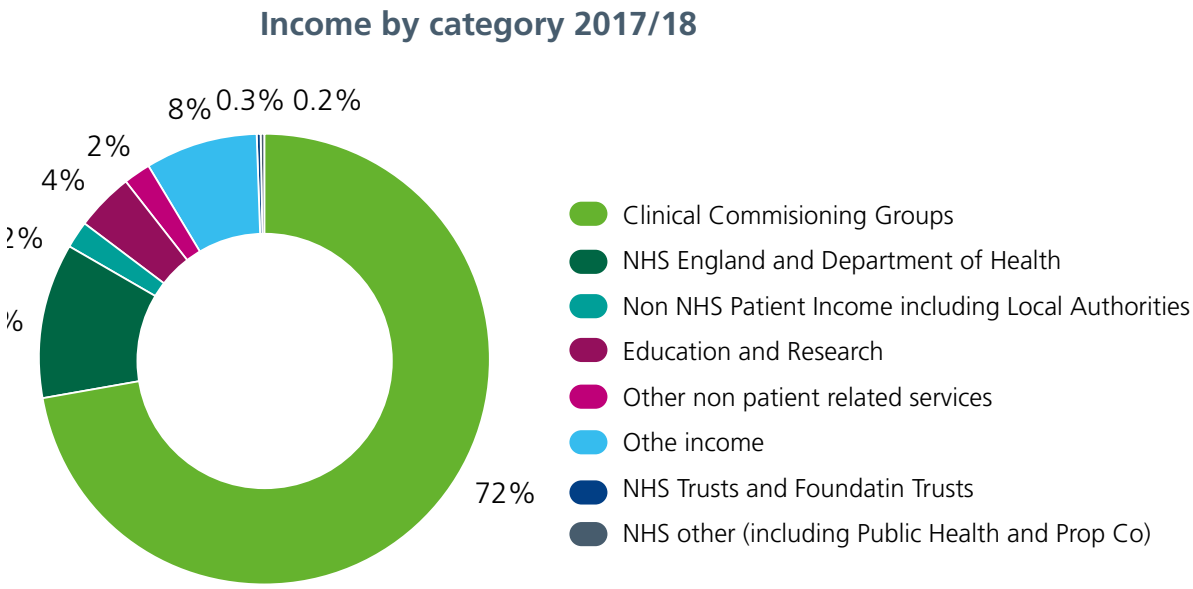
The largest items driving this increase are £17.813m (2016/17, £5.3m) STF, and £7m (2016/17, £3m) taper relief from NHSE in respect of Midland Met double running costs. Also driving the variance is an increase in non-elective income due to the move to the new HRG4+, and prices for maternity increased by circa 20%. More activity with the Trust's host commissioner, SWBCCG, as well agreement of a year-end settlement was also a driver for increased income year on year.

Figure 6.2

Sources of Income	2017/18	2016/17
	£000's	£000's
NHS England and Department of Health	353,748	343,930
NHS Trusts and Foundation Trusts	52,393	56,536
Clinical Commissioning Groups	12,195	11,820
NHS Other (including Public Health England and Prop Co)	21,251	20,351
Non NHS Patient Income including Local Authorities	10,988	5,387
Education and Research	41,217	17,543
Other Non-Patient Related Services	1,589	3,560
Other Income	777	1,070
Total Income	**494,158**	**460,197**

Within Figure 6.3, the pie chart below, the largest element 72% of the Trust's resources flowed directly from CCGs and 11% from NHSE with the next significant element 4% being education, training and research funds. The Trust is an accredited body for the purposes of training undergraduate medical students, postgraduate doctors and other clinical trainees. It also has an active and successful research community.

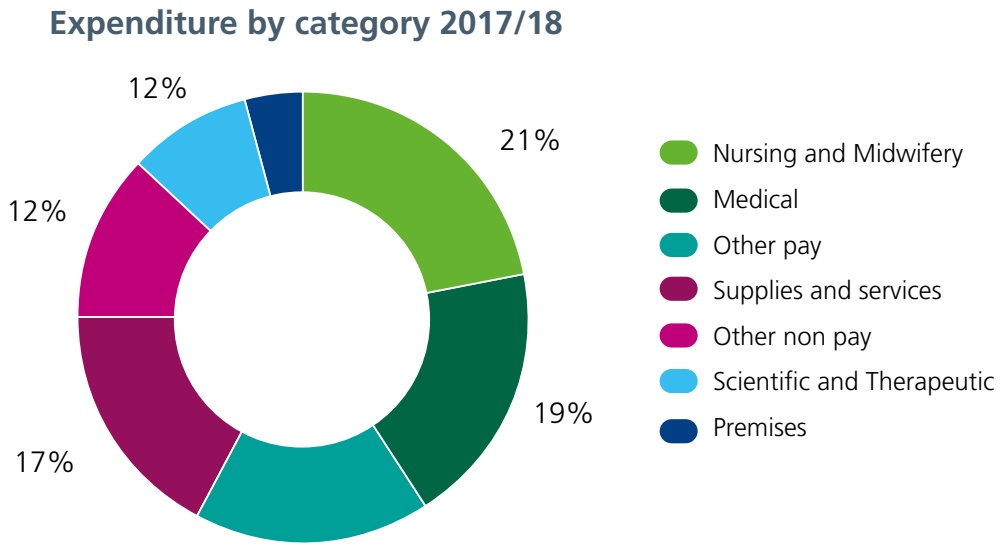
Figure 6.3



Expenditure

Figure 6.4, the pie chart below shows that 67% of the Trust's cost was pay and, within this, the three largest groups were nursing and midwifery 22%, medical staff 19% and scientific and therapeutic 9%. The remaining 33% of operational expenditure was non pay, the largest element of which was clinical supplies and services which included drug costs at 17%.

Figure 6.4



Use of Capital Resources

Capital expenditure differs to day to day operational budgets and involves tangible and non-tangible items costing more than £5,000 and having an expected life of more than one year. In total, the Trust's gross spend during 2017/18 on

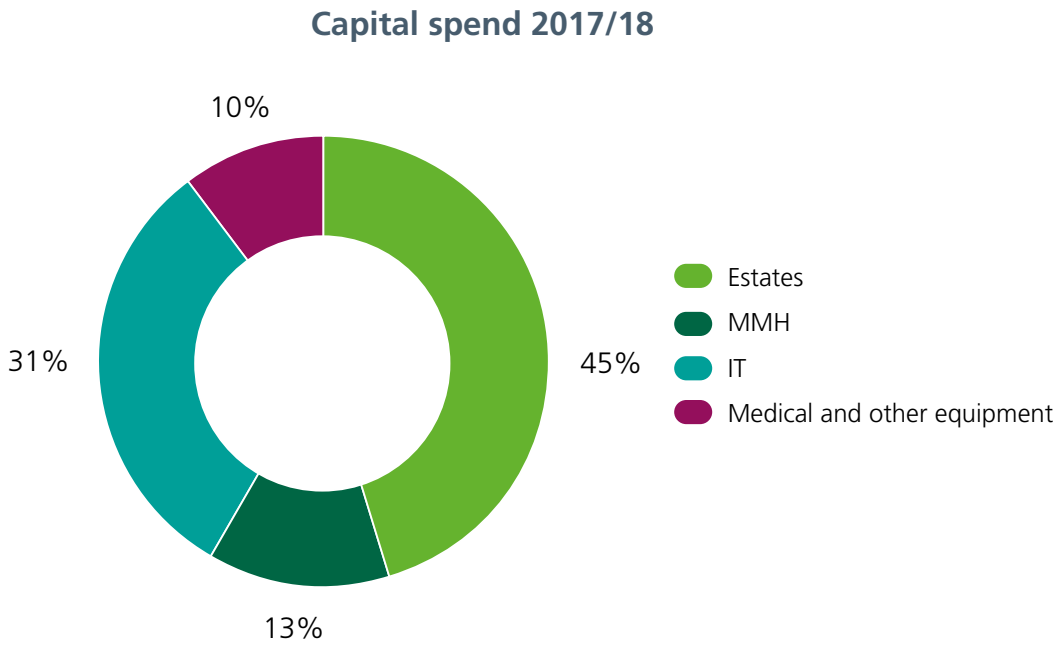
capital items was £26.263m. This is adjusted by any donated items and the book value of assets disposed when measured against the CRL (see above). A breakdown of this gross expenditure is shown in the pie chart below.

Figure 6.5

The Trust spent a significant proportion – 58% - of its capital budget on the Midland Metropolitan Hospital (MMH) and Estates. Specifically, £14.422m was spent on MMH and upgrading the Trust's residual Estate, and including ensuring compliance with statutory standards.

Medical and Other Equipment accounted for £2.249m, all of which has a direct impact on clinical quality improvement. IT spend totalled £8.314m, of which £5.791m was for the Electronic Patient Record system, Unity.

Figure 6.5



Audit

The Trust's External Auditors are Grant Thornton UK LLP. They were appointed for 2017/18 by the Trust, following a competitive tendering process undertaken during 2016/17 ready for when the previous contract with KPMG LLP expired. The cost of the work undertaken by the Auditor in 2017/18 was £67k including VAT. The fee in respect of auditing charitable fund accounts at £7k is excluded from this sum, but the audit of the Quality Accounts is included.

As far as the Directors are aware, there is no relevant audit information of which the Trust's Auditors are unaware. In addition the Directors have taken all the steps they ought to have taken as directors to ensure they are aware of any relevant audit information and to establish that the Trust's Auditor is aware of that information.

The members of the Audit and Risk Management Committee at 31 March 2018 were Marie Perry (Chair), Olwen Dutton, Harjinder Kang and Waseem Zaffar.

Statement of directors responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

25/5/18 Date ..... Chief Executive

25/5/18 Date ..... Finance Director

10

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Revenue from patient care activities	3	420,702	411,619
Other operating revenue	4	73,456	48,578
Operating expenses	6, 8	(469,284)	(459,951)
Operating surplus/(deficit) from continuing operations		**24,874**	**246**
Finance income	11	49	66
Finance expenses	12	(1,810)	(2,191)
PDC dividends payable		(6,863)	(5,117)
Net finance costs		**(8,624)**	**(7,242)**
Other gains / (losses)	13	16,288	-
Surplus / (deficit) for the year from continuing operations		**32,538**	**(6,996)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations		**-**	**-**
Surplus / (deficit) for the year		**32,538**	**(6,996)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	3,061	654
Revaluations	16.1	235	-
Total comprehensive income / (expense) for the period		**35,834**	**(6,342)**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	15	106	166
Property, plant and equipment	16	227,475	207,430
Trade and other receivables	20	62,941	43,017
Other assets	21	-	-
Total non-current assets		**290,522**	**250,613**
Current assets			
Inventories	19	4,742	5,268
Trade and other receivables	20	52,880	17,100
Other assets	21	-	8,043
Cash and cash equivalents	23	9,691	23,902
Total current assets		**67,313**	**54,313**
Current liabilities			
Trade and other payables	24	(59,549)	(63,473)
Borrowings	27	(2,166)	(903)
Provisions	29	(1,855)	(1,147)
Other liabilities	26	(4,657)	(5,039)
Total current liabilities		**(68,227)**	**(70,562)**
Total assets less current liabilities		**289,608**	**234,364**
Non-current liabilities			
Borrowings	27	(31,776)	(33,953)
Provisions	29	(3,454)	(3,396)
Total non-current liabilities		**(35,230)**	**(37,349)**
Total assets employed		**254,378**	**197,015**
Financed by			
Public dividend capital		226,891	205,362
Revaluation reserve		9,744	7,574
Other reserves		9,058	9,058
Income and expenditure reserve		8,685	(24,979)
Total taxpayers' equity		**254,378**	**197,015**

The notes on pages 6 to 55 form part of these accounts.

Signed .....

Name Toby Lewis
Position Chief Executive
Date **25/05/2018**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**205,362**	**7,574**	**9,058**	**(24,979)**	**197,015**
Surplus/(deficit) for the year	-	-	-	32,538	**32,538**
Other transfers between reserves	-	(37)	-	37	**-**
Impairments	-	3,061	-	-	**3,061**
Revaluations	-	235	-	-	**235**
Transfer to retained earnings on disposal of assets	-	(1,089)	-	1,089	**-**
Public dividend capital received	21,529	-	-	-	**21,529**
Taxpayers' equity at 31 March 2018	**226,891**	**9,744**	**9,058**	**8,685**	**254,378**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**161,710**	**6,930**	**9,058**	**(17,993)**	**159,705**
Prior period adjustment	-	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**161,710**	**6,930**	**9,058**	**(17,993)**	**159,705**
Surplus/(deficit) for the year	-	-	-	(6,996)	**(6,996)**
Other transfers between reserves	-	(10)	-	10	**-**
Impairments	-	654	-	-	**654**
Public dividend capital received	43,652	-	-	-	**43,652**
Taxpayers' equity at 31 March 2017	**205,362**	**7,574**	**9,058**	**(24,979)**	**197,015**

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Other reserves
The other Reserve of £9.058m (as per the Statement of Financial Position) represents the difference between the carrying value of Assets at the Trust inception date and the value of PDC attributed to the Trust. This reserve was created under the guidance of the Department of Health as a result of imbalances between the transfer of assets to Sandwell Primary Care Trusts and the issue of Public Dividend Capital (PDC) to Sandwell & West Birmingham Hospitals when the remainder of the Trust merged with City Hospital NHS Trust to become Sandwell and West Bromwich NHS Trust on 1st April 2002.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		24,874	246
Non-cash income and expense:			
Depreciation and amortisation	6.1	14,893	14,015
Net impairments	7	(8,436)	(5,161)
Income recognised in respect of capital donations	4	(164)	(62)
(Increase) / decrease in receivables and other assets		(47,247)	(42,773)
(Increase) / decrease in inventories		526	(1,172)
Increase / (decrease) in payables and other liabilties		(3,454)	12,463
Increase / (decrease) in provisions		758	(66)
Net cash generated from / (used in) operating activities		**(18,250)**	**(22,510)**
Cash flows from investing activities			
Interest received	11	49	66
Purchase of intangible assets	15.1	(13)	-
Purchase of property, plant, equipment and investment property		(27,367)	(16,718)
Sales of property, plant, equipment and investment property		18,800	-
Receipt of cash donations to purchase capital assets		164	-
Net cash generated from / (used in) investing activities		**(8,367)**	**(16,652)**
Cash flows from financing activities			
Public dividend capital received		21,529	43,652
Capital element of PFI, LIFT and other service concession payments		(914)	(84)
Interest paid on PFI, LIFT and other service concession obligations		(1,799)	(2,145)
PDC dividend (paid) / refunded		(6,410)	(5,655)
Net cash generated from / (used in) financing activities		**12,406**	**35,768**
Increase / (decrease) in cash and cash equivalents		**(14,211)**	**(3,394)**
Cash and cash equivalents at 1 April - brought forward		**23,902**	**27,296**
Prior period adjustments			**-**
Cash and cash equivalents at 1 April - restated		**23,902**	**27,296**
Cash and cash equivalents at 31 March	23.1	**9,691**	**23,902**

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern
These accounts have been prepared on a going concern basis.

NHS organisations are required to produce financial statements in line with International Accounting & Financial Reporting Standards. The NHS also has the benefit of additional guidance in the group accounting manual (GAM). The impact of this is that Trusts should prepare financial statements on a going concern basis unless management concludes that the entity is not a going concern. IAS 1 requires this conclusion to be based on a management assessment of an entity's ability to continue as a going concern.

Management Assessment of Going Concern

Having reported a surplus above plan for the financial year 2017/18 the Trust has earned additional STF monies. This, together with the recovery actions undertaken internally, has enhanced the Trust's cumulative breakeven position by nearly 100% compared to 2016/17. The cumulative position is now at the highest level for 10 years. While many of the recovery actions have been cash generating in nature they have also been non-recurrent as the underlying recovery is delayed. Consequently the Trust enters 2018/19 with an underlying deficit.

This scenario was anticipated and during 2016/17 the Trust developed two year financial plans that addressed the deficit with the intention of securing underlying break even over that period. These plans recognise a potential for delay in recovery and a consequent short-term cash requirement. This cash requirement was to be addressed by receipt of a Department of Health (DH) loan.
Plan cash flow forecasts for the Trust confirm that there will be requirement for a DH loan in Q1 2018/19. The necessary NHSI teams are sighted on this, including the capital cash team; the mechanism for this has been confirmed by the NHSI. Based on this evidence it is clear that the Trust has financial plans which address the liquidity risks and secure the Trust's ability to make good liabilities as they fall due.

There is an explicit need for the services currently provided by the Trust as evidenced by the following:

- The Trust remains a partner of the Black Country Sustainability and Transformation Plan. The Trust's ongoing contribution to the health economy is recognised and appears to remain an integral component over the course of the period up to and including 2021.
- The Trust's Commissioners' intentions for 2018/19 also reaffirm that the Trust services are required to deliver their plans for serving the needs of the local population.

The Trust meets the criteria to be considered a going concern and the financial statements for the period 2017/18 have been prepared on that basis.

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Board of Sandwell and West Birmingham Hospitals NHS Trust acts as a corporate Trustee for the Charitable Funds, however it has confirmed that the Charitable Funds are not material to the Trust accounts and has therefore not consolidated.

Note 1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.3.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Charitable Funds

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1st April 2013, the Trust has established that as it is the corporate Trustee of the Sandwell and West Birmingham Hospitals NHS Trust Charities, charity number 1056127, it effectively has the power to exercise control so as to obtain economic benefits.

Total donations received during 2017/18 were £1.2m and total resources expended were £2.1m which represent 0.27% of the Trust's Exchequer Funds.

IAS 1, Presentation of Financial Statements, says that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material and this guidance is reiterated in the GAM for 2017/18.

Thus, In line with IAS 1, charitable funds are not consolidated into Sandwell and West Birmingham Hospitals NHS Trust's accounts on grounds of materiality.

PFI Asset Valuation

From 1st April 2015, the Trust has accounted for the Valuation of its PFI Hospital (BTC) on the basis of Depreciated Replacement Cost excluding VAT, prior to this judgement the Trust included VAT in the Valuation

Managed Equipment Scheme

On 1st May 2016 the Trust entered into a Managed Service Contract for the provision and maintenance of imaging equipment. The contract is for a period of 10 years with an option to extend for a further 2 years. The estimated value of the contract is £30m and anticipated capital value of equipment to be provided under the contract is £18m. The accounting treatment for the scheme was determined to be considered as an IFRIC12 Service concession and included within 'on SOFP' PFI schemes included in Note 34.

Note 1.3.2 Sources of estimation uncertainty

Property Valuation

Assets relating to land and buildings were subject to a formal valuation at 1st April 2015, completed on an 'alternate MEA' basis. An Existing Use Value alternative MEA approach was used which assumes the asset would be replaced with a modern equivalent, i.e. not a building of identical design - but with the same service potential as the existing assets. The alternative modern equivalent asset may well be smaller (reduced Gross Internal Area) than the existing asset which reflects the challenges Healthcare Providers face when utilising historical NHS Estate. A subsequent annual valuation is performed at 31st March each year to ensure a true and fair view was reflected.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of costs incurred to date compared to total expected costs.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The NHS Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

The Trust receives revenue for the training of Medical and other Clinical Staff Groups under Learning and Development Agreements, this revenue is included within Note 4

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised if:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to the NHS Trust;
• it is expected to be used for more than one financial year;
• the cost of the item can be measured reliably; and either
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement
Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
● Land and non-specialised buildings – market value for existing use.
● Specialised buildings – depreciated replacement cost, modern equivalent asset basis.
HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

The estimated useful economic life of an asset is the period over which the NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the *GAM*, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met. Fair value is open market value including alternative uses.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The NHS Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's Statement of Financial Position.

Other assets contributed by the NHS Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Note 1.8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.12 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below in note 1.13

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.
Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined by reference to quoted market prices where possible, otherwise by valuation techniques.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Where a bad debt provision is used and an asset is impaired, the asset's carrying value is written down directly against the provision.

Note 1.13 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.13.1 The Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13.2 The Trust as lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trusts' net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.10% (2016/17: positive 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A short term rate of negative 2.42% (2016/17: negative 2.70%) for expected cash flows up to and including 5 years
• A medium term rate of negative 1.85% (2016/17: negative 1.95%) for expected cash flows over 5 years up to and including 10 years
• A long term rate of negative 1.56% (2016/17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the NHS trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at note 29.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The NHS Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 30 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 30, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Where the time value of money is material, contingencies are disclosed at their present value.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

● IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

The Trust has reviewed these Accounting Standards and determined that it is not practicable to assess the impact on the Financial Statements if they were already implemented.

Note 2 Operating Segments

The Board, as 'Chief Operating Decision Maker', has determined that the Trust operates in one material segment which is the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure.

The provision of healthcare (including medical treatment, research and education) is within one main geographical segment, the United Kingdom, and materially from Departments of HM Government in England.

The Trust has only one business segment which is provision of healthcare. A segmental analysis is therefore not applicable.

Note 3 Revenue from patient care activities

Note 3.1 Revenue from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	40,767	45,533
Non elective income	117,405	108,097
First outpatient income	28,815	27,342
Follow up outpatient income	39,300	42,742
A & E income	24,906	22,359
High cost drugs income from commissioners (excluding pass-through costs)	30,469	27,136
Other NHS clinical income	91,850	92,190
Community services		
Community services income from CCGs and NHS England	29,720	27,091
Income from other sources (e.g. local authorities)	7,255	8,440
All services		
Private patient income	158	172
Other clinical income	10,057	10,517
Total income from activities	**420,702**	**411,619**

Note 3.2 Revenue from patient care activities (by source)

Revenue from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	52,313	51,239
Clinical commissioning groups	353,748	343,930
Department of Health and Social Care	80	-
Other NHS providers	1,589	3,560
NHS other	777	1,070
Local authorities	8,745	9,008
Non-NHS: private patients	165	172
Non-NHS: overseas patients (chargeable to patient)	2,612	1,100
NHS injury scheme	593	1,283
Non NHS: other	80	257
Total income from activities	**420,702**	**411,619**
Of which:		
Related to continuing operations	420,702	411,619
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	2,612	1,100
Cash payments received in-year	466	309
Amounts added to provision for impairment of receivables	1,231	735
Amounts written off in-year	288	123

Note 4 Other operating revenue

	2017/18	2016/17
	£000	£000
Research and development	2,471	1,668
Education and training	18,780	18,683
Receipt of capital grants and donations	164	62
Non-patient care services to other bodies	10,988	5,190
Sustainability and transformation fund income	17,813	5,297
Other income *	23,240	17,678
Total other operating income	**73,456**	**48,578**
Of which:		
Related to continuing operations	73,456	48,578
Related to discontinued operations	-	-

* Other Revenue includes £7m (£3m - 2016/17) that the Trust received for non recurrent funding in support of the development and transition to the Midland Metropolitan Hospital (MMH). That funding is part of a total of £22.3m which the trust expects to receive over the period 2016-2020. Such funding is in line with national arrangements for supporting large scale infrastructure projects such as MMH. There are also a number of other sources of Revenue from the Trust's Catering Facilities and Car Parking for Staff and Patients.

Note 5 Fees and charges

There are no Fees and Charges for the year ended 31st March 2018

Note 6.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies*	11,459	9,236
Purchase of healthcare from non-NHS and non-DHSC bodies	3,171	3,397
Purchase of social care	-	-
Staff and executive directors costs	311,504	311,043
Remuneration of non-executive directors	62	64
Supplies and services - clinical (excluding drugs costs)	41,339	40,580
Supplies and services - general	7,140	6,950
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	38,183	38,553
Inventories written down	-	8
Consultancy costs	425	930
Establishment	4,650	4,518
Premises	21,432	19,026
Transport (including patient travel)	1,792	1,839
Depreciation on property, plant and equipment	14,820	13,853
Amortisation on intangible assets	73	162
Net impairments	(8,436)	(5,161)
Increase/(decrease) in provision for impairment of receivables	2,202	1,382
Change in provisions discount rate(s)	53	388
Audit fees payable to the external auditor		
audit services- statutory audit**	67	91
other auditor remuneration (external auditor only)	-	14
Internal audit costs	254	220
Clinical negligence	10,608	7,577
Legal fees	191	97
Insurance	104	90
Research and development	1,309	242
Education and training	3,121	1,111
Rentals under operating leases	150	44
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	2,537	2,166
Other	1,074	1,531
Total	**469,284**	**459,951**
Of which:		
Related to continuing operations	469,284	459,951
Related to discontinued operations	-	-

* Services from NHS bodies does not include expenditure which falls into a category below

** Audit Fees - External Audit fees are disclosed inclusive of VAT. The contract for 2017/18 was £55,950 plus VAT (2016/17 was £75,380 plus VAT).

Note 6.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	10
3. Taxation compliance services	-	4
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**-**	**14**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £500k (2016/17: £0k).

Note 7 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	-	58
Changes in market price	(8,436)	(5,219)
Total net impairments charged to operating surplus / deficit	**(8,436)**	**(5,161)**
Impairments charged to the revaluation reserve	(3,061)	(654)
Total net impairments	**(11,497)**	**(5,815)**

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	247,353	238,645
Social security costs	24,260	23,743
Apprenticeship levy	1,180	-
Employer's contributions to NHS pensions	27,659	27,185
Termination benefits	919	-
Temporary staff (including agency)	15,821	24,167
Total gross staff costs	**317,192**	**313,740**
Recoveries in respect of seconded staff	-	-
Total staff costs	**317,192**	**313,740**
Of which		
Costs capitalised as part of assets	2,679	2,697

Note 8.1 Retirements due to ill-health

During 2017/18 there were 6 early retirements from the trust agreed on the grounds of ill-health (9 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £305k (£323k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The trust offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST), the contribution rate is 1%.

Note 10.1 Sandwell And West Birmingham Hospitals NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Sandwell And West Birmingham Hospitals NHS Trust is the lessee.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	150	44
Total	**150**	**44**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	160	43
- later than one year and not later than five years;	231	120
- later than five years.	109	151
Total	**500**	**314**
Future minimum sublease payments to be received	-	-

The Trust entered into new Lease Arrangements with the Homes and Communities Agency, the values for which are included in the analysis above. The details of this transaction can be found in Note 13 of these Accounts.

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	49	66
Total	**49**	**66**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Interest on late payment of commercial debt	-	1
Main finance costs on PFI and LIFT schemes obligations	1,277	1,332
Contingent finance costs on PFI and LIFT scheme obligations	525	813
Total interest expense	**1,802**	**2,146**
Unwinding of discount on provisions	8	45
Other finance costs	-	-
Total finance costs	**1,810**	**2,191**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	1

Note 13 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	16,518	-
Losses on disposal of assets	(230)	-
Total gains / (losses) on disposal of assets	16,288	-

During 2017/18 the Trust sold assets at the City site which led to a net gain on disposal of £16,288k. These assets comprise land and buildings and the Trust's ability to sell them arises from the investment in the new Midland Metropolitan Hospital (MMH) in Smethwick. This investment is a key enabler of the delivery of the Trust's vision to become the best integrated care organisation in the NHS.

This vision will involve the Trust delivering a range of services from the City, Sandwell, MMH and Rowley sites as well as a number of community locations. Completion of the MMH will allow the Trust to cease the use of outdated building infrastructure and deliver patient care within a modern facility. At the City site, as a direct consequence of this, the Trust will need to retain only the Birmingham Treatment centre (BTC) and the Birmingham and Midland Eye Centre (BMEC). Given the demand for housing in the local area the Trust has worked with the Homes and Communities Agency (HCA) to agree a deal that provides best value for patient services as well as meeting the housing needs of local residents.

The HCA have purchased the land excluding that element required to support the delivery of patient services at the City Hospital site predominantly, BTCentre and BMEC. The transaction was completed in August 2017 and the agreement includes the Trust leasing the assets back until the point at which MMH is available. The HCA intention is to ensure the land is employed for the development of homes.

Note 14 Discontinued operations

The Trust had no discontinued operations in 2017/18.

	Software licences £000	Licences & trademarks £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**2,954**	**43**	**2,997**
Additions	13	-	**13**
Gross cost at 31 March 2018	**2,967**	**43**	**3,010**
Amortisation at 1 April 2017 - brought forward	**2,831**	**-**	**2,831**
Provided during the year	73	-	**73**
Amortisation at 31 March 2018	**2,904**	**-**	**2,904**
Net book value at 31 March 2018	**63**	**43**	**106**
Net book value at 1 April 2017	**123**	**43**	**166**

Note 15.2 Intangible assets - 2016/17

	Software licences £000	Licences & trademarks £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**2,954**	**101**	**3,055**
Impairments	-	(58)	**(58)**
Valuation / gross cost at 31 March 2017	**2,954**	**43**	**2,997**
Amortisation at 1 April 2016 - as previously stated	**2,669**	**-**	**2,669**
Provided during the year	**162**	**-**	**162**
Amortisation at 31 March 2017	**2,831**	**-**	**2,831**
Net book value at 31 March 2017	**123**	**43**	**166**
Net book value at 1 April 2016	**285**	**101**	**386**

Note 15.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Purchased		
Software licences	0	5
Licences & trademarks	0	1

Note 16.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**16,640**	**145,067**	**13,823**	**105,283**	**3,833**	**37,860**	**1,997**	**324,503**
Additions	-	9,397	5,460	2,824	-	8,478	91	**26,250**
Reversals of impairments	115	2,946	-	-	-	-	-	**3,061**
Revaluations	2,013	(59)	-	-	-	-	-	**1,954**
Reclassifications	-	2,899	(2,899)	-	-	-	-	**-**
Transfers to/ from assets held for sale	(1,075)	-	-	-	-	-	-	**(1,075)**
Disposals / derecognition	(1,218)	(844)	-	(1,213)	(246)	-	-	**(3,521)**
Valuation/gross cost at 31 March 2018	**16,475**	**159,406**	**16,384**	**106,894**	**3,587**	**46,338**	**2,088**	**351,172**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**1**	**-**	**85,839**	**3,465**	**26,136**	**1,632**	**117,073**
Provided during the year	**-**	**6,736**	**-**	**4,274**	**163**	**3,578**	**69**	**14,820**
Impairments	-	6,949	-	-	-	-	-	**6,949**
Reversals of impairments	(1,778)	(13,607)	-	-	-	-	-	**(15,385)**
Revaluations	1,778	(59)	-	-	-	-	-	**1,719**
Disposals / derecognition	-	(20)	-	(1,213)	(246)	-	-	**(1,479)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**88,900**	**3,382**	**29,714**	**1,701**	**123,697**
Net book value at 31 March 2018	**16,475**	**159,406**	**16,384**	**17,994**	**205**	**16,624**	**387**	**227,475**
Net book value at 1 April 2017	**16,640**	**145,066**	**13,823**	**19,444**	**368**	**11,724**	**365**	**207,430**

Note 16.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**16,640**	**140,725**	**10,283**	**101,531**	**3,833**	**31,689**	**1,997**	**306,698**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	4,837	3,540	4,446	-	6,206	-	**19,029**
Reversals of impairments	-	654	-	-	-	-	-	**654**
Revaluations	-	(1,149)	-	-	-	-	-	**(1,149)**
Disposals / derecognition	-	-	-	(694)	-	(35)	-	**(729)**
Valuation/gross cost at 31 March 2017	**16,640**	**145,067**	**13,823**	**105,283**	**3,833**	**37,860**	**1,997**	**324,503**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**-**	**-**	**82,000**	**3,295**	**23,461**	**1,561**	**110,317**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**6,369**	**-**	**4,533**	**170**	**2,710**	**71**	**13,853**
Reversals of impairments	-	(5,219)	-	-	-	-	-	**(5,219)**
Revaluations	-	(1,149)	-	-	-	-	-	**(1,149)**
Disposals/ derecognition	-	-	-	(694)	-	(35)	-	**(729)**
Accumulated depreciation at 31 March 2017	**-**	**1**	**-**	**85,839**	**3,465**	**26,136**	**1,632**	**117,073**
Net book value at 31 March 2017	**16,640**	**145,066**	**13,823**	**19,444**	**368**	**11,724**	**365**	**207,430**
Net book value at 1 April 2016	**16,640**	**140,725**	**10,283**	**19,531**	**538**	**8,228**	**436**	**196,381**

Note 16.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	16,475	136,538	16,384	10,657	205	16,442	386	**197,087**
On-SoFP PFI contracts and other service concession arrangements	-	21,527	-	6,603	-	172	1	**28,303**
Owned - government granted	-	975	-	-	-	-	-	**975**
Owned - donated	-	366	-	734	-	10	-	**1,110**
NBV total at 31 March 2018	**16,475**	**159,406**	**16,384**	**17,994**	**205**	**16,624**	**387**	**227,475**

Note 16.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	16,640	124,681	13,823	10,826	368	11,712	364	**178,414**
On-SoFP PFI contracts and other service concession arrangements	-	19,195	-	7,849	-	-	1	**27,045**
Owned - government granted	-	861	-	-	-	-	-	**861**
Owned - donated	-	329	-	769	-	12	-	**1,110**
NBV total at 31 March 2017	**16,640**	**145,066**	**13,823**	**19,444**	**368**	**11,724**	**365**	**207,430**

16.3 (cont). Property, plant and equipment

Asset lives for currently held assets are as follow:-

	Min life	Max life
	Years	Years
Buildings excluding dwellings	19	63
Plant & machinery	5	15
Transport equipment	4	7
Information technology	5	10
Furniture & fittings	0	10

Note 17 Donations of property, plant and equipment

During 2017-18 the Trust received Donated equipment as detailed below, for each item - there were no specific restrictions imposed by the donor

	Cost
Item	**£000**
Barry RFA Haloflex Energy Generator	42
Keeler Symphony Digital Slit Lamp with Motorised Stand	11
Oculus Pentacam HR	47
Wide Field Camera	40
Digital Reminiscence Therapy Software Package	13
Video Nasopharyngo Scope	11
Total	164

Note 18 Revaluations of property, plant and equipment

The Trust's property assets (land and buildings) were revalued during the year by the District Valuation Service, who are independant of the Trust and using Modern Equivalent Asset valuation techniques with a valuation date of 31st March 2018. Valuation was undertaken with reference to the size, location and Service Potential of existing buildings and the basis on which they would be replaced by Modern Equivalent Assets.

The Trust owns Non Operational Land assets of £850,000 which are currently held as surplus assets and are included within the Land Valuation in Note 16.1. These assets are required to be valued at 'Fair Value' in accordance with IFRS13. The valuation technique applied by the appointed Valuer in respect of all the Fair Value figures contained in his assessment was the market approach using prices and other relevant information generated by market transactions involving identical or comparable assets.

Note 19 Investment Property

The Trust does not have any investment properties.

Note 19 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	1,456	1,523
Consumables	3,087	3,553
Energy	199	192
Total inventories	**4,742**	**5,268**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £38,649k (2016/17: £38,061k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £8k).

Note 20.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	43,017	14,877
Capital receivables (including accrued capital related income)	604	-
Provision for impaired receivables	(5,040)	(3,134)
Prepayments (non-PFI)	1,281	1,090
PFI lifecycle prepayments	9,278	-
PDC dividend receivable	-	190
VAT receivable	1,666	2,003
Other receivables	2,074	2,074
Total current trade and other receivables	**52,880**	**17,100**
Non-current		
Provision for impaired receivables	(19)	(156)
Other receivables *	62,960	43,173
Total non-current trade and other receivables	**62,941**	**43,017**
Of which receivables from NHS and DHSC group bodies:		
Current	35,985	9,591
Non-current	-	-

The great majority of trade is with NHS Clinical Commissioning Groups (CCG's) . As CCG's are funded by Government to buy NHS patient care no credit scoring of them is considered necessary.

* The Non Current Other Receivable balance represents payments the Trust has made towards the construction of a new PFI Hospital (see information below). These payments are carried in Receivables until the PFI Hospital achieves Financial Close. The balance will be transferred to the Liabilities of the Trust. This will reduce the liability taken on by the Trust as the hospital is brought on to the Statement of Financial Position

* On 11/12/2015, the Trust entered into a PF2 contract to design, build, finance and maintain a new hospital at Grove Lane, named the Midland Metropolitan Hospital. Following a PF2 procurement and resultant funding competition, the Trust appointed The Hospital Company (Sandwell) Ltd as the prime contractor to deliver the project. The Hospital Company (Sandwell) contracted with Carillion Construction Ltd as prime contractor for construction. Carillion PLC and associated construction companies entered administration in January 2018 and since then the construction of the new site has largely halted. At year-end, the value of the work completed has been independently certified to be £206m and the Trust has made capital contributions towards this of £62m. Under the termination for contractor default clauses of a PF2 contract, these contributions are well protected and Management are now considering a range of options to complete the project. These range from restructuring but continuing the current PF2, reletting a new PF2 or taking ownership of the works completed to date and letting a new non-PF2 contract. Having considered the likely scenarios, Management are comfortable that the £62m paid to date is adequately protected and will generate at least that much value under the chosen option.

Note 20.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**3,290**	**2,057**
Increase in provision	2,202	1,382
Amounts utilised	(433)	(149)
At 31 March	**5,059**	**3,290**

Note 20.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	204	-	35	-
30-60 Days	210	-	126	-
60-90 days	171	-	77	-
90- 180 days	1,106	-	476	-
Over 180 days	3,368	-	2,576	-
Total	**5,059**	**-**	**3,290**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	15,508	-	2,592	-
30-60 Days	-	-	1,275	-
60-90 days	1,408	-	1,102	-
90- 180 days	3,484	-	1,838	-
Over 180 days	1,165	-	1,022	-
Total	**21,565**	**-**	**7,829**	**-**

Impairment of receivables is based on an assessment of individual amounts receivable taking into account the age of the debt and other known circumstances regarding the debt or the debtor.

Note 21 Other assets

	31 March 2018	31 March 2017
Current	**£000**	**£000**
Short term PFI finance lease asset	-	8,043
Total other current assets	-	8,043

Note 22 Non-current assets held for sale and assets in disposal groups

	2017/18	2016/17
	£000	**£000**
NBV of non-current assets for sale and assets in disposal groups at 1 April	-	-
Assets classified as available for sale in the year*	1,075	-
Assets sold in year*	(1,075)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	-	-

* During 2017/18 the Trust sold assets at the City site. These assets comprise land and buildings and the Trust's ability to sell them arises from the investment in the new Midland Metropolitan Hospital (MMH) in Smethwick. This investment is a key enabler of the delivery of the Trust's vision to become the best integrated care organisation in the NHS.
This vision will involve the Trust delivering a range of services from the City, Sandwell, MMH and Rowley sites as well as a number of community locations. Completion of the MMH will allow the Trust to cease the use of outdated building infrastructure and deliver patient care within a modern facility. At the City site, as a direct consequence of this, the Trust will need to retain only the Birmingham Treatment centre (BTC) and the Birmingham and Midland Eye Centre (BMEC).
Given the demand for housing in the local area the Trust has worked with the Homes and Communities Agency (HCA) to agree a deal that provides best value for patient services as well as meeting the housing needs of local residents.
The HCA have purchased the land excluding that element required to support the delivery of patient services at the City Hospital site predominantly, BTCentre and BMEC. The transaction was completed in August 2017 and the agreement includes the Trust leasing the assets back until the point at which MMH is available. The HCA intention is to ensure the land is employed for the development of homes.

Note 22.1 Liabilities in disposal groups

The Trust had no disposal groups in 2017/18 and therefore have no liabilities in disposal groups.

Note 23.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**23,902**	**27,296**
Net change in year	(14,211)	(3,394)
At 31 March	**9,691**	**23,902**
Broken down into:		
Cash at commercial banks and in hand	32	29
Cash with the Government Banking Service	9,659	23,873
Total cash and cash equivalents as in SoFP	**9,691**	**23,902**
Total cash and cash equivalents as in SoCF	**9,691**	**23,902**

Note 23.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	3	1
Total third party assets	**3**	**1**

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	18,606	26,670
Capital payables	6,101	7,218
Accruals	22,433	18,503
Receipts in advance (including payments on account)	5,877	4,946
Social security costs	3,543	3,408
Other taxes payable	2,726	2,728
PDC dividend payable	263	-
Total current trade and other payables	**59,549**	**63,473**
Of which payables from NHS and DHSC group bodies:		
Current	11,644	10,012
- outstanding pension contributions at year end	3,841	3,762

Note 24.2 Early retirements in NHS payables above

There are no early retirements required to be included in the payables note above

Note 25 Other financial liabilities

The Trust have no other financial liabilities.

Note 26 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	4,657	5,039
Total other current liabilities	**4,657**	**5,039**

Note 27 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	2,166	903
Total current borrowings	**2,166**	**903**
Non-current		
Obligations under PFI, LIFT or other service concession contracts	31,776	33,953
Total non-current borrowings	**31,776**	**33,953**

Note 28 Finance leases

The Trust has no finance leases as a lessor or as a lessee other than those detailed in Note 34.

Note 29.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2017	**1,017**	**302**	**9**	**137**	**3,078**	**4,543**
Change in the discount rate	7	-	-	-	46	**53**
Arising during the year	49	87	-	773	223	**1,132**
Utilised during the year	(91)	-	(2)	(98)	(150)	**(341)**
Reversed unused	(47)	-	-	(39)	-	**(86)**
Unwinding of discount	2	-	-	-	6	**8**
At 31 March 2018	**937**	**389**	**7**	**773**	**3,203**	**5,309**
Expected timing of cash flows:						
- not later than one year;	90	389	7	773	596	**1,855**
- later than one year and not later than five years;	361	-	-	-	570	**931**
- later than five years.	486	-	-	-	2,037	**2,523**
Total	**937**	**389**	**7**	**773**	**3,203**	**5,309**

Provisions relating to Early Departure Costs covers pre 1995 early retirement costs. Liabilities and the timing of liabilities are based on pensions provided to individual ex employees and projected life expectancies using government actuarial tables. The major uncertainties rest around life expectancies assumed for the cases.

Legal claims cover the Trust's potential liabilities for Public and Employer liability. Potential liabilities are calculated using professional assessment of individual cases by the Trust's insurers. The Trust's maximum liability for any individual case is £10,000 with the remainder being covered by insurers.

Other provisions cover Injury Benefits £2,749,000, HMRC Off Payroll Engagement £314,000 and National Poisons potential expenditure of £76,000 and Carbon Reduction Provision of £64,000

Injury benefit provisions are calculated with reference to the NHS Pensions Agency and actuarial tables for life expectancy.

Redundancy provisions covers staff who will be made redundant as part of the Trust's ongoing restructuring scheme

The timing and amount of the cashflows is shown above but it must be pointed out that, in the case of provisions, there will always be a measure of uncertainty. However, the values listed are best estimates taking all the relevant information and professional advice into consideration.

Note 29.2 Clinical negligence liabilities

At 31 March 2018, £170,234k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Sandwell And West Birmingham Hospitals NHS Trust (31 March 2017: £154,786k).

Note 30 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(167)	(188)
Other -Pension, Injury Liabilities and VAT	(345)	(92)
Gross value of contingent liabilities	**(512)**	**(280)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(512)**	**(280)**
Net value of contingent assets	-	-

Both the legal claims and Pension and Injury Liabilities were informed by NHS Resolution. The Other Contingent Liability incudes £306,000 to HMRC for a pending VAT review, the outcome of which is expected by 30th June 2018

Note 31 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	7,433	2,659
Intangible assets	-	-
Total	**7,433**	**2,659**

Note 32 Other financial commitments

The Trust has no other financial commitments which are not leases, PFI contracts or other service concession arrangements.

Note 33 Defined benefit pension schemes

The Trust has no defined benefit pension schemes other than disclosed in Note 9 - Pension costs.

Note 34 On-SoFP PFI, LIFT or other service concession arrangements

The information below is required by the Department of Heath for inclusion in national statutory accounts.

Midland Metropolitan Hospital (MMH)

A contract for the development of a new hospital was signed by the Trust and its PFI partner on 11/12/2015. The purpose of the scheme is to deliver a modern, state of the art acute hospital facility on the Grove Lane site in Smethwick, Birmingham.

The suspension of work on the Midland Metropolitan Hospital (MMH) following the liquidation of the main contractor has delayed the programmed completion date. The hospital was being delivered through PF2 which involves a 30 year concession period ending in 2048/49. At the end of that concession period the asset would pass into the ownership of the Trust or successor body.

There remains commitment to complete the project and currently a range of options are being explored to secure that completion.

The anticipated asset value of the hospital when brought into use will be £323,638,000

The Trust shall receive £97m of Public Dividend Capital which it expects to pay to its PFI partner as a contribution to the costs of the hospital development

The Trust is contractually committed to a total Unitary Payment cost in respect of the Midland Metropolitan Hospital of £698,443,000 payable over the life of the 30 year concession

Note 16.1 (Property, Plant and Equipment) includes £16,385,837 (2016/17 £13,107,786) as Assets under Construction in respect of the Midland Metropolitan Hospital. This represents costs incurred directly by the Trust in support of the hospital development

The Trust currently operates the Birmingham Treatment Centre (BTC) under a PFI concession and accounts for a Managed Equipment Service (MES) as a PFI scheme. The values below represent the financial obligations relating to the BTC and MES Scheme only

Birmingham Treatment Centre (BTC)

Length of Contract is 30 Years

The purpose of the scheme was to provide a modern, acute facility on the City Hospital site which has now been fully operational since June 2005.The Trust is committed to the full unitary payment until 30th June 2035 at which point the building will revert to the ownership of the Trust.

Managed Equipment Scheme (MES)

Length of Contract is 10 Years

The Scheme provides for the maintenance and replacement of the Trust's Imaging Equipment. This contract was assessed against the scope of IFRC12 to establish the appropriate accounting treatment and it was determined that the criteria to account for the scheme as an on SOFP service concession arrangement had been met. The contract, with Siemens Healthcare Limited, commenced on 1st May 2016 and the Trust is committed to the full unitary payment until May 2026 at which point the ownership of the equipment will revert to the Trust

Note 34.1 Imputed finance lease obligations

Sandwell And West Birmingham Hospitals NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**46,986**	**41,117**
Of which liabilities are due		
- not later than one year;	3,411	(5,868)
- later than one year and not later than five years;	12,295	12,546
- later than five years.	31,280	34,439
Finance charges allocated to future periods	(13,044)	(14,304)
Net PFI, LIFT or other service concession arrangement obligation	**33,942**	**26,813**
- not later than one year;	2,166	(7,140)
- later than one year and not later than five years;	7,935	7,979
- later than five years.	23,841	25,974

Note 34.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	128,408	136,061
Of which liabilities are due:		
- not later than one year;	7,845	7,653
- later than one year and not later than five years;	33,390	32,576
- later than five years.	87,173	95,832

Note 34.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	7,550	7,117
Consisting of:		
- Interest charge	1,277	1,332
- Repayment of finance lease liability	(7,151)	83
- Service element and other charges to operating expenditure	2,537	2,166
- Capital lifecycle maintenance	1,113	2,723
- Contingent rent	525	813
- Addition to lifecycle prepayment	9,249	-
Total amount paid to service concession operator	**7,550**	**7,117**

Note 35 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust had no Off-SoFP PFI, LIFT and other service concession arrangements

Note 36 Financial instruments

Note 36.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with CCG's and the way those CCG's are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCG's, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 36.2 Carrying values of financial assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	103,596	-	-	-	**103,596**
Cash and cash equivalents at bank and in hand	9,691	-	-	-	**9,691**
Total at 31 March 2018	**113,287**	**-**	**-**	**-**	**113,287**

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	56,834	-	-	-	**56,834**
Cash and cash equivalents at bank and in hand	23,902	-	-	-	**23,902**
Total at 31 March 2017	**80,736**	**-**	**-**	**-**	**80,736**

Note 36.3 Carrying value of financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018			
Obligations under PFI, LIFT and other service concession contracts	33,942	-	**33,942**
Trade and other payables excluding non financial liabilities	51,797	-	**51,797**
Total at 31 March 2018	**85,739**	**-**	**85,739**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Obligations under PFI, LIFT and other service concession contracts	34,856	-	**34,856**
Trade and other payables excluding non financial liabilities	63,473	-	**63,473**
Total at 31 March 2017	**98,329**	**-**	**98,329**

Note 36.4 Fair values of financial assets and liabilities

The Trust considers that Book value is a reasonable approximation of fair value

Note 36.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	53,988	63,473
In more than one year but not more than two years	2,349	-
In more than two years but not more than five years	5,585	5,791
In more than five years	23,817	29,065
Total	**85,739**	**98,329**

Note 37 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	6	0
Bad debts and claims abandoned	32	314	35	148
Stores losses and damage to property	7	30	12	48
Total losses	**39**	**344**	**53**	**196**
Special payments				
Ex-gratia payments	47	92	76	145
Total special payments	**47**	**92**	**76**	**145**
Total losses and special payments	**86**	**436**	**129**	**341**
Compensation payments received		-		-

Note 38 Gifts

There are no cases of the Trust making gifts.

Note 39 Related parties

During the year two of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, have undertaken material transactions with Sandwell & West Birmingham Hospitals NHS Trust :-

Cathryn Thomas (Non Executive Director of the Trust) and Vice Dean of Medicine and Programme Director MBChB - University of Birmingham

Raffaela Goodby (Director of People and Organisation Development of the Trust) and Independent Member of Governing Body & Director of Multi Academy Trust, Sandwell College

The Department of Health is regarded as a related party. During the year 2017/18 Sandwell and West Birmingham Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These are listed below:-

	Revenue	Expenditure	Receivables	Payables
	£000	**£000**	**£000**	**£000**
NHS Sandwell & West Birmingham CCG	268,631	-	3,285	1,816
NHS Birmingham Cross City CCG	42,309	598	278	920
Health Education England	18,420	35	384	25
NHS Birmingham South & Central CCG	23,518	-	601	616
NHS Walsall CCG	5,115	231	26	221
NHS Resolution	-	10,922	-	-
The Dudley Group NHS Foundation Trust	867	1,931	245	171
Walsall Healthcare NHS Trust	1,396	663	1,362	546
Sandwell College	233	42	33	-
University of Birmingham	271	1,539	198	728

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Department for Education and Skills in respect of University Hospitals Birmingham NHS Foundation Trust, Sandwell MBC and Birmingham City Council.

The Trust has also received capital payments from a number of charitable funds including Sandwell & West Birmingham Hospitals NHS Trust Charity, certain of the trustees for which are also members of the Trust board. The summary financial statements of the Funds Held on Trust are included in this annual report and accounts.

Note 40 Prior period adjustments

There are no Prior Period Adjustments in 2017/18

Note 41 Events after the reporting date

There are no events to report that occurred after the reporting period.

Note 42 Third Party Assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2017 £000s	31 March 2016 £000s
Third party assets held by the Trust - Patients' Monies	**3**	1

Note 43 Better Payment Practice code

	2017/18 Number	**2017/18 £000**	**2016/17 Number**	**2016/17 £000**
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	112,769	261,359	107,147	255,483
Total non-NHS trade invoices paid within target	62,371	202,845	56,239	204,246
Percentage of non-NHS trade invoices paid within target	55.31%	77.61%	52.49%	79.95%
NHS Payables				
Total NHS trade invoices paid in the year	3,021	28,549	2,141	31,490
Total NHS trade invoices paid within target	1,439	18,995	1,011	16,038
Percentage of NHS trade invoices paid within target	47.63%	66.53%	47.22%	50.93%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later. During 2016/17 a cash management initiative became a component of the financial recovery programme. This saw creditors days extended and a consequent reduction in the BPPC measure. During 2017/18 this initiative has continued and, through the finance and investment committee, the board has approved further extension of creditor payments so long as the obligations to creditors are balanced against the Trust's cash requirements. As a consequence the Trust's performance against BPPC reflects an approved and managed position.

Note 44 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	**2016/17 £000**
Cash flow financing	34,826	46,962
External financing requirement	**34,826**	**46,962**
External financing limit (EFL)	36,838	56,399
Under / (over) spend against EFL	2,012	9,437

Note 45 Capital Resource Limit

	2017/18 £000	**2016/17 £000**
Gross capital expenditure	26,263	19,029
Less: Disposals	(3,117)	-
Less: Donated and granted capital additions	(164)	(62)
Charge against Capital Resource Limit	22,982	18,967
Capital Resource Limit	23,212	18,968
Under / (over) spend against CRL	230	1

Note 46 Breakeven duty financial performance

	2017/18
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	22,365
Remove CQUIN risk reserve adjustment	1,800
Breakeven duty financial performance surplus / (deficit)	24,165

Note 47 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		7,260	2,193	1,863	6,523	6,751	4,653	3,857	(11,933)	24,165
Breakeven duty cumulative position	4,669	11,929	14,122	15,985	22,508	29,259	33,912	37,769	25,836	50,001
Operating income		384,774	387,870	424,144	433,007	439,022	446,590	443,698	460,197	494,158
Cumulative breakeven position as a percentage of operating income		3.10%	3.64%	3.77%	5.20%	6.66%	7.59%	8.51%	5.61%	10.12%

Independent auditor's report to the Directors of Sandwell & West Birmingham NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Sandwell & West Birmingham NHS Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report set out on pages 4 to 89, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities set out on page 94, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts

Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit & Risk Management Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in

all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Sandwell & West Birmingham NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

M C Stocks

Mark C Stocks
Partner
for and on behalf of Grant Thornton UK LLP

The Colmore Building
20 Colmore Row
Birmingham
B4 6AT

25 May 2018

For more information, please visit the Trust's website at www.swbh.nhs.uk

If you are unable to find the information you need on the website, then please contact the Communications Team by telephone on 0121 507 5303, by email at swbh.comms@nhs.net, or by post at:

Communications Department
Trinity House
Sandwell General Hospital
Lyndon
West Bromwich
West Midlands
B74 4HJ

The Freedom of Information Act (2000) entitles you to request information on a variety of subjects, including our services, infection rates, performance, and staffing. For more details on how to make a Freedom of Information request you can visit our website – click Contact and scroll to Freedom of Information on the left hand side. Alternatively, you can click on this link to visit the section: https://www.swbh.nhs.uk/contact-locations/freedom-of-information/

How to find us
For more details on how to get to our hospital sites, you can go on our website and select the 'Contact Us' tab (https://www.swbh.nhs.uk/contact-locations/find-us/).

To contact us by telephone, please call 0121 554 3801.

Birmingham City Hospital (this site includes Birmingham Treatment Centre, Birmingham Eye Centre, the Birmingham Skin Centre, and our midwife-led facility Serenity.) Dudley Road Birmingham West Midlands B18 7QH

Sandwell General Hospital Lyndon West Bromwich West Midlands B71 4HJ

Rowley Regis Community Hospital Moor Lane Rowley Regis West Midlands B65 8DA

Leasowes Intermediate Care Centre Oldbury Road Smethwick West Midlands B66 1JE

Car parking
Car parks are situated near the main entrances of each hospital site. Vehicles are parked and left at the owner's risk. Spaces for disabled badge holders can be found at various points all around our site. The car parks operate a pay by foot facility, except for two pay and display car parks at City Hospital. One is directly in front of the main entrance (for blue badge holders only), and the other is located by Hearing Services.

Reduced car parking charges
If a patient is seen more than one hour late in clinic, then they do not have to pay extra for their parking. Ask for a form at the reception desk, then please take the completed form to either the BTC Reception (at City), or to the General Enquires desk (found in the main reception at Sandwell). Please note there will still be a minimum charge of £2.80. You will then be given a ticket that allows you to exit the car park without further charge.

Parking rates from May 2017/18

Standard Tariff (except Rowley Regis)
Up to 15 minutes - FREE
Up to 1 hour - £2.80
Up to 2 hours -£3.80
Up to 3 hours -£4.30
Up to 5 hours -£4.80
Up to 24 hours - £5.30

Concessions
One Shot Tickets - 4 for £10
Season Tickets
3 days £9 (+ £5 refundable deposit)
7 days £18 (+ £5 refundable deposit)
3 months £42 (+ £5 refundable deposit)

Rowley Regis
Up to 15 minutes – FREE
Up to 6 hours - £2.80
From 6-24 hours - £5.30

Discounted parking charge options
For regular visitors and patients there are the following discounted parking charge options: Season tickets Three days unlimited parking - £9.00. One week unlimited parking - £18.00. Three months unlimited parking - £42.00. A £5 refundable deposit is required for season tickets. One Shot Tickets – four for £10.

Blue Badge Holders
The tariff applies to Blue Badge Scheme users. Parking for blue badge holders is located as close to main hospital buildings as possible.

Patients on benefits
Anyone on a low income who is entitled to certain benefits or receives income support can claim for reimbursement of bus fare or receive a token to allow free exit from hospital car parks. Bring proof of your benefits to any of the main receptions, or to the City Hospital Cash Office (located on the ground floor main corridor).

Patient Advice and Liaison Service (PALS)
By contacting PALS, you can talk to someone who is not involved in your care. You can ask questions, get advice or give your opinions.

Providing help and support with the power to negotiate solutions or speedy resolutions of problems, PALS also acts as a gateway to independent advice and will help solve your problem either formally or informally. Contact PALS by emailing swb-tr.pals@nhs.net or by phoning 0121 507 5836 (10am – 4pm, Monday – Friday). Please leave a message if the line is engaged/you are calling outside office hours.

We have introduced Purple Points across our sites as a new way to ensure inpatients and their loved ones can speak to someone who can help them resolve a concern whilst they are still in our care. Patients and/or their relatives can use phones at our Purple Points, located outside inpatient wards, to call our advisors between 9am and 9pm every day.

. They will contact staff on the ward in question, who will aim to resolve the concern so that we can make a difference at the time, rather than when they have gone home. The patient and/or relative will be kept up-to-date, ensuring they are happy with the outcome. Alternatively, they can call the team to compliment individual staff, teams or services. The phone line is also available in foreign languages. Patients or their loved ones can also call 0121 507 4999 direct from their own phone.

To make an official complaint

To make a complaint, you can send it in writing to:

Complaints Department
Sandwell & West Birmingham Hospitals NHS Trust
City Hospital
Dudley Road Birmingham
B18 7QH

Or by emailing swbh.complaints@nhs.net, or by phoning 0121 507 4346 (10am – 4pm, Monday – Friday). Please leave a message if the line is engaged/you are calling outside office hours.

April - James Morris, MP, with Richard Samuda, Sandwell and West Birmingham Hospitals NHS Trust Chairman, with the team from Heart of Sandwell Day Hospice.

May - Mayor of Sandwell Coun Ahmadul Haque and Coun Susan Eaves as Deputy Mayor. The Mayor chose to support Your Trust Charity during his year of service.

August - The Deteriorating Patient and Resuscitation Team led vital research into chest compressions. Pictured is John Hulme, Critical Care Consultant.

September - Our first ever annual Speak Up Day was a huge success, with more than 1,000 staff signing up to the promise to always speak up. Pictured are a selection of colleagues who made their promise to Speak Up.

December - We have teamed up with the Red Cross in helping to support patients at home. (L-r) Kate Rowley, Physiotherapist, Paul Bennett, Trainee Aadvanced Nurse Practitioner, patient Graham Harrison, and Red Cross Support Worker, Pauline Nettleford.

January - Welcoming the Safety Plan, are Tracy Weston, ward manager for D17 and Anthea Forsythe, staff nurse. The initiative has seen a 30 per cent reduction in falls.

June - National audit results showed that our young diabetes patients are 'the best' in self-managing their condition. Pictured are some of the team, (l-r) Dr Chizo Agwu, Consultant Paediatrician, diabetes patient Lauren Smith, with Paediatric Diabetes Nurse Specialists Lizbeth Hudson and Sammie Bissell.

July - The Topping out ceremony at Midland Met Hospital saw the West Midlands Mayor Andy Street attend and speak about the development.

October - In October we celebrated Black History Month. Dr Donna Thompson, Consultant Dermatologist talks about her own history.

November - Our Care Quality Commission report was released, and 70 per cent of our services are now rated as 'good' or 'outstanding'. Pictured are the Connected Palliative Care Team (above) and the Stroke Newton 4 Team (below).

February - Kam Dhami (L), Director of Governance, talking to stroke patient Barry Fisher (R) about how to use our Purple Point.

March - We launched our Nurse Escalator Programme which will help elevate nurses quickly through the ranks. Welcoming the initiative are (l-r) Cordu Jarra, Ssenior Staff Nurse, Gemma Stone, Healthcare Assistant, Nina Faraon, senior staff nurse, Elaine Newell Chief Nurse, Shirley Castro Cclinical Lead Nurse, Susan Grantham, Ward Manager.

YEARS OF THE NHS 1948 - 2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Audit and Risk Committee

Venue Room 13, Education Centre, Sandwell General Hospital **Date** 4th May 2018; 1000h – 1200h

Present

Members Present		In Attendance
Mrs M Perry	Chair	Mr T Lewis (item 5 only)
Mr H Kang	Non-Executive Director	Miss K Dhami
Ms O Dutton	Non-Executive Director	Mr T Waite
		Mrs P Gardner
		Ms D McLannahan
		Miss C Dooley
		Mr M Gennard
		Mr A Hussain
		Mr B Vaughan
		Mr M Stocks
		Mrs E Quinn

Minutes	Paper Reference
1 Welcome, apologies and declarations of interest	**Verbal**
Ms Perry welcomed all present to the meeting. Apologies had been received from Waseem Zaffar, Tim Reardon, Nicola Coombe and Sophie Coster.	
2 Minutes of the previous meeting held on 24th January 2018	**AR (05/18) 001**
The minutes of the previous meeting held on 24th January 2018 were agreed as a true record.	
3 Matters and actions arising from previous meetings	**AR (05/18) 002**
The Committee noted that any outstanding actions were to be discussed as part of the agenda at the next meeting on 23rd May. The item in relation to Data Quality had been reassigned to Dave Baker, Director of Partnerships & Innovation, who was to be invited to future committee meetings.	
4 Review of Unaudited Annual Accounts	**AR (05/18) 003**
Mr Waite presented the report that deals with the draft financial statements for the year ended 31 March 2018.	

He reported that External Audit opinions on Value for Money (VFM) will be provided by the end of the month. Mr Waite stressed the importance of being sighted on matters for the ISA 260 in time for the next meeting on 23rd May and for submission of the Accounts by the end of the month deadline.

Mrs Perry expressed the importance of the need for clarity from the External Audit team prior to comment, particularly the I&E position. Mr Waite sought to clarify this point as follows, and highlighted that this formed part of the update from the Finance and Investment Committee to the Trust Board:

2017.18 Year	Actual £m	Plan £m	Variance £m
Report headline	13.9	9.9	4.0
STF adjustment	(7.6)	(10.5)	2.9
CQUIN adjustment	-	1.8	(1.8)
Control Total surplus	6.3	1.2	5.1

2017.18 Year	Actual £m
Report headline	13.9
'Bonus' STF accrual	10.2
Impairment reversal	8.4
Draft Accounts surplus	32.5

Mr Waite summarised that the majority of key matters of accounting judgement had been dealt with at the last meeting in January since when, there had been the demise of Carillion. The situation over the next few weeks remains fluid and could potentially influence accounting judgements

Mr Stocks re-confirmed the External Audit opinion that the 2017/18 annual accounts should be prepared on the basis that SWBH Trust is a going concern and that the current accounting judgement in relation to Carillion would not adjust events in terms of either disclosure or impact (not on the balance sheet).

The Committee challenged and confirmed its agreement that the Accounts could be signed off at the next meeting on 23rd May, subject to any pending amendments relating to changes regarding the position with the Midland Metropolitan Hospital.

5 Draft Annual Governance Statement	**AR (05/18) 004**

Mr Lewis was in attendance to present the AGS. He highlighted the areas that had been managed during 2017/18, to include Cyber Security and Coroner Regulation 28 Reports. The areas of concern and for focus in 2018/19 were drawn out: the liquidation of Carillion Construction, I.T. infrastructure and a more devolved

operating level of financial management.

In terms of the demise of Carillion, Mr Lewis reported that going forward, the residual area of control was not just the Midland Metropolitan Hospital, but the reconfiguration of services. This will be reflected in the AGS.

6 External Audit Progress Report and Sector Update	AR (05/18) 005

Mr Stocks presented the report and made the assumption that it had been read in advance of the meeting. He highlighted that since the date of the last meeting, a value for money risk had been identified in respect of the Midland Metropolitan Hospital build following the collapse of Carillion. This would require a formal change to the Audit programme, as a review will need to be undertaken to ensure the Trust had made informed decisions.

In terms of progress in relation to the audit of the annual accounts, Mr Stocks reported that the position is not where it needs to be however, Ms McLannahan is now overseeing information requests to the Trust's finance team to ensure a rapid response. Ms McLannahan reported that the position is recoverable and that good progress had been since the beginning of the week.

Mrs Perry stressed the importance that the papers for the next meeting on 23rd May are issued no later than Friday 18th May to allow Committee members sufficient time for preparation. The External Audit report on the 2017/18 Annual Accounts was therefore to be submitted by the deadline, regardless of whether or not it was completed. Any identified gaps would be discussed at the meeting. In the interim, Ms McLannahan committed to keep Mrs Perry updated of the position.

7 Internal Audit Annual Report and Head of Internal Audit Opinion	AR (05/18) 006

Mr Gennard presented the report that provides the Committee with an overview of the work completed by Internal Audit in 2017/18 and advises the Head of Internal Audit opinion, based on the work undertaken.

Mr Gennard reported that the overall audit opinion was positive, however, work undertaken has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective. He highlighted four partial assurance opinions:

- Compliance with Overseas Visitors Charging Policy;
- Maximising Delivery of the Production Plan;
- I.T. Disaster Recovery and Business Continuity Planning;
- Safeguarding Children.

Ms Dhami reported that the Trust had now appointed an Overseas Visitors Manager to facilitate better grip and control in this area. Ms Dutton queried if the Trust had any so-called 'Windrush' patients, following the recent media coverage in this respect. Ms Dhami was not aware that this was the case but would further investigate this for inclusion within the Governance Pack to be discussed at the next meeting.

The Committee received and noted the report.

8 Internal Audit Progress Report Compendium	AR (05/18) 007

Mr Hussain presented the progress report and summarised that since the date of the last meeting, five reports have been finalised, with a further four reports issued in draft. The Committee noted that four overdue management actions remain open on the tracker and are being followed up with the relevant responsible officers. Mrs Perry was satisfied that any outstanding actions are consistently reduced when reported.

9 Local Counter Fraud Specialist (LCFS) Workplan	AR (05/18) 008

Mr Vaughan presented the report and made the assumption that it had been read in advance of the meeting.

He highlighted the areas of proactive work covered across the plan and the level of resource required to deliver the plan.

Mrs Perry felt that good proactive work was being undertaken by the LCFS and was generating effective results.

10 Local Counter Fraud Specialist (LCFS) Annual Report	**AR (05/18) 009**

The Committee received and noted the update on progress against the 2017/18 counter fraud work plan. Mr Vaughan highlighted the various positive pieces of work undertaken by the LCFS to raise staff awareness of fraud. The self-assessment, together with the level of LCFS resource was challenged and confirmed by the Committee.
Mr Vaughan reported that staff engagement at the Trust was higher than that elsewhere. Mrs Perry felt that this was reflected in effectiveness results and was a positive note to be highlighted to the Board.

11 Committee Effectiveness	**Verbal**

The Committee felt the matters on the agenda were the key matters that it needed to focus its attention on.

12 Matters to raise to the Trust Board	**Verbal**

The Committee agreed the following matters should be raised to the Trust Board:

a) External Audit re-confirmed opinion that the 2017/18 annual accounts should be prepared on the basis that SWBH Trust is a going concern. Current accounting judgement in relation to Carillion would not adjust events in terms of either disclosure or impact (not on balance sheet);
b) Progress is being monitored in relation to the audit for the expected accounts;
c) Positive Internal Audit opinion. Recommendations as expected.
d) Positive feedback from the Local Counter Fraud Specialist (LCFS) in terms of reactive reporting and staff engagement;
e) Two accounting issues were identified for discussion at the next meeting:
    - treatment of a prospective Midland Metropolitan Hospital deal;
    - a clear explanation of treatment of pre-payment.

13 Any other business	**Verbal**

Mrs Perry asked that the Annual Report is circulated to Committee members and Audit colleagues. Miss Dooley committed to making arrangements with the Director of Communications in this respect.

Details of the next meeting

The next meeting will be held on 23rd May 2018 at 1000 – 1200h in the Education Centre, Sandwell Hospital.

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MAJOR PROJECTS AUTHORITY COMMITTEE UPDATE	
Date of meeting	18th May 2018
Attendees	Mr Richard Samuda, Mr Tony Waite, Ms Raffaela Goodby, Mr Mark Reynolds, Mr Alan Kenny, Dr Dean Harris, Mr Liam Kennedy and Ms Clare Dooley
Apologies	Mr Mike Hoare, Mr Toby Lewis, Ms Rachel Barlow and Mrs Olwen Dutton
Key points of discussion relevant to the Board	**IT INFRASTRUCTURE** An update on the 3 red rated risks was provided: • The LAN work is complete and is no longer red. There is a specific issue relating to an endoscopy washer that will be resolved by Informatics and Medical Engineering. • Resolution of WAN issues is delayed as a new firewall needs to be purchased. This will be a 6 – 8 week delay. The underlying cause was due to the complexities of N3 (the NHS network) that stopped the original plan proceeding. • Storage issues are on track to be resolved by end May 2018. During the last month there has been a significant issue with IT desktops that has affected users across the Trust. A fix has been developed and will be rolled out by Tuesday 22nd May. **Cerner**: • A solution is now in place for printing to USB printers. • A solution has not yet been identified on router issues and work is ongoing with Cerner which is anticipated to take 3-4 weeks to resolve. • Citrix – our PAS holds an older version of Citrix which requires updating as not compatible with Unity. Intensive and urgent work is taking place to resolve these issues but at the point of the meeting a definitive solution had not yet been identified. Fundamentally if this is not resolved it will have an impact on Unity go-live. This issue is recorded on Trust and Project risk registers). It was noted there are around 60 systems currently operating across the Trust which are running on obsolete infrastructure. The digital committee review/oversee these issues and MPA will receive further updates on all systems at next meeting. **UNITY UPDATE** • Timeline sets out key landmarks towards August go-live with readiness gateways set (30/60/90 days). • An Implementation Team (PMO) function has been established and formal gateways between SWBH and Cerner are in place (hard-stop gateways). • Some red rated items remain, particularly Citrix (as described above) and user training behind schedule (capacity and release issues).

	• First dress rehearsal covered 50% of in-patient and 30% out-patient areas and a 3 week Unity Fayre will take place which will include drop-in sessions and walkabouts for all areas to check logins work and assist to set up user's home pages/personal preferences. • Full dress rehearsal will include complete end to end patient care (e.g. scanning devices, reporting, command and control systems). • Review sessions on walkthrough experiences takes place weekly led by Chief Operating Officer and the implementation team will report on deployment success (and risks, hazards and issues) at these meetings. • An updated report on risks/hazards/incidents will be provided to the next (June) meeting.
Positive highlights of note	• LAN issues have been resolved (no longer an IT infrastructure red risk)
Matters of concern or key risks to escalate to the Board	• Citrix system compatibility issues with Unity/potential impact on go-live. • Unity user training behind schedule.
Matters presented for information or noting	None
Decisions made	None
Actions agreed	An updated report on Unity risks/hazards/incidents will be provided to the next (June) meeting.

Mr Richard Samuda
Chair of the Major Projects Authority Committee
For the meeting of the Trust Board scheduled for 7th June 2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Major Projects Authority Committee Minutes

Venue	Room 13, Education Centre, Sandwell General Hospital	Date	20th April 2018 0930 – 1100

Members Present:

Mr Mike Hoare	Non-Executive Director (Chair)
Mr Toby Lewis	Chief Executive
Mr Tony Waite	Director of Finance
Mr Alan Kenny	Director of Estates and New Hospital
Mr Mark Reynolds	Chief Information Officer
Ms Rachel Barlow	Chief Operating Officer

In attendance:

Ms Clare Dooley	Head of Corporate Governance

1. Welcome, apologies and declarations of interest	Verbal
Apologies were received from Mr Samuda, Ms Dutton and Mrs Goodby.	
2. Minutes of the previous meeting	SWBMPA (04/18) 001
The minutes of the meeting held on 23rd March 2018 were accepted as an accurate record with the following minor amendment: • Item 4.1 should refer to "N3" network not M3.	
3. Matters arising (action log)	SWBMPA (04/18) 002
• Unity readiness survey will be a report to May MPA meeting. • Financial gain paper is in progress and will be provided to June MPA meeting. • Stretch on equipment assets review will be provided to June Board meeting, and will now advise on spread across two sites to 2022.	
4.0 IT: Infrastructure 4.1 Informatics Infrastructure Scorecard	SWBMPA (04/18) 003
Mr Reynolds advised that an IT infrastructure plan paper would be provided to digital committee (later today) following previous assessment discussions at MPA on improvement/sustainability for the next two years. Mr Reynolds provided an update on actions/mitigation measures to reduce and close current red risks in relation to WAN, LAN and back-up (storage). It was noted these should be resolved throughout April/May with all concluded by end May 2018. It was confirmed that the Barracuda system is in place but not yet live and an update on this issue will be provided to the next MPA meeting. Mr Reynolds reported that actions, anticipated to take 3 to 4 weeks to resolve, that are required following the annual cyber security assessment (from an external company), will be updated at the May MPA meeting.	

Finally, Mr Reynolds clarified that his current focus is IT infrastructure and Dean Harris (Deputy CIO) will focus on implementation of Unity.

5.0 IT: EPR 5.1 Unity Dress Rehearsal Feedback and Milestones/Risks	SWBMPA (04/18) 004

Ms Barlow provided a verbal report on progress, 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 around 130 staff, took part in week one, with clear visibility of the training/technical team across the Trust.

Familiarity of the Unity product/brand is increasing but staff are not yet fully familiar or confident with the system, although managing this is moving at pace. The technical support "floor-walker" model, used in some areas during week one, was the preferred/most successful approach.

Overall there was good clinical engagement, good feedback on training and local workflow application but issues with logins and network reliability/connectivity were highlighted with further communication work/ engagement work identified.

It was noted 15th June is last official day for sign off of final Unity product and this is discussed weekly at implementation meeting.

It was agreed that at the May MPA meeting Unity will be a main focus item, to include:

- Implementation plan through to December 2018
- Outputs from the first dress rehearsal
- Risks, issues and hazards report
- Readiness checklist (including training competencies)

The final point to note was that Citrix/IPM resolution is awaited as a quote on a critical component is required and this will be reported back to the next MPA meeting.

Estates 6.1 Update on the Hospital Company Progress	Verbal

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.

6.2 2018/19 Capital Plan Delivery	SWBMPA (04/18) 005
Mr Kenny provided the capital plan programme, focussing on the non-Midland Met estate, which is 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. It is anticipated that year-end financial position will reduce impact on 2018/19 capital schemes and SGH schemes/works will be delivered in full.	
7.0 Meeting Effectiveness	Verbal
The members were of the view the meeting had facilitated useful discussions.	
8.0 Matters to raise to the Trust Board.	Verbal
• Unity full dress rehearsal • Midland Met progress position • Capital scheme delivery	
9. 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 18th May 2018 at 9.30 am in the Anne Gibson Committee Room, City Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE UPDATE	
Date of meeting	25 May 2018, 10.45am – 12.15pm
Attendees	Ms. O. Dutton (Chair), Ms. M. Perry, Mr. R. Samuda, Ms. R. Barlow, Mr. D. Baker, Mrs. P. Gardner, Dr. D. Carruthers and Miss K. Dhami
Apologies	Apologies were received from Ms. C. Parker
Key points of discussion relevant to the Board	• Patient Story for June Board : A patient will be attending this month's Trust Board meeting to tell the story about her visit to Critical Care where she was admitted with sepsis which led to the development of multi organ failure. During her 10-day stay she was sedated & required organ support for her lungs, heart and kidneys. Throughout her admission, her care and the commencement of rehabilitation was coordinated and delivered by all members of the Critical Care wider MDT. Her husband was supported throughout. • Integrated Quality and Performance Report and Persistent Reds : . Improvements and focus are evident in several other areas including the 'persistent reds' action plan;. Specific under-performance is likely to continue for Cancer performance signals pressure for May and June 62 day targets, with Q1 being at risk. Diagnostic performance (DM01) are below target for the second month running, with recovery in June; HSMR and RAMI weekend mortality indicators are highlighting the Trust as an outlier, whilst elective cancellations show a significant improvement in-month Performance Targets 2018-19 : A&E performance trajectory has been signed off with NHSI and NHSE. All other national performance standards remain consistent to last year. CCG may signal local level changes as part of signing off the final 2018-19 contract. IQPR Persistent Red indicators are progressing with focus on '12x resolve items. One indicator resolved in April (A&E unplanned re-attendances reduced to 4.6% from 7.9% in February and over-achieved the standard of 5%). We will now try to hold this for 3 months before considering removing it from persistent red reporting. Several others are showing significant improvement such as elective cancellations down from 1.7% to 0.9%, only 0.1% to go and looking forward to May we know that the treatment functions underperforming for RTT will drop from 4 to 3 with Oral Surgery beginning to perform. Neutropenic Sepsis continues to improve and the improvement may be greater as one of the breaches may be validated out meaning the performance is ~95%. Open referrals is the only persistent red that seems to be trending in the wrong direction. Trajectories are being pulled together for all the persistent reds. The IQPR incorporates a couple of new indicators this month, it should be noted that they are in early stages of reports. • Serious Incident Themes : 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. • Coroners Inquests : Regulation 28 : The Coroner has raised concerns over 2 recent cases and has requested via Regulation 28 reports for specific actions to be taken in addition to those set out within the submitted SI reports. One case relates to management of head injury and imaging of the neck, while the other is in relation to results being reviewed and acted on to aid decision making on patient management. Progress in addressing the concerns was presented. • Consistency of Care Programme Data : Data was attached and discussed for week commencing 7 May 2018. Medicine and PCCT Groups have met weekly with

QUALITY AND SAFETY COMMITTEE UPDATE	
	Executives since the beginning of January 2018 to provide assurance around a range of basic care indicators. Medicine have an improved trajectory with three wards displaying 100% in all elements in the last two weeks and five wards in the last week. This triangulates with the Safety Plan, demonstrating over a three month period from January to March, where missed checks were at a level of 36 in January and a reduction to 10 in March. PCCT increased trajectory of improvement over the last six weeks 100% across all wards and triangulates well with the Safety Plan data. Assurance processes with ward walkabouts, mock CQC and peer quality assurance reviews. Ward dashboards are being implemented and ward discharge will be discussed at Board Development session in June. • Quality Plan : The Quality Plan was relaunched at the Leadership Conference on 22/05/2018. The aim was to remind participants of the aim and scope of the plan and the reasons behind the focus on particular areas. Some have moved forward already in specific departments (e.g. neonatal), others have a body of work already proposed and underway (e.g. sepsis) and others overlap with ongoing developmental work in examining mortality in the Trust. A quality improvement process will be followed with engagement of junior doctors and other clinical staff under the guidance of a clinical lead for each area and support from the improvement team. The Leadership conference also tasked groups to look at approaches to both disease specific aspects of the plan as well as cross cutting areas that are relevant to all clinical groups. The feedback on the workshops is being collated and will inform the quality improvement plans • Complaints Annual Report : The complaints annual report provided details of the launch of Purple Point, the early success in out of hour's access and the promotion of positive feedback as well as concerns. Key areas for focus for the Complaints Team include learning from complaints, sharing this across the Trust. A total of 876 formal complaints, and 2242 informal complaints were made against the Trust in 2017/18. 92% of complaints have been responded to in time in 2017/18 against the 81% result from 2016/17. • Maternal Death : The details of the unfortunate maternal death of a 40 year old lady, was shared with members. The patient had a cardiac arrest during the birth of her 5th child. An investigation is taking place. Staff have been thanked for their support provided to the family and their professionalism throughout. • Changing Places: A child is suing a theme park for not having any changing facilities with hoist equipment which visitors with a disability can use. The matter was discussed in relation to such a need in the Trust. The issue was passed to the learning disability team to explore
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 • Reduction in un-planned re-attendances. • Mortality data being presented at Board.
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 7 June 2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE MINUTES

Venue Anne Gibson Committee Room, City Hospital **Date** 27 April 2018; 1045 - 1215

Members attending:		**In attendance:**	
Ms. O. Dutton	Non-Executive Director & Chair	Mrs. S. Cattermole	Executive Assistant
Ms. M. Perry	Non-Executive Director	Ms. C. Dooley	Head of Corporate Governance
Mrs. E. Newell	Chief Nurse		
Mr. D. Baker	Director of Partnerships and Innovation		
Miss K. Dhami	Director of Governance		
Ms. R. Barlow	Chief Operating Officer		
Dr. D. Carruthers	Medical Director		

Minutes	**Paper Reference**
1. Welcome, apologies for absence and declarations of interest	***Verbal***
Apologies were received from Mr. R. Samuda and Mrs. C. Parker. The members present did not have any interests to declare.	
2. Minutes of the previous meeting	***SWBQS (04/18) 002***
The minutes of the previous meeting held on the 23rd March 2018 were approved as a correct record.	
3. Matters and actions arising from previous meetings	***SWBQS (04/18) 003***
Ms. Dooley informed members that the Board Assurance Framework will be presented to future Quality and Safety Committee meetings. All other items for discussion were agenda items.	
4. Patient story for the April Trust Board	***Verbal***
Ms. Newell informed members that 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.	
5. CQC Improvement Plan: Progress Report	***SWBQS (04/18) 004***
The CQC Improvement Plan Progress Report was tabled and discussed by Committee members. 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. 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.	

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.

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.

6. Integrated Quality and Performance Report and Persistent Reds	***SWBQS* (04/18) *005 & 006***

An overview of the year-end delivery of performance across the IQPR was summarised in the supplement summary by Mr. Baker. To note, 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) and Cancer which has had a couple of dips but has achieved each quarter and the persistent Reds. Challenges include: A&E (83.3% to 87.2% prior year); cancelled operations (1.2% v 0.8% target) and workforce compliance around sickness (4.5% versus 3% target) and nursing turnover rates (13.5% 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. 2018-19 confirmation of CQUIN leadership to be confirmed to avoid potential delays in delivery. 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. Some are within our control e.g. RTT Validation. Some are not e.g. Workforce matters relating to ESR which will continue to run a month in arrears.

A summary of performance of persistent reds up to March 2018 was outlined. 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. Teams will be looked to resolve items that have moved largely into the right direction through March. Items 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 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%. Queries were raised as to whether this target was ambitious but work is being done to look at new ideas to make an impact along with a staged target.

There was an in-depth discussion regarding medical workforce risks, in particular the reduction in the number of middle-grade doctors and the difficulties in being able to recruit. Item to be added to the Trust Risk Register.

7. Neonatal Peer Review Report and Trust Response	***SWBQS (04/18) 007***

Mrs. Newell informed committee members that 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.

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

8. Amenable Mortality and Sepsis	*SWBQS (04/18) 008*

Dr. Carruthers explained that 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.

Dr. Carruthers also presented a paper on Sepsis and asked Committee members to consider the 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 were also outlined. Local initiatives around sepsis management have been communicated via Hot topics and focus on a sepsis awareness campaign. Members were informed that 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 were discussed in more detail in the improvement programme section for sepsis that was circulated. Dr. Carruthers agreed to provide a Sepsis flowchart to the Board for ease of clarity of the Sepsis Screening and Sepsis 6 bundle.

9. Maternity Summit Action Plan	*SWBQS (04/18) 009*

Ms. Newell asked the Board 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.

ACTION : Maternity Summit Action Plan to be given at July 2018 Q&S Meeting.

10. Draft 2017/18 Quality Account	*SWBQS (04/18) 010*

The 2017/18 annual Quality account detailing the Trust's performance for 2017/18 was outlined by Dr. Carruthers. 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. Comments are to be fed back to Dr. Carruthers.

11. Quality Plan	*SWBQS (04/18) 011*

Dr. Carruthers clarified that 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. Any modifications to the Quality Plan will be fed into Quality and Safety.

12. Complaints Report : Q4	***Verbal***

Miss Dhami 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 by the members as positive and demonstrated an organisation that was open to patient feedback and learning. An update report was given on the first 2 months of the Purple Point initiative. Detailed were calls received and how they were managed.

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

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

14. Meeting Effectiveness	***Verbal***

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

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

There were no other items for discussion.

16. Date and time of the next meeting

Next meeting: 25 May 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: Room 13, Education Centre, Sandwell Hospital

Date: 27 April 2018, 0900h – 1030h

Members present:		**In attendance:**	
Mr Mike Hoare	Chair	Ms Dinah McLannahan	Deputy Director of Finance
Mr Richard Samuda	Non-Executive Director (via telephone)	Miss Clare Dooley	Head of Coprorate Governance
Mr Harjinder Kang	Non-Executive Director		
Mrs Marie Perry	Non-Executive Director		
Mr Toby Lewis	Chief Executive		
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. No apologies had been received. The members present did not have any interests to declare.	
2. Minutes of the previous meeting held on 23 March 2018	**FIC (04/18) 002**
The minutes were agreed as a true record.	
2.1. Matters arising and update on actions from the previous meetings	FIC (04/18) 002(a)
The Committee noted that there were no on-going actions.	
3. Financial Performance – P12 March 2018	**FIC (04/18) 003**
The Committee received the P12 report and noted that the Trust was reporting having met each of its three key financial targets [Control Total; CRL & EFL] for the financial year 2017/18. Specifically, P&L performance was £5.1m better than pre-STF Control Total. The delivery of surplus over and above Control Total should, subject to audit confirmation of the draft accounts, secure 'bonus' STF monies of £10.2m. The funds are expected to be received in Quarter 2. Mr Waite committed to circulate the NHSI guidance in relation to the calculation of STF bonus to the Committee members. Mr Waite confirmed that the finance report was consistent with the P12 return to NHSI on 17 April and that subsequently the draft accounts had been submitted in accordance with the April deadline.	

A reconciliation of the P12 finance report to Control Total and to draft accounts is shown in the tables below:

2017.18 Year	Actual £m	Plan £m	Variance £m
Report headline	13.9	9.9	4.0
STF adjustment	(7.6)	(10.5)	2.9
CQUIN adjustment	-	1.8	(1.8)
Control Total surplus	6.3	1.2	5.1

2017.18 Year	Actual £m
Report headline	13.9
'Bonus' STF accrual	10.2
Impairment reversal	8.4
Draft Accounts surplus	32.5

Mr Waite drew the Committee's attention to key matters of accounting judgement relevant to those draft accounts and specifically, the carrying value of the £63m pre-payment on Midland Met PF2 contract post the demise of Carillion. This matter and any other such judgements will be managed via the Audit and Risk Management Committee.

Cash balances as at 31st March were noted as £9.7m, being £9.4m ahead of the NHSI plan and compliant with the trust's EFL target.

Capital expenditure was noted to be at £26.2m for the year and compliant with CRL target.

The underlying financial position exit run rate of deficit £22.7m is consistent with that at the start of 2017/18 so the Trust has achieved real financial balance for the year. That is a differential achievement.

Addressing that deficit on a basis consistent with securing sustainable finances is a focus of the 2018/19 financial plan.

4. Financial Plan 2018-19: Control Total	**FIC (03/18) 004**

Mr Waite reminded the Committee that, as confirmed by the Board at its April meeting, the acceptance of the control total had been delegated to this FIC meeting, prior to final plan submission due with NHSI on 30th April.

Consistent with a revised Control Total issued by NHSI, the financial plan requires savings / margin generation of c£37m. The Committee noted the progress on CIP development, specifically, plans totalling £28.7m against that CIP target of £37m.

The Committee noted that there are specific opportunities to bridge the 'gap' of c£9m. To do that shall require satisfactory resolution with NHSE Specialised Commissioning and the realisation of one or more

commercialisation opportunities previously reported.

The Committee challenged and [re-]confirmed its decision to endorse the acceptance of a revised financial control total for 2018.19 and this should now necessarily be considered by the Board.

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

The Committee wished to highlight the following matters:

- Over-performance for the 2017/18 financial year - better than pre-STF Control Total by £5.1m. Consequent recovery of £10.2m 'bonus' STF which should be received as cash in Q2 of the new financial year;
- Recommendation to accept a revised 2018/19 Control Total being consistent with good governance and a credible route to the potential achievement of that obligation;
- The Audit & Risk Management Committee are sighted on the 2017/18 Carillion-related matters of accounting judgement.

6. Meeting Effectiveness Feedback	**Verbal**

The Committee felt the matters on the agenda were the key matters that it needed to focus its attention on.

7. Any Other Business	**Verbal**

There were no other items of business.

Details of the next meeting	**Verbal**

The next Finance and Investment Committee meeting will be held on 25th May 2018 at 0900h – 1030h Room 13, Education Centre, Sandwell General Hospital.

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Public Health, Community Development and Equality Committee

Venue D29 Meeting Room, City Hospital **Date** 15th February 2018, 1400h – 1530h

Members Present		In Attendance	
Prof Kate Thomas (Chair)	KT	Mrs Ruth Wilkin	RW
Mr Waseem Zaffar	WZ	Dr David Carruthers	DC
Ms Elaine Newell	EN		
Mr Toby Lewis	TL	**Secretariat**	
Mrs Raffaela Goodby	RG	Miss Rosie Fuller	RF

Minutes	**Paper Reference**
1 Welcome and Apologies	**Verbal**

Apologies were received from Mr Richard Samuda and Mrs Chris Rickards.

Prof Thomas welcomed Dr David Carruthers to the meeting as Medical Director and formally, on behalf of the Committee, wished farewell to Mrs Newell, Chief Nurse who is retiring in April 2018. Prof Thomas thanked Mrs Newell for her contribution to this Committee and wished her well for the future.

2 Minutes from the meeting held on 16th November 2017	**SWBPH (02/18) 002**

The minutes of the meeting held on the 16th November 2017 were accepted as an accurate record of the meeting.

2a Minutes from the extraordinary meeting held on 20th December 2017	**SWBPH (02/18) 003**

The minutes of the extraordinary meeting held on the 20th December 2017 were accepted as an accurate record of the meeting.

3 Actions arising from previous meetings and matters arising (not on agenda)	**SWBPH (02/18) 004**

An update on the following actions was noted:

3 - Locally Sourced Food – Mr Lewis will discuss further with Cllr Zaffar and provide a diagram of where current food is sourced.
5 - Body Release Dataset – The information obtained highlighted the demographic of the area, therefore the information will be re-circulated presenting demography. The policy on early release of bodies was tabled and a request for any comments to be provided to Mr Lewis by the end of March 2018.

Cllr Zaffar requested information on mortuary opening hours, which will be provided.

Mrs Goodby requested to share the policy with the Muslim Liaison Group. Mr Lewis advised the information requested be obtained before sharing the policy as this will be helpful for future discussions. The Committee discussed the need for some communications with staff on awareness of the policy.

Mr Lewis suggested a communications campaign, in conjunction with awareness of organ donation, following the agreement from Dr Sahota (previous non executive director) who has accepted the invitation to become Chair of the Organ Donation Committee. Mr Lewis continued to state he would discuss with Dr Carruthers organ donation and the review from learning from deaths.

6 - Agreement to promote health checks with Sandwell Council: Mr Lewis confirmed the action may move to Mrs Goody from Dr Carruthers and this would be discussed at regular 1:1 meetings.

6 – Contact with Birmingham City Council: Mr Lewis has meet with Mr Graham Betts from the City Council and Mr Andy Williams from the Sandwell CCG to discuss the 100,000 local residents in Western Birmingham.

8 – Invitation to Director of Estates and New Hospital: Mrs Goodby will provide a briefing note to Mr Kenny prior to an invitation being issued.

9 – Future Work Programme: Mr Lewis will provide this programme to the Committee.

Gender pay gap: Mrs Goodby confirmed the Trust was on track to submit data on the gender pay gap. This is a Government requirement and Mr Lewis commented the Trust has a 'unique selling point' as we are trying to create a female friendly hospital, particularly with the high numbers of female doctors employed by the Trust.

4 Halal Food – update on communication campaign	**Verbal**

Mrs Wilkin updated the Committee on the communications to patients and staff on availability of Halal and other specialised foods. It was reported the catering team will have personal income targets set from 1st April 2018 to increase the flow through the system without the need to increase pricing. There is an app service for staff to pre-order food and collect when convenient, and the team are now looking at times when staff require food, i.e. after clinics, Friday prayers and training sessions, to ensure food is available at peak times.

The Committee discussed the wide range of foods available from Halal, Vegan and Kosher and suggested in the future other specialist foods such as low carb, high energy foods would be available. Mr Lewis stated the app should help with this type of information. Following a comment on Muslim prayer times in regard to food availability, Cllr Zaffar would advise Mrs Goodby of prayer times.

ACTION:

- Cllr Zaffar to provide Mrs Goodby of Muslim prayer times

5 Community Development Map • Map highlighting ward areas of Birmingham	**SWBPH (02/18) 005**

Mrs Wilkin commented the paper is an update on the new developments and engagements with community groups.

Mrs Wilkin stated the data from the Birmingham constituent area was obtained from Census data and showed many areas where English spoken is not a first language/limited. Challenges remain but there are opportunities to work with smaller local groups to establish gaps in activities for the Trust to provide. Mrs Wilkin continued to inform the Committee that through the Midland Met Hospital development, positive engagement is taking place with the community working in Smethwick by inviting groups to visit the site and forming a pipeline of ambassadors for the future.

It was also reported that the Trust will be involved in the Windrush 70 celebrations, the Simmer Down Festival in Handsworth park during August and the NHS 70 birthday celebrations.

Mr Lewis stated the Trust needs to demonstrate that we are supporting all our community not just through language but other ways, for example deaf/hard of hearing community.

Mrs Goodby reported on the "Us IT" Programme for health professional refugees to unlock the barriers of language to assist with re-training. This initiative links in with a programme for staff at the Trust to undertake language courses at the Birmingham Language Centre, to provide basic questions that are required in the hospital environment. The courses will be run during work hours and currently 50 members have signed up.

Prof Thomas informed the Committee there is a West Midlands Strategic Migration Service and work with the home office on migration tracking of communities. This office may have information on where migrants originate and where they settle in the UK. This type of early intelligence on where migrants will settle in the West Midlands will be invaluable for the Trust in having a future strategy for its migrant community.

ACTION:

- Mrs Wilkin to contact Cllr Zaffar on the service of the West Midlands Strategic Migration Service and how it can help with the Trust preventable strategy.

6 Action Plan for Eastern and Central European Communities	**SWBPH (02/18) 005**

Mrs Wilkin tabled an additional paper, and provided an update on actions of work in partnership with Birmingham City Council and Birmingham & Solihull Mental Health Trust. Current actions the Trust is taking forward are:

1. Create, publish and promote a guide to accessing NHS care in Sandwell and West Birmingham for Eastern European new migrants
2. Create a staff network of Eastern European colleagues and link to our existing staff networks for inclusion and diversity

Mrs Wilkin commented Trust staff supporting the Eastern European community will have a small impact on how well they are serviced and she informed the Committee an Executive Sponsor to lead on this network will be progressed over the next 3 months.

The Committee discussed the NHS Guide which was produced by Primary Care Trusts, noting this format could be adopted to produce a local guide to highlight services for Eastern and Central European patients who do not have an understanding of a primary care model. Prof Thomas commented that once this has been completed for the Eastern European Community the guide can be made available to other communities. Mrs Wilkin agreed the guide could be produced in different languages making it unique for each community.

ACTION:

- Mrs Wilkin to progress an Executive Sponsor to sit on the Staff Network group.

7 Diversity Pledges: Discussion	**SWBPH (02/18) 007**

Mrs Goodby discussed items 7 and 8 under this item.

Mrs Goodby reported of work with the colleague and patient pledges to take place over the next 12 months, and advised other pledges may be designed during this time. Mrs Goodby confirmed 5 patient pledges have been consulted upon with clinical groups, Clinical Leadership Executive and the Trust Board and it has been agreed that during the next 6 months these will be developed further to enhance these pledges.

Mr Lewis stated an implementation model would be required for each pledge including how resourced and identification of an implementation team for each pledge, as some pledges encompass specific needs. Mrs Goodby advised the Committee that Stuart Young, Head of Diversity & Inclusion will be managing the projects overseen by the People & OD Committee and this Committee. Mr Young, a registered nurse, will also be able to provide some clinical perspective on the pledges. The Committee discussed the elements of both patient and colleague pledges and how they impact on each other. Mrs. Goodby agreed there is some natural cross over between pledges that would influence patient care such as the Learning Disability Network staff members. Prof Thomas advised on the language used to describe issues of mental health, as many people do not see a mental health condition as a disability.

Mrs Goodby informed the Committee that the Public Health and Equality Committee has representatives from clinical and corporate groups and will monitor the pledges. It was also confirmed the Assistance Dog Policy and Transgender Policy are now at approval stage and will be communicated to all in the usual way.

Dr Carruthers commented on a visually impaired patient who attends clinics with an assistance dog. Her story could be a patient story for the Trust Board to help launch the Assistance Dog Policy. Mrs Newell was interested in this patient story, which could be used to dispel fears staff may have. It was agreed Dr Carruthers and Mrs Newell would discuss further outside of the meeting.

Cllr Zaffar spoke of the need to promote the policy on assistance dogs to stop staff discriminating or acting without thought, especially in the Muslim community, as many do not understand some of the associated issues. Mrs Newell responded that upon the relaunch of the Assistance Dog Policy some guidance or 'did you know' bullets could be incorporated into the communications as well as putting water stations for dogs in areas of the trust. This would provide a visual reminder as well as raising and improving awareness.

ACTION:

- Dr Carruthers and Mrs Newell to discuss the topic of assistance dogs for a future Patient Story for the Trust Board.

8 Diversity Pledges: Implementation Model	**SWBPH (02/18) 008**

This item was discussed in conjunction with Item 7.

9 Volunteers • HelpForce Programme	**SWBPH (02/18) 009**

Mrs Wilkin reported on the work and actions of Helpforce. The first of 3 projects has begun on keeping patients mobile while in hospital. The other projects: transport and pathway coordinators for patients with dementia will be scoped out for action in Quarter 1. It was noted 10 support volunteers have received additional training and are based on the OPAU at Sandwell and D26 at City. The aim for the volunteers will be to assist patients to continue walking on the ward as well as accompanying patients to the retail outlets on site. It is hoped the success from this model can then be adopted and replicated in the assessment units and other wards. It was indicated there is a similar project running in Southampton which has formed the basis for the project at this Trust and lessons/reflections from that project will be examined by the team. Mrs Newell informed the Committee she Chairs a monthly meeting which monitors the project on behalf of Helpforce.

Prof Thomas asked about the measures in place to demonstrate the impact the project was having. Mrs Wilkin and the team would be reviewing data such as length of stay, falls, nutrition, and weight on discharge/muscle wastage on discharge nevertheless, demonstrating changes would be difficult as it was accepted that many changes would be very small. However, Helpforce who have funded the new volunteer data base system for the 1st year will collect data and provide a questionnaire to establish how mobile inpatients were during their stay, as they would want to see immediate results to aid with their evidence to support applications for external funding. Mrs Newell commented helping patients to remain mobile while in hospital reduces the numbers of falls so patient experiences improves.

Following a discussion on volunteer induction, Mrs Wilkin reassured the Committee that the volunteers undergo the normal induction programme, along with additional training on the volunteer support role. All volunteers do not identify which patients require help and are not initially not left unsupervised and they know the parameters to which they are assisting in. Mr Lewis stated this programme was not financially beneficial to the Trust but the benefits for the patients and how we serve the community provides the benefit. Prof Thomas asked if the scheme extended to other activities for patients. Mrs Wilkin responded to the Committee there are crafts on the wards, walking routes from wards to the coffee shop etc. and it is envisaged that there will be vegetable growing established in due course.

10 Public Health Plan Priorities • Reducing Premature Infant Mortality • Tackling lifestyle factors for all our patients through Making Every Contact Count • Reducing alcohol related hospital admissions	**SWBPH (02/18) 010 – to follow**

Mr Lewis reported there was work in development to establish a team, along with recruitment to a Public Health Manager role, and he provided an update on the following 2 priorities:

- MECC
- Reducing alcohol related hospital admissions

The electronic recording of data under Unity will move the focus to pre-admission and the pre-assessment process. The use of Unity will record conversations that are taking place and percentage/amount recorded. These results will then be used to performance manage, provide training and offer more insight than previously available. The challenge will then be for the Local Authority, already under some pressure to act, upon the referrals made. Sally Bradberry and the team have an alcohol intervention model which could be marketed and Mr Lewis would review the team attending a future meeting to discuss the model.

Mrs Goodby stated Sally Bradberry and the team are looking at the frequent patient related admissions as they account for 24 out of 600 attendees. Sally's work will involve accessing primary care to help manage patient anxiety. The introduction of making GP appointments from A&E will have a big impact in managing frequent visitors and Mr Lewis stressed collaboration with GPs will benefit all patients across our community.

ACTION:

- Sally Bradbury and the Alcohol team attending a future Committee to discuss its intervention model.

11 2018 Work Programme	**Verbal**

This item was deferred until the next meeting.

12 Matters to raise to the Board	

The following items were agreed to be raised to the Board:

- Update on Halal food and food/choice availability.
- Work on community map and new staff network to be formed.
- Diversity pledges and patient pledges to be worked up further in the next 6 months.
- Volunteers and work undertaken by Helpforce to keep patients mobile while an inpatient.

13 Any Other business	

No other business was discussed

14 Date of Next meeting	**Verbal**

The next meeting will be held on 9th May 2018, 1pm, Room 13, the Education Centre, Sandwell General Hospital

15 Future Meeting dates:	**Verbal**

The future dates were noted by the Committee.

- 13th September 2018
- 15th November 2018
- 14th February 2019

Signed ……..

Print ……..

Date ……..

Paper ref:	TB (06/18) 014

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**	7th June 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 project initiation document for the Integrated Care System across Sandwell and western Birmingham, which we might expect from April 2019 to later how services are delivered and commissioned.

(b) The disappointing position of IT infrastructure and control, which will necessitate a further short delay to Unity deployment at the Trust into later in 2018.

(c) Progress with our financial improvement plan, and delivery of 2018-19 budget

(d) Work to both reduce length of stay and our bed stock, whilst cutting waits for emergency care

(e) The overall position with the Midland Metropolitan delay, the cost impact of that, and emerging plans to consider acute reconfiguration in 2019

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	
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

June 2018

In the last month we brought together our top 200 leaders to focus on priorities in the year ahead at our annual leadership conference. We want to build a more engaged organisation, reflective of our drive to achieve a Trust-wide Good rating from the CQC, to sit alongside our Outstanding rating for Caring, achieved last year. In that context we review this month progress within our regional Eye Hospital, which combines fantastic scientific innovation with some administrative practices. Attached to my report is an outline project initiation document for the Integrated Care System, or ICS, which we are stewarding locally across both western Birmingham and Sandwell. The aims we have developed are reflected in the document but our commitment is to tackle issues of health, housing and employment, with a determination to invest more in primary care and mental wellbeing, and proportionately less in acute hospital care. This is consistent with our 2020 vision – as we look to be at the forefront of a more preventative health model. A commitment recognised by Matthew Swindells in praising the Trust at the conference as being distinctively committed to a change in the model of care.

The continued hiatus with the Midland Metropolitan Hospital continues to distract staff and concern local people. Campaigns have been launched locally across the political spectrum. Whilst our discussions with officials show no lack of commitment to action, the reality is that a worked up way forward dating from March has been set aside now in favour of an outline plan which presently does not see material decisions made before the autumn. We are working tirelessly to improve on that pace. With 2022 now the most likely date for completion, the Board will be invited in coming meetings to consider interim acute reconfiguration proposals, which the Secretary of State has acknowledged may be necessary next year. In our private board meeting we consider the commercial future of our PFI partnership, as well as how to stem the cost of the site's deterioration.

1. Our patients

More than one hundred patients had their care cancelled or reorganised with our latest IT infrastructure issues in month. The Board will recognise that this makes it impossible to achieve the Unity go-live date of August if we are to credibly have a period of stability before deployment. I outlined to the last meeting the connection between our Unity project and our Quality Plan, especially in the area of reducing medication error and dispensing delay through putting in place the Electronic Prescribing Management project. The product is strategically key too because it offers us access to the HIE which connects our data with that held by GPs and potentially in time by Care Homes. We will deploy in 2018. But that means that grip and drive now needs to be employed around infrastructure. A draft plan is in circulation to that effect and we will bring external expertise onto the sites to help oversee and deploy that. Meanwhile, a complete IT change freeze is in operation. We will make sure that during June all cancelled patients are seen.

In line with the Board's discussion last month the coming month and the three thereafter will see a relentless focus on sepsis care within the Trust. Data reviewed by the quality and safety committee suggests that we have improved within A&E our ability to identify at risk patients, and to deploy

NEWS2 as an assessment tool. We have work to do within our medical wards and performance data on progress will be added to the Wednesday executive/medicine group Consistency of Care meetings as we aim to use MDTs in each of our wards to deliver improved pace of intervention for at risk patients. At the same time, I can confirm that we are investing further in critical care within the Trust with a growth in consultant numbers and in our 24/7 outreach team. This follows last year's investment in NIV and in complex surgical care, the latter of which has led to vastly improved laparotomy audit outcomes. The most acutely unwell patients would be but one example of where a service stretched across two sites needs rationalisation and change, which cannot now await Midland Met.

Since the turn of the year we have been working to ensure we can meet our 21-day standard for all reported incidents in the Trust to be investigated, actioned, and fed back to the reporter. This is part of our wider commitment to learning, and we discussed serious incidents 2017-18 at the last meeting in detail. Attached as an annex to this report is the action plan arising from a review undertaken by NHS Improvement across our services, focused on oncology. This confirms that the Trust meets all national accepted standards but that we are ourselves wish to go further and will aim to do so by the middle this fiscal year. The executive quality committee has done good work driving up reporting turnaround times, and as at today's meeting only two clinical areas have reports in backlog beyond our standard. Meanwhile, our latest Trust-wide Speak Up day has provided a chance again to emphasis our commitment to openness and action, and this subject dominates the monthly team brief which is also appended.

The integrated quality and performance report illustrates some strong areas of improvement, including in theatre cancellation. The new 23 hour theatre unit opens this week, which we expect will help us to further cut on the day cancellations. We also begin to report short notice clinic and theatre slots, which whilst they are sometimes necessary, need to be restricted and need to not stand in the way of patient choice. Healthwatch have advocated strongly locally for us to have outstanding administrative practice in this regard and I very much hope that this dataset will provide a window into our performance as we move towards that.

2. Our workforce

PDR progress for Q1 is going well. Fewer than 300 of our over 6,500 staff are not yet booked in. Our focus now is on ensuring that the objective set by our teams are fulfilling and deliver the broader ambitions of our system. Our OD committee will assess progress in July.

This month sees our new Occupational Health department open. This huge expansion reflects contracts across the area. Given our discussions about sickness management, there is much to do in coming months to try and improve in particular our mental health management as a secondary diagnosis. We will seek to track from next month how many staff are on long term sick at any given time, as we aim to reduce by at least fifty that figure.

Work continues to finalise our staff engagement plan. The Trust will work alongside Wigan, Wrightington and Leigh, and a wider network to implement a plan to move our Trust level engagement to 3.9 or better. As a first step to that we need to improve our Your Voice participation from below 20% to above 35%. We know that to deliver these improvements we need to make a large series of local changes. But at a corporate level we need to tackle the frustrations of working

life at the Trust, including our IT and our car parking. Proposals to tackle the latter by the end of 2019 on both main acute sites are included in the commercial section of our private meeting.

Like a number of other Trusts we have been active in seeking changes to current arrangements on the management of tier 2 visas. We have more than 20 senior medical vacancies and trainee roles on top of that, together with roles we have added to deliver our production plan. As we look forward to our workforce plan, we will need to consider our sourcing plan for each role, in line with our BAF risk around labour supply. As we move towards Brexit we will also finalise an analysis of likely departures over coming months.

The Board will recall that we began a small workforce consultation in March, impacting fewer than thirty employees. The process is now largely complete and I will orally update the meeting, but would propose concluding the process is delegated through me given that Raffaela has led the process to date.

With the delay to Midland Met, we need to consider again our approach to smoking on our sites. Recent publications by Public Health England make very clear an expectation of a smoke free site but the Board has been previously mindful of the need for this to be real and to not displace an issue to local pavements. We have now a plan to invest in smoking shelters, but wish the Board, with advice from our public health committee to reconfirm intent. Specifically, are we going for a ban in 2018, 2019, 2020 or 2022 linked to Midland Met? And given emerging evidence on vapping is the Board prepared to revise a position and solely ban this from buildings not grounds – thus avoiding a dual shelter issue.

3. **Our partners and commissioners**

Over a year ago the Trust, with regret, gave notice on our gynae-oncology surgical services. Notwithstanding that intention, staff continue to provide the service pending transfer to a new centre or centres. Our detailed risk assessment of the service has led us to agree interim arrangements with local providers to provide support, up to and including some operations being conducted from this summer in Wolverhampton. We understand commissioners remain committed to a Birmingham based centre in due course and we will work alongside neighbouring Trusts to secure that.

The Trust will sign a 2018/19 contract with the CCG during this week, which seeks to reflect a shared financial plan. No contract variation with NHS England can yet be agreed given disagreements around neonatal funding, oncology stranded costs and the need to firm up an agreement on gynae oncology funding. Together these items amount to over £5m of divergence.

4. **Our regulators**

NHS England and NHS Improvement have announced their intention to change their structures, and alter how local regulation operates. We would expect that, in time, this will make it simpler to understand the local direction of policy and to reconcile that to how we are evaluated. In due course we would expect that ourselves and the local CCG will be subject to simultaneous assessment rather than the current distinct arrangements.

5. Our STP and ICSs

We are undertaking, alongside other hospital Trusts, a sustainability assessment of our services in order to help us to consider how best we might operate in collaboration across the STP partnership. In line with our prior Black Country Alliance work, we would expect some surgical services to feature in our assessment as we look to ensure sub-specialisation is retained locally.

A capital submission will be made in July from the STP. We would very much hope that this submission will include investment in primary and mental health services, as well as confirming the funds to expand the A&E department at Walsall. Our own 2019 interim reconfiguration programme to address the delay to Midland Met will also be incorporated.

In addition to the exceptional annexes cited above, I attach my routine items including our feedback report from Clinical Leadership Executive. The safe staffing data shows continued cause for concern about our gynae oncology ward staffing, and some issues to be considered about paediatric staffing arrangements. The Clinical Leadership Executive has supported the temporary redeployment of some staff to support the position in gynae oncology, pending implementation of the changes outlined above.

Toby Lewis, Chief Executive

June 1st 2018

Annexes

- Safer Staffing Report
- Recruitment Scorecard
- Team Talk Summary
- Serious Incident Report
- Integrated Care System Project Initiation Document
- Freedom to Speak Up Guardian Report
- ***CNST Maternity Rebate – for decision***
- ***Implementation of AEQUIP – for decision***
- Clinical Leadership Executive Summary - to be tabled

Safe Staffing Return Summary

			Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
			Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff						Cumulative count over the month of patients at 23:59 each day	Registered midwives / nurses	Care Staff	Overall
Month	Site Code	Site Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)				
Jul-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2138	2330	526	527	414	500	0	18	109.0%	100.2%	120.8%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	25676	27032	15249	16705	14064	17337	6905	8503	105.3%	109.5%	123.3%	123.1%				
	RXK10	ROWLEY REGIS HOSPITAL	2826	3265	4417	4556	1243	1985	1788	2085	115.5%	103.2%	159.7%	116.6%				
	RXK01	SANDWELL GENERAL HOSPITAL	30666	32776	19123	22015	15612	18588	8817	13232	106.9%	115.1%	119.1%	150.1%				
	Total		61305	65403	39314	43803	31332	38409	17510	23837	106.7%	111.4%	122.6%	136.1%				
Aug-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1839	1807	497	475	472	560	0	28	98.3%	95.6%	118.7%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	24155	24753	13808	14687	13967	16362	6858	8233	102.5%	106.4%	117.2%	120.0%				
	RXK10	ROWLEY REGIS HOSPITAL	2964	3200	3816	3937	1176	1794	1553	1860	107.9%	103.2%	152.6%	119.8%				
	RXK01	SANDWELL GENERAL HOSPITAL	28245	29172	16759	19191	14679	16520	7932	11384	103.3%	114.5%	112.5%	143.5%				
	Total		57202	58932	34879	38290	30293	35236	16343	21505	103.0%	109.8%	116.3%	131.6%				
Sep-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2137	2080	454	475	472	532	0	119	97.3%	104.5%	112.8%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	24208	27604	14308	17278	13993	20283	6794	10406	114.0%	120.8%	144.9%	153.2%				
	RXK10	ROWLEY REGIS HOSPITAL	1274	1472	1216	1382	403	1185	587	756	115.5%	113.6%	294.4%	128.9%				
	RXK01	SANDWELL GENERAL HOSPITAL	27883	32528	16822	23743	14654	20124	7392	15185	116.7%	141.1%	137.3%	205.4%				
	Total		55501	63684	32800	42877	29521	42124	14773	26466	114.7%	130.7%	142.7%	179.2%				
Oct-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2199	2139.917	546.75	548.5	434.75	519	0	28	97.3%	100.3%	119.4%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	25273	27384.5	14779.5	15814.42	14038.5	16711.07	6797	8913.5	108.4%	107.0%	119.0%	131.1%				
	RXK10	ROWLEY REGIS HOSPITAL	3308	3480.067	3886.5	4283.25	1230	1876.5	1590	2006	105.2%	110.2%	152.6%	126.2%				
	RXK01	SANDWELL GENERAL HOSPITAL	31768.25	33296.75	19265.22	21818.3	16182.5	19034.25	8175	11998.83	104.8%	113.3%	117.6%	146.8%				
	Total		62548	66301	38478	42464	31886	38141	16562	22946	106.0%	110.4%	119.6%	138.5%				
Nov-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2082.5	2122.167	569.75	590.9167	490.25	499.75	0	55.75	101.9%	103.7%	101.9%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	26188.75	26959.63	15119	15017.5	14937	16194.5	6939	8142	102.9%	99.3%	108.4%	117.3%				
	RXK10	ROWLEY REGIS HOSPITAL	3040.5	2955.25	3894	3722.75	1306.5	1463	1511.5	1800	97.2%	95.6%	112.0%	119.1%				
	RXK01	SANDWELL GENERAL HOSPITAL	29371	30796.57	18168.5	19839.58	15566	17377.82	7733	11116.5	104.9%	109.2%	111.6%	143.8%				
	Total		60683	62834	37751	39171	32300	35535	16184	21114	103.5%	103.8%	110.0%	130.5%				
Dec-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1963.75	1844.167	554	471.5	518	465.5	0	139.25	93.9%	85.1%	89.9%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	26367.75	26839.52	15860.5	15872.08	15638.5	16717.67	7044	7930	101.8%	100.1%	106.9%	112.6%				
	RXK10	ROWLEY REGIS HOSPITAL	3280	3003	3634.5	3553.5	1262.5	1255.5	1501.5	1622.5	91.6%	97.8%	99.4%	108.1%				
	RXK01	SANDWELL GENERAL HOSPITAL	30676	30848.75	17822	19391.08	16710.5	17467	8177.017	10390.08	100.6%	108.8%	104.5%	127.1%				
	Total		62288	62535	37871	39288	34130	35906	16723	20082	100.4%	103.7%	105.2%	120.1%				
Jan-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2123.25	2227.333	505.5	492.25	582.75	555	129.5	157.5	104.9%	97.4%	95.2%	121.6%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	30328.5	30574.63	15962.5	15937.82	18989.5	20653.42	7731	8767.25	100.8%	99.8%	108.8%	113.4%				
	RXK10	ROWLEY REGIS HOSPITAL	2919	3183.5	3472.5	3411.5	1333	1558.5	1429	1542.25	109.1%	98.2%	116.9%	107.9%				
	RXK01	SANDWELL GENERAL HOSPITAL	29286.5	30702.12	17609.5	19883.43	16561.5	18341	8455	11660.25	104.8%	112.9%	110.7%	137.9%				
			64657	66888	37550	39725	37467	41108	17745	22127	103.1%	105.8%	109.7%	124.7%				
Feb-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1867.25	2053.5	464.5	462	490.25	518	129.5	101.75	110.0%	99.5%	105.7%	78.6%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	27390.25	27677.75	14544.5	14620.48	17409.5	18193.92	6915.5	7414.25	101.0%	100.5%	104.5%	107.2%				
	RXK10	ROWLEY REGIS HOSPITAL	2542	2743.25	3000.5	3185.5	1194.5	1192	1457.5	1407	107.9%	106.2%	99.8%	96.5%				
	RXK01	SANDWELL GENERAL HOSPITAL	25298.5	27136.1	14521.5	16240.82	14720	16798	7292	9867.25	107.3%	111.8%	114.1%	135.3%				
			57098	59611	32531	34509	33814	36702	15795	18790	104.4%	106.1%	108.5%	119.0%				
Mar-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2353.25	2352.417	501.5	447	573.5	565.25	148	139.5	100.0%	89.1%	98.6%	94.3%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	29823.73	30744.15	16727.5	15515.32	18670	21136.23	7507.5	7752	103.1%	92.8%	113.2%	103.3%				
	RXK10	ROWLEY REGIS HOSPITAL	2702.5	3084.9	3546.75	3896.583	1211.5	1717.75	1670.5	2067	114.1%	109.9%	141.8%	123.7%				
	RXK01	SANDWELL GENERAL HOSPITAL	28133.5	30365.28	15989.5	17373.25	15995	20147.07	7760.517	10975.02	107.9%	108.7%	126.0%	141.4%				
			63013	66547	36765	37232	36450	43566	17087	20934	105.6%	101.3%	119.5%	122.5%				
Apr-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1502	1941	305.5	396.25	444	536.5	92.5	101.75	129.2%	129.7%	120.8%	110.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	30171.5	31776.33	16684	15468.25	18810.5	20221.75	7285.5	8325	105.3%	92.7%	107.5%	114.3%				
	RXK10	ROWLEY REGIS HOSPITAL	2614	2568.5	3772	3448.067	1116.5	1351.5	1763	1778	98.3%	91.4%	121.0%	100.9%				
	RXK01	SANDWELL GENERAL HOSPITAL	27100	29153.3	15850.25	17460.35	16443.5	18445.28	7508	10431.5	107.6%	110.2%	112.2%	138.9%				
			61388	65439	36612	36773	36815	40555	16649	20636	106.6%	100.4%	110.2%	123.9%				
May-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2034.5	1941	434	402.25	573.5	527.25	138.75	138.75	95.4%	92.7%	91.9%	100.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	32094.5	32675.33	16822.25	16256	19465	21176.25	7493	8437	101.8%	96.6%	108.8%	112.6%				
	RXK10	ROWLEY REGIS HOSPITAL	2645.5	2576.067	3508.5	3169.083	1083.5	1475.067	1842.5	2033	97.4%	90.3%	136.1%	110.3%				
	RXK01	SANDWELL GENERAL HOSPITAL	26561	27802.15	15591.5	17242.17	16839	17383.17	8199.5	10655	104.7%	110.6%	103.2%	129.9%				
			63336	64995	36356	37070	37961	40562	17674	21264	102.6%	102.0%	106.9%	120.3%				
Jun-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2276.25	2172.167	419	426	555	527.25	166.5	184.75	95.4%	101.7%	95.0%	111.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	28309.5	29468.17	15410.18	14755.27	18281	19637.77	6748.5	7504.317	104.1%	95.8%	107.4%	111.2%				
	RXK10	ROWLEY REGIS HOSPITAL	2442	2374.75	3676.5	3263	1302.5	1494	1587	1916.5	97.2%	88.8%	114.7%	120.8%				
	RXK01	SANDWELL GENERAL HOSPITAL	26826	28578.08	15516.5	17366.28	15139.5	17222.75	8432.5	10183	106.5%	111.9%	113.8%	120.8%				
			59854	62593	35022	35811	35278	38882	16935	19789	104.6%	102.3%	110.2%	116.9%				
Jul-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	930	1951.583	465	512.75	589	555	0	166.5	209.8%	110.3%	94.2%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	32069.5	27187.57	13190.5	13134.5	27450.5	19260.02	8199.5	7613.267	84.8%	99.6%	70.2%	92.9%				
	RXK10	ROWLEY REGIS HOSPITAL	3208	2495	3565	2970.667	2139	1486.75	2495.5	1923	77.8%	83.3%	69.5%	77.1%				
	RXK01	SANDWELL GENERAL HOSPITAL	30178.5	26279.73	15686	15236.02	23885.5	17973.25	11764.5	11337.25	87.1%	97.1%	75.2%	96.4%				
			66386	57914	32907	31854	54064	39275	22460	21040	87.2%	96.8%	72.6%	93.7%				
Aug-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	930	806	465	370.75	573	518.25	0	171	86.7%	79.7%	90.4%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	31861.5	24502	13158.25	11459.75	27419.5	18006.17	7843	7162.517	76.9%	87.1%	65.7%	91.3%				
	RXK10	ROWLEY REGIS HOSPITAL	3208.5	2431.5	3565	3108.117	2139	1589.75	2495.5	2150.5	75.8%	87.2%	74.3%	86.2%				
	RXK01	SANDWELL GENERAL HOSPITAL	29192	24223	14735.5	15146	22765.5	17481.07	11251	11176.75	83.0%	102.8%	76.8%	99.3%				
			65192	51963	31924	30085	52897	37595	21590	20661	79.7%	94.2%	71.1%	95.7%				
Sep-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	900	935	450	378.5	555	472	166.5	194.75	103.9%	84.1%	85.0%	117.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	28394	26595.9	11679	13003.83	24495	20277.5	7651	7903	93.7%	111.3%	82.8%	103.3%				
	RXK10	ROWLEY REGIS HOSPITAL	3105	2663	3450	3364.5	2070	1881.25	2415	2336	85.8%	97.5%	90.9%	96.7%				
	RXK01	SANDWELL GENERAL HOSPITAL	27587	25604	14651	16277.83	21016	18495	11561.5	11814.52	92.8%	111.1%	88.0%	102.2%				
			59986	55798	30230	33025	48136	41126	21794	22248	93.0%	109.2%	85.4%	102.1%				
Oct-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	930	969.3333	465	344.75	573.5	536.75	157.25	178.25	104.2%	74.1%	93.6%	113.4%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	30986	34295.28	13485.5	16855.07	26737.5	28120.5	8215	10881.25	110.7%	125.0%	105.2%	132.5%				
	RXK10	ROWLEY REGIS HOSPITAL	3208.5	3267.667	3565	3678	2139	2590.25	2495.5	2913.5	101.8%	103.2%	121.1%	116.8%				
	RXK01	SANDWELL GENERAL HOSPITAL	27183.5	30355.55	15523.5	21546.75	21761	24224.5	10848	16673.5	111.7%	138.8%	111.3%	153.7%				
			62308	68888	33039	42425	51211	55472	21716	30647	110.6%	128.4%	108.3%	141.1%				
Nov-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	435	435	217	191	536	536	157	138	104.2%	74.1%	93.6%	113.4%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	24755	23194	9789	9919	22694	21079	7217	7434	110.7%	125.0%	105.2%	132.5%				
	RXK10	ROWLEY REGIS HOSPITAL	2738	2309	1738	1837	1826	1871	1493	1446	101.8%	103.2%	121.1%	116.8%				
	RXK01	SANDWELL GENERAL HOSPITAL	24276	23016	12497	12096	20417	19181	10173	9660	111.7%	138.8%	111.3%	153.7%				
			52204	48954	24241	24043	45473	42667	19040	18678	93.8%	99.2%	93.8%	98.1%				
Dec-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	450	232	195	573	545	185	148	96.8%	84.1%	95.1%	80.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	28783	27400	12089	11327	27170	24752	9454	8471	95.2%	93.7%	91.1%	89.6%				
	RXK10	ROWLEY REGIS HOSPITAL	3044	2561	1975	2027	2030	2007	1689	1586	84.1%	102.6%	98.9%	93.9%				
	RXK01	SANDWELL GENERAL HOSPITAL	26109	24203	13225	12669	21872	20396	10342	10095	92.7%	95.8%	93.3%	97.6%				
			58401	54614	27521	26218	51645	47700	21670	20300	93.5%	95.3%	92.4%	93.7%				
Jan-16	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	198	573	564	148	148	100.0%	85.3%	98.4%	100.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	26001	24220	10586	9949	24291	23361	8611	7795	93.2%	94.0%	96.2%	90.5%				
	RXK10	ROWLEY REGIS HOSPITAL	2867	2417	1798	1775	1912	1888	1235	1223	84.3%	98.7%	98.7%	99.0%				
	RXK01	SANDWELL GENERAL HOSPITAL	25861	24488	12914	12728	21731	20994	10454	10439	94.7%	98.6%	96.6%	99.9%				
			55194	51590	25530	24650	48507	46807	20448	19605	93.5%	96.6%	96.5%	95.9%				
Feb-16	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	420	420	210	195	518	518	148	148	100.0%	92.9%	100.0%	100.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	27047	25992	11249	10768	25705	24916	8501	8412	96.1%	95.7%	96.9%	99.0%				
	RXK10	ROWLEY REGIS HOSPITAL	3906	3279	3664	3960	2604	2557	2779	3098	83.9%	108.1%	98.2%	111.5%				
	RXK01	SANDWELL GENERAL HOSPITAL	25483	23052	12166	12244	21532	19958	9856	9788	90.5%	100.6%	92.7%	99.3%				
			56856	52743	27289	27167	50359	47949	21284	21446	92.8%	99.6%	95.2%	100.8%				
Mar-16	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	555	465	277	221	462	573	157	194	83.8%	79.8%	124.0%	123.6%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	24357	27553	10043	11106	22770	26280	7890	8653	113.1%	110.6%	115.4%	109.7%				
	RXK10	ROWLEY REGIS HOSPITAL	3936	3194	4367	4836	2625	2530	3224	3693	81.1%	110.7%	96.4%	114.5%				
	RXK01	SANDWELL GENERAL HOSPITAL	28158	25581	13813	13543	23643	21025	10958	10617	90.8%	98.0%	88.9%	96.9%				
			57006	56793	28500	29706	49500	50408	22229	23157	99.6%	104.2%	101.8%	104.2%				
Apr-16	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	457	225	206	555	555	148	175	101.6%	91.6%	100.0%	118.2%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	28863	27928	11830	10759	27267	25879	9244	8557	96.8%	90.9%	94.9%	92.6%				

	RXK10	ROWLEY REGIS HOSPITAL	4185	3631	4702	5260	2790	2754	3417	3881	86.8%	111.9%	98.7%	113.6%					
	RXK01	SANDWELL GENERAL HOSPITAL	27066	24907	13360	13080	21663	20686	10532	10611	92.0%	97.9%	95.5%	100.8%					
			60564	56923	30117	29305	52275	49874	23341	23224	94.0%	97.3%	95.4%	99.5%					
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	435	435	217	195	536	536	166	185	100.0%	89.9%	100.0%	111.4%	192	5.1	2.0	7.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
May-16	RXK02	CITY HOSPITAL	29134	29287	11975	11748	27549	27239	9115	8696	100.5%	98.1%	98.9%	95.4%	8856	6.4	2.3	8.7
	RXK10	ROWLEY REGIS HOSPITAL	4323	3879	4858	5417	2883	2871	3605	4005	89.7%	111.5%	99.6%	111.1%	2624	2.6	3.6	6.2
	RXK01	SANDWELL GENERAL HOSPITAL	28077	26369	14260	13294	22336	21643	10737	10506	93.9%	93.2%	96.9%	97.8%	9535	5.0	2.5	7.5
			61969	59970	31310	30654	53304	52289	23623	23392	96.8%	97.9%	98.1%	99.0%	21207.00	5.3	2.5	7.8
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	453	225	198	555	555	166	138	100.7%	88.0%	100.0%	83.1%	135	7.5	2.5	10.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jun-16	RXK02	CITY HOSPITAL	28741	27744	12036	11512	27323	25997	9142	8558	96.5%	95.6%	95.1%	93.6%	8704	6.2	2.3	8.5
	RXK10	ROWLEY REGIS HOSPITAL	4144	3873	4656	4953	2790	2801	3495	3805	93.5%	106.4%	100.4%	108.9%	2222	3.0	3.9	6.9
	RXK01	SANDWELL GENERAL HOSPITAL	26756	25382	13609	13418	21064	20441	10916	10982	94.9%	98.6%	97.0%	100.6%	9235	5.0	2.6	7.6
			60091	57452	30526	30081	51732	49794	23719	23483	95.6%	98.5%	96.3%	99.0%	20296			
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	232	573	573	148	148	100.0%	100.0%	100.0%	100.0%	228	4.6	1.7	6.2
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jul-16	RXK02	CITY HOSPITAL	29688	29249	12664	12068	28090	27187	9242	8886	98.5%	95.3%	96.8%	96.1%	9155	6.2	2.3	8.5
	RXK10	ROWLEY REGIS HOSPITAL	4242	3762	5170	5197	3500	3465	3455	3540	88.7%	100.5%	99.0%	102.5%	2178	3.3	4.0	7.3
	RXK01	SANDWELL GENERAL HOSPITAL	27279	25652	14225	14196	21640	20847	11353	11587	94.0%	99.8%	96.3%	102.1%	9872	4.7	2.6	7.3
			61674	59128	32291	31693	53803	52072	24198	24161	95.9%	98.1%	96.8%	99.8%	21433	19	11	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	221	573	573	175	175	100.0%	95.3%	100.0%	100.0%	228	4.6	1.7	6.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Aug-16	RXK02	CITY HOSPITAL	29313	27693	12062	12037	27582	25849	8198	8735	94.5%	99.8%	93.7%	106.6%	9155	5.8	2.3	8.1
	RXK10	ROWLEY REGIS HOSPITAL	3967	3395	4972	4965	3439	3310	3067	3079	85.6%	99.9%	96.2%	100.4%	2178	3.1	3.7	6.8
	RXK01	SANDWELL GENERAL HOSPITAL	25853	25600	20636	14598	21640	20464	11640	12846	99.0%	70.7%	94.6%	110.4%	9872	4.7	2.8	7.4
			59598	57153	37902	31821	53234	50196	23080	24835	95.9%	84.0%	94.3%	107.6%	21433	18	10	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	476	225	195	555	555	157	222	105.8%	86.7%	100.0%	141.4%	174	5.9	2.4	8.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Sep-16	RXK02	CITY HOSPITAL	29457	28063	12304	12574	27112	25549	8197	8677	95.3%	102.2%	94.2%	105.9%	9026	5.9	2.4	8.3
	RXK10	ROWLEY REGIS HOSPITAL	3028	2638	3851	3963	2773	2726	2426	2426	87.1%	102.9%	98.3%	100.0%	1852	2.9	3.4	6.3
	RXK01	SANDWELL GENERAL HOSPITAL	26309	25107	13815	14727	20919	19649	11129	12282	95.4%	106.6%	93.9%	110.4%	9236	4.8	2.9	7.8
			59244	56284	30195	31459	51359	48479	21909	23607	95.0%	104.2%	94.4%	107.8%	20238	20	11	31
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	446	232	217	573	573	157	120	95.9%	93.5%	100.0%	76.4%	144	7.1	2.3	9.4
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Oct-16	RXK02	CITY HOSPITAL	32594	31145	15120	15025	28558	26663	9885	10501	95.6%	99.4%	93.4%	106.2%	9327	6.2	2.7	8.9
	RXK10	ROWLEY REGIS HOSPITAL	2219	2103	2656	2717	2744	1844	2560	2536	94.8%	102.3%	67.2%	99.1%	2262	1.7	2.3	4.1
	RXK01	SANDWELL GENERAL HOSPITAL	28494	27372	14486	16860	22514	21304	12135	13988	96.1%	116.4%	94.6%	115.3%	10266	4.7	3.0	7.7
			63772	61066	32494	34819	54389	50384	24737	27145	95.8%	107.2%	92.6%	109.7%	21999	20	10	30
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	442	225	210	555	545	166	148	98.2%	93.3%	98.2%	89.2%	557	1.8	0.6	2.4
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Nov-16	RXK02	CITY HOSPITAL	31002	30282	13483	13765	27240	25886	8953	9971	97.7%	102.1%	95.0%	111.4%	8630	6.5	2.8	9.3
	RXK10	ROWLEY REGIS HOSPITAL	3382	3220	4072	4197	3874	3257	2981	2957	95.2%	103.1%	84.1%	99.2%	808	8.0	8.9	16.9
	RXK01	SANDWELL GENERAL HOSPITAL	27689	27013	14098	15959	21701	21057	11727	13140	97.6%	113.2%	97.0%	112.0%	7341	6.5	4.0	10.5
			62523	60957	31878	34131	53370	50745	23827	26216	97.5%	107.1%	95.1%	110.0%	17336	23	16	39
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	202	573	573	157	138	100.0%	87.1%	100.0%	87.9%	188	5.5	1.8	7.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Dec-16	RXK02	CITY HOSPITAL	31106	30016	13528	12482	27055	26094	8854	8909	96.5%	92.3%	96.4%	100.6%	8615	6.5	2.5	9.0
	RXK10	ROWLEY REGIS HOSPITAL	3242	3102	3941	4041	3456	2845	2830	2890	95.7%	102.5%	82.3%	102.1%	2679	2.2	2.6	4.8
	RXK01	SANDWELL GENERAL HOSPITAL	28559	27573	14815	15907	22509	21876	12260	13625	96.5%	107.4%	97.2%	111.1%	10387	4.8	2.8	7.6
			63372	61156	32516	32632	53593	51388	24101	25562	96.5%	100.4%	95.9%	106.1%	21869	19	10	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	322	356	217	210	536	536	37	37	110.6%	96.8%	100.0%	100.0%	180	5.0	1.4	6.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jan-17	RXK02	CITY HOSPITAL	31579	31020	13938	13564	27429	26766	8904	9225	98.2%	97.3%	97.6%	103.6%	9215	6.3	2.5	8.7
	RXK10	ROWLEY REGIS HOSPITAL	2924	3101	3578	4062	3168	2880	2614	2998	106.1%	113.5%	90.9%	114.7%	2607	2.3	2.7	5.0
	RXK01	SANDWELL GENERAL HOSPITAL	28919	27969	14877	17262	22491	22021	12307	14590	96.7%	116.0%	97.9%	118.6%	10304	4.9	3.1	7.9
			63744	62446	32610	35098	53624	52203	23862	26850	98.0%	107.6%	97.4%	112.5%	22306	18	10	28
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	270	315	210	191	518	481	0	46	116.7%	91.0%	92.9%	#DIV/0!	175	4.5	1.4	5.9
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Feb-17	RXK02	CITY HOSPITAL	27838	27199	13363	13030	24460	23721	8831	9138	97.7%	97.5%	97.0%	103.5%	8319	6.1	2.7	8.8
	RXK10	ROWLEY REGIS HOSPITAL	2852	2816	3409	3694	3110	2722	2512	2655	98.7%	108.4%	87.5%	105.7%	2242	2.5	2.8	5.3
	RXK01	SANDWELL GENERAL HOSPITAL	26276	25767	13759	15260	19922	19628	12317	13527	98.1%	110.9%	98.5%	109.8%	9359	4.9	3.1	7.9
			57236	56097	30741	32175	48010	46552	23660	25366	98.0%	104.7%	97.0%	107.2%	20095	18	10	28
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1361	1521	945	615	1642	1430	356	525	111.8%	65.1%	87.1%	147.5%	207	14.3	5.5	19.8
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Mar-17	RXK02	CITY HOSPITAL	27241	26683	13748	13163	24777	23662	10047	9645	98.0%	95.7%	95.5%	96.0%	9536	5.3	2.4	7.7
	RXK10	ROWLEY REGIS HOSPITAL	3239	3038	3947	4107	3588	3072	3340	3328	93.8%	104.1%	85.6%	99.6%	2420	2.5	3.1	5.6
	RXK01	SANDWELL GENERAL HOSPITAL	23762	23020	13865	15342	18052	17437	12492	13552	96.9%	110.7%	96.6%	108.5%	9625	4.2	3.0	7.2
			55603	54262	32505	33227	48059	45601	26235	27050	97.6%	102.2%	94.9%	103.1%	21788	26	14	40
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1335	1416	915	648	1590	1541	345	363	106.1%	70.8%	96.9%	105.2%	210	14.1	4.8	18.9
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Apr-17	RXK02	CITY HOSPITAL	28695	27561	13723	13252	26964	24779	9890	9750	96.0%	96.6%	91.9%	98.6%	9329	5.6	2.5	8.1
	RXK10	ROWLEY REGIS HOSPITAL	3144	2958	3855	4022	2820	2460	3885	3897	94.1%	104.3%	87.2%	100.3%	2274	2.4	3.5	5.9
	RXK01	SANDWELL GENERAL HOSPITAL	23021	21873	13713	14464	17400	16747	12336	12769	95.0%	105.5%	96.2%	103.5%	9569	4.0	2.8	6.9
			56195	53808	32206	32386	48774	45527	26456	26779	95.8%	100.6%	93.3%	101.2%	21382	26	14	40
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	292	337	232	217	573	518	0	55	115.4%	93.5%	90.4%	#DIV/0!	238	3.6	1.1	4.7
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
May-17	RXK02	CITY HOSPITAL	30870	31048	14867	13613	28345	27360	10345	10004	100.6%	91.6%	96.5%	96.7%	9915	5.9	2.4	8.3
	RXK10	ROWLEY REGIS HOSPITAL	3254	3078	4397	4186	2914	2536	4014	3919	94.6%	95.2%	87.0%	97.6%	1536	3.7	5.3	8.9
	RXK01	SANDWELL GENERAL HOSPITAL	26141	25145	14245	14637	22440	22611	12412	12946	96.2%	102.8%	100.8%	104.3%	10047	4.8	2.7	7.5
			60557	59608	33741	32653	54272	53025	26771	26924	98.4%	96.8%	97.7%	100.6%	21736	18	12	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	0	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	328	0.0	0.0	0.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jun-17	RXK02	CITY HOSPITAL	32092	31476	15977	14308	29009	27747	11086	11521	98.1%	89.6%	95.6%	103.9%	9390	6.3	2.8	9.1
	RXK10	ROWLEY REGIS HOSPITAL	3157	2937	4381	3949	2825	2476	3890	3867	93.0%	90.1%	87.6%	99.4%	2282	2.4	3.4	5.8
	RXK01	SANDWELL GENERAL HOSPITAL	24642	24373	13973	14438	19970	19498	12336	13033	98.9%	103.3%	97.6%	105.7%	9303	4.7	3.0	7.7
			59891	58786	34331	32695	51804	49721	27312	28421	98.2%	95.2%	96.0%	104.1%	21303	13	9	23
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	300	345	225	180	555	555	0	0	115.0%	80.0%	100.0%	#DIV/0!	276	3.3	0.7	3.9
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jul-17	RXK02	CITY HOSPITAL	30894	29888	14741	13461	28584	26702	9817	10265	96.7%	91.3%	93.4%	104.6%	9579	5.9	2.5	8.4
	RXK10	ROWLEY REGIS HOSPITAL	3075	3000	4281	3966	2850	2490	3915	3879	97.6%	92.6%	87.4%	99.1%	2269	2.4	3.5	5.9
	RXK01	SANDWELL GENERAL HOSPITAL	25308	24971	14711	14847	22287	22588	13274	13555	98.7%	100.9%	101.4%	102.1%	9811	4.8	2.9	7.7
			59577	58204	33958	32454	54276	52335	27006	27699	97.7%	95.6%	96.4%	102.6%	21935	16	9	26
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	292	345	232	183	573	555	0	18	118.2%	78.9%	96.9%	#DIV/0!	249	3.6	0.8	4.4
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Aug-17	RXK02	CITY HOSPITAL	29837	27218	14638	12947	27665	24649	9611	10160	91.2%	88.4%	89.1%	105.7%	9277	5.6	2.5	8.1
	RXK10	ROWLEY REGIS HOSPITAL	3567	3346	4843	4529	2923	2671	4011	3988	93.8%	93.5%	91.4%	99.4%	2571	2.3	3.3	5.7
	RXK01	SANDWELL GENERAL HOSPITAL	27288	24118	15703	14697	19737	22381	14390	13733	88.4%	93.6%	113.4%	95.4%	9906	4.7	2.9	7.6
			60984	55027	35416	32356	50898	50256	28012	27899	90.2%	91.4%	98.7%	99.6%	22003	16	9	26
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	292	341	225	210	555	555	0	9	116.8%	93.3%	100.0%	#DIV/0!	221	4.1	1.0	5.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Sep-17	RXK02	CITY HOSPITAL	29975	29324	14254	13068	27601	25914	9786	9775	97.8%	91.7%	93.9%	99.9%	9578	5.8	2.4	8.2
	RXK10	ROWLEY REGIS HOSPITAL	4077	3925	5520	5029	2790	2790	3825	3802	96.3%	91.1%	100.0%	99.4%	2479	2.7	3.6	6.3
	RXK01	SANDWELL GENERAL HOSPITAL	23096	23380	14607	14929	22186	19522	13397	14694	101.2%	102.2%	88.0%	109.6%	9901	4.3	3.0	7.3
			57440	56970	34606	33236	53132	48781	27008	28270	99.2%	96.0%	91.8%	104.7%	22179	17	10	27
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	300	307	232	217	573	536	0	55	102.3%	93.5%	93.5%	#DIV/0!	174	4.8	1.6	6.4
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Oct-17	RXK02	CITY HOSPITAL	30867	29794	14429	13236	28148	27059	9541	10173	96.5%	91.7%	96.1%	106.6%	10063	5.6	2.3	8.0
	RXK10	ROWLEY REGIS HOSPITAL	4215	4054	5695	5318	2883	2894	3951	3883	96.2%	93.4%	100.4%	98.3%	2613	2.7	3.5	6.2
	RXK01	SANDWELL GENERAL HOSPITAL	27170	26684	16362	16357	21864	22266	14852	16136	98.2%	100.0%	101.8%	108.6%	11129	4.4	2.9	7.3
			62552	60839	36718	35128	53468	52755	28344	30247	97.3%	95.7%	98.7%	106.7%	23979	18	10	28
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	285	315	225	210	555	527	0	27	110.5%	93.3%	95.0%	#DIV/0!	142	5.9	1.7	7.6
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Nov-17	RXK02	CITY HOSPITAL	29837	29413	14421	13001	27261	26670	9670	9875	98.6%	90.2%	97.8%	102.1%	9713	5.8	2.4	8.1
	RXK10	ROWLEY REGIS HOSPITAL	3951	3772	5319	5175	2698	2686	3687	3675	95.5%	97.3%	99.6%	99.7%	2495	2.6	3.5	6.1
	RXK01	SANDWELL GENERAL HOSPITAL	26841	25880	16620	16475	21943	21656	15566	16284	96.4%	99.1%	98.7%	104.6%	11132	4.3	2.9	7.2
			60914	59380	36585	34861	52457	51539	28923	29861	97.5%	95.3%	98.2%	103.2%	23482	19	11	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	322	367	232	210	573	545	0	27	114.0%	90.5%	95.1%	#DIV/0!	167	5.5	1.4	6.9
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Dec-17	RXK02	CITY HOSPITAL	30881	29460	14839	13013	28229	27029	10254	9650	95.4%	87.7%	95.7%	94.1%	9260	6.1	2.4	8.5
	RXK10	ROWLEY REGIS HOSPITAL	4203	3700	5700	5371	2883	2859	3951	3849	88.0%	94.2%	99.2%	97.4%	2419	2.7	3.8	6.5
	RXK01	SANDWELL GENERAL HOSPITAL	28278	26344	17809	16640	26185	22192	17449	16449	93.2%	93.4%	84.8%	94.3%	11549	4.2	2.9	7.1
			63684	59871	38580	35234	57870	52625	31654	29975	94.0%	91.3%	90.9%	94.7%	23395	18	11	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	300	311	232	221	573	555	0	74	103.7%	95.3%	96.9%	#DIV/0!	165	5.2	1.8	7.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE									0.0%	0.0%	0.0%	0.0%				
Jan-18	RXK02	CITY HOSPITAL	30895	30238	14915	13260	28552	27494	10692	10035	97.9%	88.9%	96.3%	93.9%	10277	5.6	2.3	7.9
	RXK10	ROWLEY REGIS HOSPITAL	4227	4001	5712	5171	2883	2715	3951	3853	94.7%	90.5%	94.2%	97.5%	2650	2.5	3.4	5.9
	RXK01	SANDWELL GENERAL HOSPITAL	29135	26317	17925	16718	26417	23255	16420	16457	90.3%	93.3%	88.0%	100.2%	11747	4.2	2.8	7.0
			64557	60867	38784	35370	58425	54019	31063	30419	94.3%	91.2%	92.5%	97.9%	24839	18	10	28
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	225	225	180	165	592	573	0	18	100.0%	91.7%	96.8%	#DIV/0!	170	4.7	1.1	5.8
	RXKTC	BIRMINGHAM TREATMENT CENTRE									0.0%	0.0%	0.0%	0.0%				
Feb-18	RXK02	CITY HOSPITAL	27868	25883	13546	11808	25716	23199	9717	9792	92.9%	87.2%	90.2%	100.8%	8985	5.5	2.4	7.9
	RXK10	ROWLEY REGIS HOSPITAL	3603	3389	4879	4446	2466	2431	3363	3144	94.1%	91.1%	98.6%	93.5%	2338	2.5	3.2	5.7
	RXK01	SANDWELL GENERAL HOSPITAL	25796	23207	15639	14543	24006	20510	14461	14598	90.0%	93.0%	85.4%	100.9%	10576	4.1	2.8	6.9
			57492	52704	34244	30962	52780	46713	27541	27552	91.7%	90.4%	88.5%	100.0%	22069	17	9	26
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	300	281	232	225	573	527	0	46	93.7%	97.0%	92.0%	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!
	RXKTC	BIRMINGHAM TREATMENT CENTRE									0.0%	0.0%	0.0%	0.0%	149			
Mar-18	RXK02	CITY HOSPITAL	31338	29058	15335	13194	28885	26543	10861	10538	92.7%	86.0%	91.9%	97.0%	9280	6.0	2.6	8.5
	RXK10	ROWLEY REGIS HOSPITAL	4215	3635	5700	5300	2883	2790	3951	3699	86.2%	93.0%	96.8%	93.6%	2603	2.5	3.5	5.9
	RXK01	SANDWELL GENERAL HOSPITAL	29113	25874	17819	16602	26534	23680	16075	16282	88.9%	93.2%	89.2%	101.3%	11855	4.2	2.8	7.0
			64966	58848	39086	35321	58875	53540	30887	30565	90.6%	90.4%	90.9%	99.0%	23887	#DIV/0!	#DIV/0!	#DIV/0!
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	292	232	225	206	555	545	0	9	79.5%	91.6%	98.2%	#DIV/0!	176	4.4	1.2	5.6
	RXKTC	BIRMINGHAM TREATMENT CENTRE									0.0%	0.0%	0.0%	0.0%				

Apr-18	RXK02	CITY HOSPITAL	29632	28013	14945	13181	27329	26065	10001	9903	94.5%	88.2%	95.4%	99.0%	8846	6.1	2.6	8.7
	RXK10	ROWLEY REGIS HOSPITAL	4125	3665	5496	5074	2790	2790	3825	3732	88.8%	92.3%	100.0%	97.6%	2420	2.7	3.6	6.3
	RXK01	SANDWELL GENERAL HOSPITAL	26303	25117	16403	15701	22312	22639	15063	15301	95.5%	95.7%	101.5%	101.6%	10958	4.4	2.8	7.2
			60352	57027	37069	34162	52986	52039	28889	28945	94.5%	92.2%	98.2%	100.2%	22400	18	10	28
3-month Avges	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	272	246	212	199	573	548	0	24	90.3%	93.6%	95.6%	#DIV/0!	115	6.9	1.9	8.8
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	50	0.0	0.0	0.0
	RXK02	CITY HOSPITAL	29613	27651	14609	12728	27310	25269	10193	10078	93.4%	87.1%	92.5%	98.9%	9037	5.9	2.5	8.4
	RXK10	ROWLEY REGIS HOSPITAL	3981	3563	5358	4940	2713	2670	3713	3525	89.5%	92.2%	98.4%	94.9%	2454	2.5	3.4	6.0
	RXK01	SANDWELL GENERAL HOSPITAL	27071	24733	16620	15615	24284	22276	15200	15394	91.4%	94.0%	91.7%	101.3%	11130	4.2	2.8	7.0
	Total	*Latest 3 month average====>*	60937	56193	36800	33482	54880	50764	29106	29021	92.2%	91.0%	92.5%	99.7%	22785	4.7	2.7	7.4

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) Collectio

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/

Hospital Site Details		Only complete sites your organisation is accountable for	Main 2 Specialties on each ward		Day				Night				Day	
					Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - 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		
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Critical Care - Sandwell	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	2880	2988	354	312	2640	2706	0	11	103.8%	88.1%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3450	3329	1380	1581	3450	3438	1380	1621	96.5%	114.6%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	540	600	360	393	990	1045	330	374	111.1%	109.2%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1633	1564	1270	1190	1012	1035	943	1000	95.8%	93.7%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPAEDICS	160 - PLASTIC SURGERY	1541	1380	1633	1529	1035	1035	1633	1564	89.6%	93.6%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1725	1656	1725	1592	1380	1380	1725	1587	96.0%	92.3%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 5 - Acute Medicine	100 - GENERAL SURGERY	300 - GENERAL MEDICINE	1322	1213	1322	1046	1058	1046	1322	1276	91.8%	79.1%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon Ground - PAU/Adolescents	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	1080	1080	356	333	990	979	337	315	100.0%	93.5%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Older Persons Assessment Unit (OPAU) - Sandwell	430 - GERIATRIC MEDICINE		1380	1293	1035	1092	1035	1058	1035	1104	93.7%	105.5%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 3 - T&O	110 - TRAUMA & ORTHOPAEDICS	430 - GERIATRIC MEDICINE	1725	1633	1644	1592	1075	1155	1644	1633	94.7%	96.8%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 4 - Stepdown/Stroke/Neurology	314 - REHABILITATION	300 - GENERAL MEDICINE	1380	1322	1035	1035	1380	1357	1035	1000	95.8%	100.0%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 5 - Haematology	304 - CLINICAL PHYSIOLOGY	300 - GENERAL MEDICINE	667	724	333	299	667	678	333	356	108.5%	89.8%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 2 - Colorectal/General Surgery	100 - GENERAL SURGERY		1725	1627	1035	1000	1380	1380	1035	1023	94.3%	96.6%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2070	1604	1035	1029	1725	1633	1035	1012	77.5%	99.4%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1460	1391	1196	1052	1115	1334	931	1115	95.3%	88.0%
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1725	1713	690	626	1380	1380	345	310	99.3%	90.7%
RXK02	CITY HOSPITAL - RXK02	CCS - Critical Care Services - City	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2880	2592	360	228	2640	2310	0	0	90.0%	63.3%
RXK02	CITY HOSPITAL - RXK02	D5/D7 - Cardiology (Female)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	3450	3542	690	690	2760	3208	0	0	102.7%	100.0%
RXK02	CITY HOSPITAL - RXK02	D11 - Male Older Adult	430 - GERIATRIC MEDICINE		1035	977	1035	954	1035	1012	690	701	94.4%	92.2%
RXK02	CITY HOSPITAL - RXK02	D15 - Gastro/Resp/Haem (Male)	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1035	1040	1023	655	1035	1035	678	644	100.5%	64.0%
RXK02	CITY HOSPITAL - RXK02	D16 - (Female)	301 - GASTROENTEROLOGY	340 - RESPIRATORY MEDICINE	1035	1000	1023	989	1035	1000	678	736	96.6%	96.7%
RXK02	CITY HOSPITAL - RXK02	D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	723	714	351	315	660	660	11	11	98.8%	89.7%
RXK02	CITY HOSPITAL - RXK02	D25 - Female Surgery	101 - UROLOGY	120 - ENT	1035	977	655	667	690	644	333	368	94.4%	101.8%
RXK02	CITY HOSPITAL - RXK02	D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1035	1029	1046	1023	1035	1035	690	690	99.4%	97.8%
RXK02	CITY HOSPITAL - RXK02	D27 - City Surgical Unit (CSU)	101 - UROLOGY	120 - ENT	1046	1040	690	638	690	690	690	621	99.4%	92.5%
RXK02	CITY HOSPITAL - RXK02	D43 - Community RTG	318- INTERMEDIATE CARE	430 - GERIATRIC MEDICINE	1380	1150	1380	1299	1035	1023	1035	1023	83.3%	94.1%
RXK02	CITY HOSPITAL - RXK02	D47 - Geriatric MEDICAL	430 - GERIATRIC MEDICINE		1035	948	1207	1058	690	690	690	690	91.6%	87.7%
RXK02	CITY HOSPITAL - RXK02	D17 (Gynae Ward)	502 - GYNAECOLOGY		558	507	396	321	720	708	360	360	90.9%	81.1%
RXK02	CITY HOSPITAL - RXK02	Labour Ward - City	501 - OBSTETRICS		3795	3101	690	569	3795	3185	690	690	81.7%	82.5%
RXK02	CITY HOSPITAL - RXK02	City Maternity - M1	501 - OBSTETRICS	424- WELL BABIES	1000	1006	667	609	1000	943	333	345	100.6%	91.3%
RXK02	CITY HOSPITAL - RXK02	City Maternity - M2	501 - OBSTETRICS	424- WELL BABIES	1000	914	627	655	1000	828	333	322	91.4%	104.5%
RXK02	CITY HOSPITAL - RXK02	AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	4140	3760	1725	1644	4140	3795	1725	1633	90.8%	95.3%
RXK02	CITY HOSPITAL - RXK02	Neonatal	422- NEONATOLOGY		2415	2526	690	396	2415	2184	720	540	104.6%	57.4%
RXK02	CITY HOSPITAL - RXK02	Serenity Birth Centre - City	501 - OBSTETRICS		1035	1190	690	471	954	1115	345	529	115.0%	68.3%
RXK03	MINGHAM MIDLAND EYE CENTRE (BMEC) - RX	Ophthalmology Main Ward - City	130 - OPHTHALMOLOGY	180 - ACCIDENT & EMERGENCY	292	232	225	206	555	545	0	9	79.5%	91.6%
RXK10	ROWLEY REGIS HOSPITAL - RXK10	Eliza Tinsley Ward - Community RTG	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	1035	839	1380	1276	690	690	1035	1046	81.1%	92.5%
RXK10	ROWLEY REGIS HOSPITAL - RXK10	Henderson	318- INTERMEDIATE CARE		1035	874	1500	1431	690	690	1035	1000	84.4%	95.4%
RXK10	ROWLEY REGIS HOSPITAL - RXK10	Leasowes	318- INTERMEDIATE CARE		1020	1038	1236	1206	720	720	720	720	101.8%	97.6%
RXK10	ROWLEY REGIS HOSPITAL - RXK10	MCCarthy	318- INTERMEDIATE CARE		1035	914	1380	1161	690	690	1035	966	88.3%	84.1%

Safe Staffing (Rota Fill Rates and CHPPD) Collectio

Organisation: RXK Sandwell And West Birmingham Hospitals NHS Trust

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Hospital Site Details		Only complete sites your organisation is accountable for	Main 2 Specialties on each ward		Day				Night				Day	
					Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - 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		
RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Critical Care - Sandwell	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	2880	2988	354	312	2640	2706	0	11	103.8%	88.1%
		Total			60352	57027	37069	34162	52986	52039	28889	28945		

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

Ward name	Main 2 Specialties on each ward	Main 2 Specialties on each ward	Day Registered midwives/nurses	Day Registered midwives/nurses	Day Care Staff	Day Care Staff	Night Registered midwives/nurses	Night Registered midwives/nurses	Night Care Staff	Night Care Staff	Day	Day	Night	Night	Care Hours Per Patient Day (CHPPD)				Note
	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	2880	2988	354	312	2640	2706	0	11	103.8%	88.1%	102.5%	#DIV/0!	215	26.5	1.5	28.0	
AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3450	3329	1380	1581	3450	3438	1380	1621	96.5%	114.6%	99.7%	117.5%	923	7.3	3.5	10.8	
Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	540	600	360	393	990	1045	330	374	111.1%	109.2%	105.6%	113.3%	401	4.1	1.9	6.0	
Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1633	1564	1270	1190	1012	1035	943	1000	95.8%	93.7%	102.3%	106.0%	831	3.1	2.6	5.8	
Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPAEDICS	160 - PLASTIC SURGERY	1541	1380	1633	1529	1035	1035	1633	1564	89.6%	93.6%	100.0%	95.8%	835	2.9	3.7	6.6	
Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1725	1656	1725	1592	1380	1380	1725	1587	96.0%	92.3%	100.0%	92.0%	995	3.1	3.2	6.2	
Lyndon 5 - Acute Medicine	100 - GENERAL SURGERY	300 - GENERAL MEDICINE	1322	1213	1322	1046	1058	1046	1322	1276	91.8%	79.1%	98.9%	96.5%	949	2.4	2.4	4.8	
Lyndon Ground - PAU/Adolescents	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	1080	1080	356	333	990	979	337	315	100.0%	93.5%	98.9%	93.5%	342	6.0	1.9	7.9	
Older Persons Assessment Unit (OPAU) -	430 - GERIATRIC MEDICINE		1380	1293	1035	1092	1035	1058	1035	1104	93.7%	105.5%	102.2%	106.7%	554	4.2	4.0	8.2	
Newton 3 - T&O	110 - TRAUMA & ORTHOPAEDICS	430 - GERIATRIC MEDICINE	1725	1633	1644	1592	1075	1155	1644	1633	94.7%	96.8%	107.4%	99.3%	857	3.3	3.8	7.0	
Newton 4 - Stepdown/Stroke/Neurology	314 - REHABILITATION	300 - GENERAL MEDICINE	1380	1322	1035	1035	1380	1357	1035	1000	95.8%	100.0%	98.3%	96.6%	838	3.2	2.4	5.6	
Newton 5 - Haematology	304 - CLINICAL PHYSIOLOGY	300 - GENERAL MEDICINE	667	724	333	299	667	678	333	356	108.5%	89.8%	101.6%	106.9%	389	3.6	1.7	5.3	
Priory 2 - Colorectal/General Surgery	100 - GENERAL SURGERY		1725	1627	1035	1000	1380	1380	1035	1023	94.3%	96.6%	100.0%	98.8%	698	4.3	2.9	7.2	
Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2070	1604	1035	1029	1725	1633	1035	1012	77.5%	99.4%	94.7%	97.8%	699	4.6	2.9	7.6	
Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1460	1391	1196	1052	1115	1334	931	1115	95.3%	88.0%	119.6%	119.8%	904	3.0	2.4	5.4	
SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1725	1713	690	626	1380	1380	345	310	99.3%	90.7%	100.0%	89.9%	528	5.9	1.8	7.6	
CCS - Critical Care Services - City	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2880	2592	360	228	2640	2310	0	0	90.0%	63.3%	87.5%	#DIV/0!	138	35.5	1.7	37.2	
D5/D7 - Cardiology (Female)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	3450	3542	690	690	2760	3208	0	0	102.7%	100.0%	116.2%	#DIV/0!	945	7.1	0.7	7.9	
D11 - Male Older Adult	430 - GERIATRIC MEDICINE		1035	977	1035	954	1035	1012	690	701	94.4%	92.2%	97.8%	101.6%	552	3.6	3.0	6.6	
D15 - Gastro/Resp/Haem (Male)	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1035	1040	1023	655	1035	1035	678	644	100.5%	64.0%	100.0%	95.0%	573	3.6	2.3	5.9	
D16 - (Female)	301 - GASTROENTEROLOGY	340 - RESPIRATORY MEDICINE	1035	1000	1023	989	1035	1000	678	736	96.6%	96.7%	96.6%	108.6%	583	3.4	3.0	6.4	
D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	723	714	351	315	660	660	11	11	98.8%	89.7%	100.0%	100.0%	226	6.1	1.4	7.5	
D25 - Female Surgery	101 - UROLOGY	120 - ENT	1035	977	655	667	690	644	333	368	94.4%	101.8%	93.3%	110.5%	258	6.3	4.0	10.3	From Donna James : FSW
D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1035	1029	1046	1023	1035	1035	690	690	99.4%	97.8%	100.0%	100.0%	593	3.5	2.9	6.4	
D27 - City Surgical Unit (CSU)	101 - UROLOGY	120 - ENT	1046	1040	690	638	690	690	690	621	99.4%	92.5%	100.0%	90.0%	403	4.3	3.1	7.4	From Donna James : D21
D43 - Community RTG	318- INTERMEDIATE CARE	430 - GERIATRIC MEDICINE	1380	1150	1380	1299	1035	1023	1035	1023	83.3%	94.1%	98.8%	98.8%	744	2.9	3.1	6.0	
D47 - Geriatric MEDICAL	430 - GERIATRIC MEDICINE		1035	948	1207	1058	690	690	690	690	91.6%	87.7%	100.0%	100.0%	534	3.1	3.3	6.3	
D17 (Gynae Ward)	502 - GYNAECOLOGY		558	507	396	321	720	708	360	360	90.9%	81.1%	98.3%	100.0%	299	4.1	2.3	6.3	From Tracy Weston : D27
Labour Ward - City	501 - OBSTETRICS		3795	3101	690	569	3795	3185	690	690	81.7%	82.5%	83.9%	100.0%	298	21.1	4.2	25.3	
City Maternity - M1	501 - OBSTETRICS	424- WELL BABIES	1000	1006	667	609	1000	943	333	345	100.6%	91.3%	94.3%	103.6%	468	4.2	2.0	6.2	
City Maternity - M2	501 - OBSTETRICS	424- WELL BABIES	1000	914	627	655	1000	828	333	322	91.4%	104.5%	82.8%	96.7%	475	3.7	2.1	5.7	
AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	4140	3760	1725	1644	4140	3795	1725	1633	90.8%	95.3%	91.7%	94.7%	1149	6.6	2.9	9.4	
Neonatal	422- NEONATOLOGY		2415	2526	690	396	2415	2184	720	540	104.6%	57.4%	90.4%	75.0%	551	8.5	1.7	10.2	
Serenity Birth Centre - City	501 - OBSTETRICS		1035	1190	690	471	954	1115	345	529	115.0%	68.3%	116.9%	153.3%	57	40.4	17.5	58.0	
Ophthalmology Main Ward - City	130 - OPHTHALMOLOGY	180 - ACCIDENT & EMERGENCY	292	232	225	206	555	545	0	9	79.5%	91.6%	98.2%	#DIV/0!	176	4.4	1.2	5.6	
Eliza Tinsley Ward - Community RTG	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	1035	839	1380	1276	690	690	1035	1046	81.1%	92.5%	100.0%	101.1%	674	2.3	3.4	5.7	
Henderson	318- INTERMEDIATE CARE		1035	874	1500	1431	690	690	1035	1000	84.4%	95.4%	100.0%	96.6%	630	2.5	3.9	6.3	
Leasowes	318- INTERMEDIATE CARE		1020	1038	1236	1206	720	720	720	720	101.8%	97.6%	100.0%	100.0%	549	3.2	3.5	6.7	
MCCarthy	318- INTERMEDIATE CARE		1035	914	1380	1161	690	690	1035	966	88.3%	84.1%	100.0%	93.3%	567	2.8	3.8	6.6	
	Trust Totals		**60352**	**57027**	**37069**	**34162**	**52986**	**52039**	**28889**	**28945**	**94.5%**	**92.2%**	**98.2%**	**100.2%**	**22400**	**4.9**	**2.8**	**7.7**	

AMU B - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	Closed
Priory 3 - General Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	
D12 - Isolation	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	
AMU 2 & West Midlands Poisons Unit - C	300 - GENERAL MEDICINE	305 - CLINICAL PHARMACOLOGY									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	Merged AMU1
Surgical Assesment Unit - City	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	Closed
D7 - Cardiology (Male)	320 - CARDIOLOGY	300 - GENERAL MEDICINE									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	Merged with D5

Recruitment Activity Report

Report Date: 24/05/2018

Criteria		Measure/Month		Actual						Forecast						Target	
				Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18		
Band 5 Nurses (excluding Theatre Practitioners)	SIP	FTE	Establishment					768.26	771.89	771.89	771.89	771.89	771.89	771.89	771.89		
		FTE	FTE In Post					642.76	642.62	637.28	631.94	626.60	626.26	668.92	673.58		
		FTE	New Starters					5.00	6.72	5.97	5.97	5.97	10.97	53.97	15.97		
		FTE	Leavers					11.01	11.61	11.31	11.31	11.31	11.31	11.31	11.31		
		FTE	Vacancies in month					125.50	129.27	134.61	139.95	145.29	145.63	102.97	98.31	88.33	----- Over Target
	Offers External Applicants	FTE	Conditional offers (in month)					31.26	20.24	4.00	20.24	20.24	20.24	20.24	20.24		
		FTE	Offers Confirmed (in month)					7.67	16.60	8.80	8.80	8.80	8.80	8.80	8.80		
Band 5 Community Nurses	SIP	FTE	Establishment	165.47	165.47	165.47	165.47	156.47	156.47	156.47	156.47	156.47	156.47	156.47	156.47		
		FTE	FTE In Post	139.82	139.43	142.26	143.26	140.35	141.10	142.43	142.17	141.90	141.64	149.37	157.11		
		FTE	New Starters	2.46	0.00	2.20	0.00	0.00	0.00	1.60	0.00	0.00	0.00	8.00	8.00		
		FTE	Leavers	0.00	0.00	5.64	0.61	0.00	0.53	0.27	0.27	0.27	0.27	0.27	0.27		
		FTE	Vacancies in month	25.65	26.04	23.21	22.21	16.12	15.37	14.04	14.30	14.57	14.83	7.10	-0.64	31.73	----- Target Met
	Offers External Applicants	FTE	Conditional offers (in month)	0.00	0.00	0.00	0.00	0.60	1.80	0.00	2.00	0.00	0.00	0.00	0.00		
		FTE	Offers Confirmed (in month)	2.00	0.00	0.00	0.00	0.00	0.60	3.00	0.00	0.00	0.00	0.00	0.00		
Band 5 Nursing (Total)	SIP	FTE	Establishment					924.73	928.36	928.36	928.36	928.36	928.36	928.36	928.36		
		FTE	FTE In Post					783.11	783.72	779.71	774.11	768.50	767.90	818.29	830.69		
		FTE	New Starters					5.00	6.72	7.57	5.97	5.97	10.97	61.97	23.97		
		FTE	Leavers					11.01	12.14	11.58	11.58	11.58	11.58	11.58	11.58		
		FTE	Vacancies in month					141.62	144.64	148.65	154.25	159.86	160.46	110.07	97.67	120.06	----- Over Target
	Offers External Applicants	FTE	Conditional offers (in month)					31.86	22.04	4.00	22.24	20.24	20.24	20.24	20.24		
		FTE	Offers Confirmed (in month)					7.67	17.20	11.80	8.80	8.80	8.80	8.80	8.80		
Band 6 Nurses (excluding Theatre Practitioners)	SIP	FTE	Establishment					388.74	383.34	383.34	383.34	383.34	383.34	383.34	383.34		
		FTE	FTE In Post					366.38	355.26	351.50	347.75	343.99	340.24	336.48	332.73		
		FTE	New Starters					2.82	0.43	2.61	2.61	2.61	2.61	2.61	2.61		
		FTE	Leavers					3.25	9.48	6.37	6.37	6.37	6.37	6.37	6.37		
		FTE	Vacancies in month					22.36	28.08	31.84	35.59	39.35	43.10	46.86	50.61	34.05	----- Target Met
	Offers External/Internal Applicants	FTE	Conditional offers (in month)					5.00	1.61	4.16	4.16	4.16	4.16	4.16	4.16		
		FTE	Offers Confirmed (in month)					9.82	0.00	2.00	2.00	2.00	2.00	2.00	2.00		
Band 6 Community Nurses	SIP	FTE	Establishment	150.15	150.15	150.15	150.15	145.95	145.95	145.95	145.95	145.95	145.95	145.95	145.95		
		FTE	FTE In Post	140.32	139.41	140.41	139.91	137.15	137.15	137.30	137.45	137.60	137.75	137.90	138.05		
		FTE	New Starters	2.60	0.00	1.36	0.00	1.00	0.00	0.50	0.50	0.50	0.50	0.50	0.50		
		FTE	Leavers	1.00	0.00	1.00	0.70	0.00	0.00	0.35	0.35	0.35	0.35	0.35	0.35		
		FTE	Vacancies in month	9.61	10.74	10.74	10.74	8.80	8.80	8.65	8.50	8.35	8.20	8.05	7.90	9.61	----- Target Met
	Offers External Applicants	FTE	Conditional offers (in month)	0.00	0.00	0.00	0.00	0.00	1.00	2.00	0.00	0.00	0.00	0.00	0.00		
		FTE	Offers Confirmed (in month)	1.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00		
Band 6 Nursing (Total)	SIP	FTE	Establishment					534.69	529.29	529.29	529.29	529.29	529.29	529.29	529.29		
		FTE	FTE In Post					503.53	492.41	488.80	485.20	481.59	477.99	474.38	470.78		
		FTE	New Starters					3.82	0.43	3.11	3.11	3.11	3.11	3.11	3.11		
		FTE	Leavers					3.25	9.48	6.72	6.72	6.72	6.72	6.72	6.72		
		FTE	Vacancies in month					31.16	36.88	40.49	44.09	47.70	51.30	54.91	58.51	43.66	----- Target Met
	Offers External Applicants	FTE	Conditional offers (in month)					5.00	2.61	6.16	4.16	4.16	4.16	4.16	4.16		
		FTE	Offers Confirmed (in month)					9.82	1.00	2.00	2.00	2.00	2.00	2.00	2.00		
Band 5 & 6 Midwives	SIP	FTE	Establishment	192.39	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	167.09	164.77	162.27	162.67	158.47	156.07	155.45	153.92	152.39	150.86	154.33	150.80		
		FTE	New Starters	3.00	0.00	3.15	0.00	0.00	1.43	2.34	1.43	1.43	1.43	6.43	1.43		
		FTE	Leavers	1.26	3.44	3.00	1.20	2.92	3.84	2.96	2.96	2.96	2.96	2.96	4.96		
		FTE	Vacancies in month	25.30	27.62	30.12	29.72	33.92	36.32	36.94	38.47	40.00	41.53	38.06	41.59	26.64	----- Over Target
	Offers External/Internal 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)	2.60	0.00	0.00	0.00	0.92	1.42	0.46	0.46	0.46	0.46	0.46	0.46		
Consultants	SIP	FTE	Establishment	320.10	320.10	320.10	320.10	321.10	322.10	322.10	322.10	322.10	322.10	322.10	322.10		
		FTE	FTE In Post	292.25	287.39	286.70	287.65	283.80	282.65	280.30	277.95	275.60	273.25	270.90	268.55		
		FTE	New Starters	1.00	0.00	2.39	0.00	3.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00		
		FTE	Leavers	0.55	4.00	3.80	2.90	3.90	0.50	3.35	3.35	3.35	3.35	3.35	3.35		
		FTE	Vacancies in month	27.85	32.71	33.40	32.45	37.30	39.45	41.80	44.15	46.50	48.85	51.20	53.55	33.36	----- Over Target
	Offers External Applicants	FTE	Conditional offers (in month)	1.00	0.00	0.00	0.00	4.00	0.00	2.00	0.00	0.00	0.00	0.00	0.00		
		FTE	Offers Confirmed (in month)	1.00	0.00	0.00	0.00	3.00	0.00	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	311.00		
		FTE	FTE In Post					257.00	258.00	251.65	250.29	246.94	243.58	240.23	236.87		
		FTE	New Starters					0.00	7.00	2.00	7.00	5.00	5.00	5.00	5.00		
		FTE	Leavers					10.71	6.00	8.36	8.36	8.36	8.36	8.36	8.36		
		FTE	Vacancies in month					54.00	54.00	59.36	60.71	64.07	67.42	70.78	74.13	36.00	----- Over Target
	Offers External Applicants	FTE	Conditional offers (in month)	0.00	0.00	0.00	0.00	3.00	1.00	3.00	3.00	3.00	3.00	3.00	3.00		
		FTE	Offers Confirmed (in month)	0.00	0.00	0.00	0.00	3.00	0.00	3.00	3.00	3.00	3.00	3.00	3.00		

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

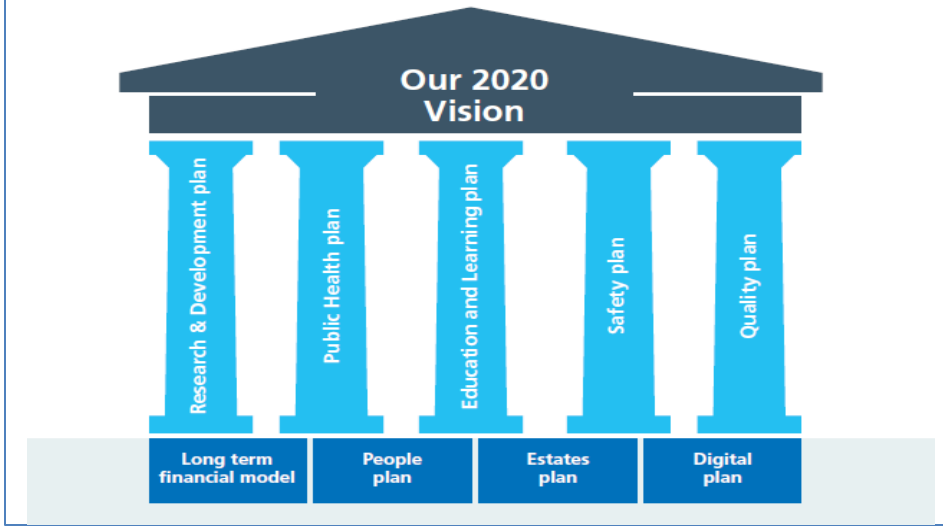
SWB TeamTalk

May 2018

Sandwell and West Birmingham Hospitals NHS Trust

Welcome to SWB Team Talk

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



SWB TeamTalk

NHS
Sandwell and West Birmingham Hospitals
NHS Trust

May 2018

Team Talk Agenda

1.00pm: Tune In: Local and national news

1.10pm: Learning from Excellence: Alcohol services feedback

1.25pm: What's on your mind? Worries and issues

1.40pm: Things you need to know – with Toby

1.50pm: This month's topic: Speaking Up

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

SWB TeamTalk

Sandwell and West Birmingham Hospitals NHS Trust

May 2018

Tune in – Local and national news

NHS 70 – A range of celebrations will take place on 5 July. There are lots of ways to get involved with activities which will go on all year round including our commemorative cookbook, tea parties and exhibitions. Look out for details in the communications bulletin and on Connect.

Coming together of NHS Improvement and NHS England – This will create one regional director role across our part of the Midlands and end the risk of different guidance to commissioners and providers. The likely guidance places a greater emphasis on STPs – both the one we are part of in the Black Country, and how STPs work together.

Your Voice survey – The survey results have been circulated to teams and are available on Connect. There is a simple message from the data. Most staff do not know what we do as a result of their feedback. This has to change where you work. What have you changed and who have you told?

Personal Health Budgets – the Government has launched a consultation seeking views to give more people the right to personal health budgets and integrated personal budgets. Find out more https://bit.ly/2ItWTec

After a diagnosis of dementia: what to expect from health and care services – A new DH document has been published (for patients and carers) outlining what should be in care plans, support available and how to take part in research. https://bit.ly/2s9KLZB

SWB TeamTalk

May 2018

NHS
Sandwell and West Birmingham Hospitals
NHS Trust

Learning from excellence:

SWBH ALCOHOL TEAM

Sally Bradberry
Alcohol Lead

Arlene Copland
Lead Alcohol Nurse

THE BURDEN OF ALCOHOL

To society - Estimated £21 billion p.a[1] (England)

- Physical and mental ill health
- Loss of productivity / benefit claims
- Family breakdown / domestic violence
- Crime / drink driving

[1] PHE, 2012. The Public Health Burden of Alcohol

THE BURDEN OF ALCOHOL

To SWBH - >300 ED primary alcohol presentations per month

- 13% admitted, 1000 bed days p.a.
- Increases to >5000 bed days p.a. if secondary alcohol presentations included
- Overall health cost to Birmingham and Sandwell £72.1 million (*data from Birmingham and Sandwell Alcohol Strategies, 2016/8*)

THE BURDEN OF ALCOHOL

To the individual

- Physical and mental ill health
- Poor self esteem
- Poverty
- Homelessness
- Fragmented relationships
- Impact on the extended family

SWBH ALCOHOL TEAM

- Funded by charitable grant for 1 year
- 7 membered team of nurses / alcohol practitioners / admin
- Operating 8am – 4pm, Monday – Friday with telephone answering service at other times
- Full team in place since January 2018

SWBH ALCOHOL TEAM - AIMS

Public health goals

- Reduce alcohol related admissions by 20% *(baseline 13% of ED presentations)*
- Increase referrals to partner alcohol agencies (Swanswell and CGL) by 50% *(baseline 20 referrals per month)*

SWB TeamTalk

NHS
Sandwell and West Birmingham Hospitals
NHS Trust

KEY OUTCOMES JAN-MARCH 2018

Activity – Reducing alcohol related admissions

Parameter	Q4	Monthly mean	Monthly Target
Estimated number of alcohol-related hospital bed days prevented (Admission prevention from ED or outpatients, reduced length of in-patient stay)	175	58	To prevent 15 bed days per month by 1st April 2018

KEY OUTCOMES JAN-MARCH 2018

Activity – Reducing alcohol related admissions

Parameter	Q4	Monthly mean	Monthly Target
Number of new referrals to the SWBH alcohol team (ED, in-patients)	534	178	A minimum of 50 new referrals per month

KEY OUTCOMES JAN-MARCH 2018

Activity – Increasing referrals to partner agencies

Parameter	Q4	Monthly mean	Monthly Target
Alcohol team referrals to community based services (substance misuse services, alcohol rehabilitation, AA, Smart groups, social services, home from hospital, homeless health exchange)	86	28.6	At least 15 referrals to community based services will be made per month

SWB TeamTalk

NHS
Sandwell and West Birmingham Hospitals
NHS Trust

KEY OUTCOMES JAN-MARCH 2018

Parameter	Q4
Income generated from alcohol team outpatient work (psychosocial interventions, pre and post detox clinics, alcohol reduction)	**£54,073.68**
Estimated financial saving due to admission prevention and reduced LOS	**£78,180.00**
SWBH alcohol team quarterly costs to the Trust	**£55,018.05**

PATIENT FEEDBACK

- ".. they are amazing and have given me hope"
- ".. was the first person to see him as a human being and not just a problem"
- ".. the detox programme has been a total lifeline to our family"
- ".. I thought he was going to die his alcohol problem was that bad. Thanks to their support and hard work our children have their dad back and me my partner"

NEXT STEPS

Secure substantive funding

- Beyond the 1st year pilot

Expand the delivery of an integrated service:

- 7 day working
- Improve links with community services (including fast track into services and rehab)
- Provide friends and family support

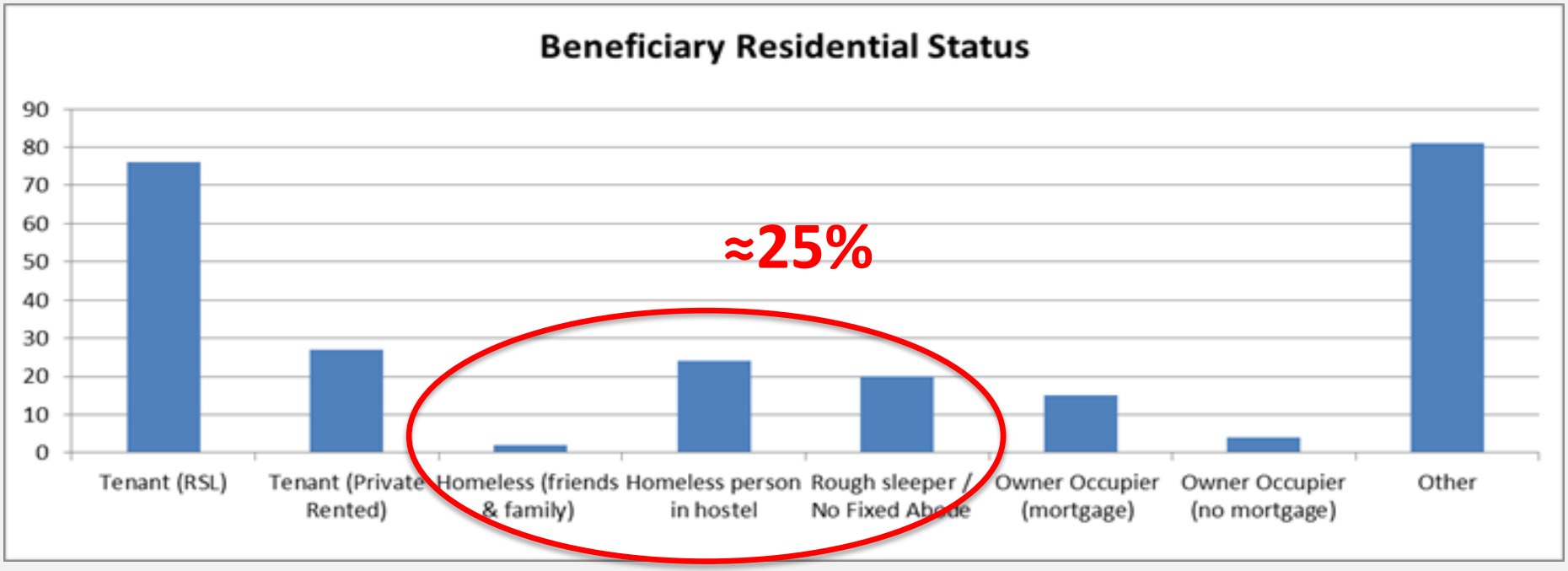
NEXT STEPS

Expand the delivery of an integrated service:

- Developing a voluntary support service, involving patients in recovery
- Drop in support expanding beyond the homeless
- Ambulatory detoxification
- Increased telephone consults and support
- Hosting an AA meeting on site

NEXT STEPS

Better understand the social impact of our patient group:



NEXT STEPS

Better understand the social impact of our patient group:

- Potential for partnership working / commissioning opportunities with other agencies:
  - Homeless charities, social housing
  - DWP / CCG
  - Crime prevention agencies

SWB TeamTalk

May 2018

NHS
Sandwell and West Birmingham Hospitals
NHS Trust

What's on your mind?

Your opportunity to raise any issues or ask a question.

Kam Dhami, Director of Governance

SWB TeamTalk

Sandwell and West Birmingham Hospitals NHS Trust

May 2018

Kam Dhami: Director of Governance
Feedback from April's Q&A sessions

Star awards

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

End PJ Paralysis

There was a 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 a request for promotion of stories from the end PJ paralysis campaign.

Car parking

The board has agreed to look at different car parking options including developing new car parks at City and Sandwell.

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. 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

Sandwell and West Birmingham Hospitals NHS Trust

May 2018

Things you need to know – from our Clinical Leadership Executive

Quality plan: The leadership conference focused extensively on patient care. Our first step is to quicken the pace of change around sepsis care. This summer our delivery of the sepsis six bundle on every ward will be studied and we aim to improve the timeliness of intervention markedly. This will help us reduce avoidable deaths in our organisation.

IT infrastructure: Unacceptable problems with our IT continue. Lots of work and resource is being committed to improving our resilience, both from cyber risk, and to maintain core systems seven days a week. By the end of 2018, and before we go live with Unity, we will see a marked improvement, both in community and hospital settings.

Thank you: We have more than halved overdue incident reports and committed to a standard whereby every incident will be investigated inside three weeks (21 days). All teams bar medicine and surgery will hit that standard next week. Meanwhile, over 6,500 PDRs have been booked since April 1st. We now need to ensure each one takes place and sets meaningful work objectives for 2018-2019.

SWB TeamTalk

Sandwell and West Birmingham Hospitals NHS Trust

May 2018

April Team Talk Topic feedback – Unity Readiness

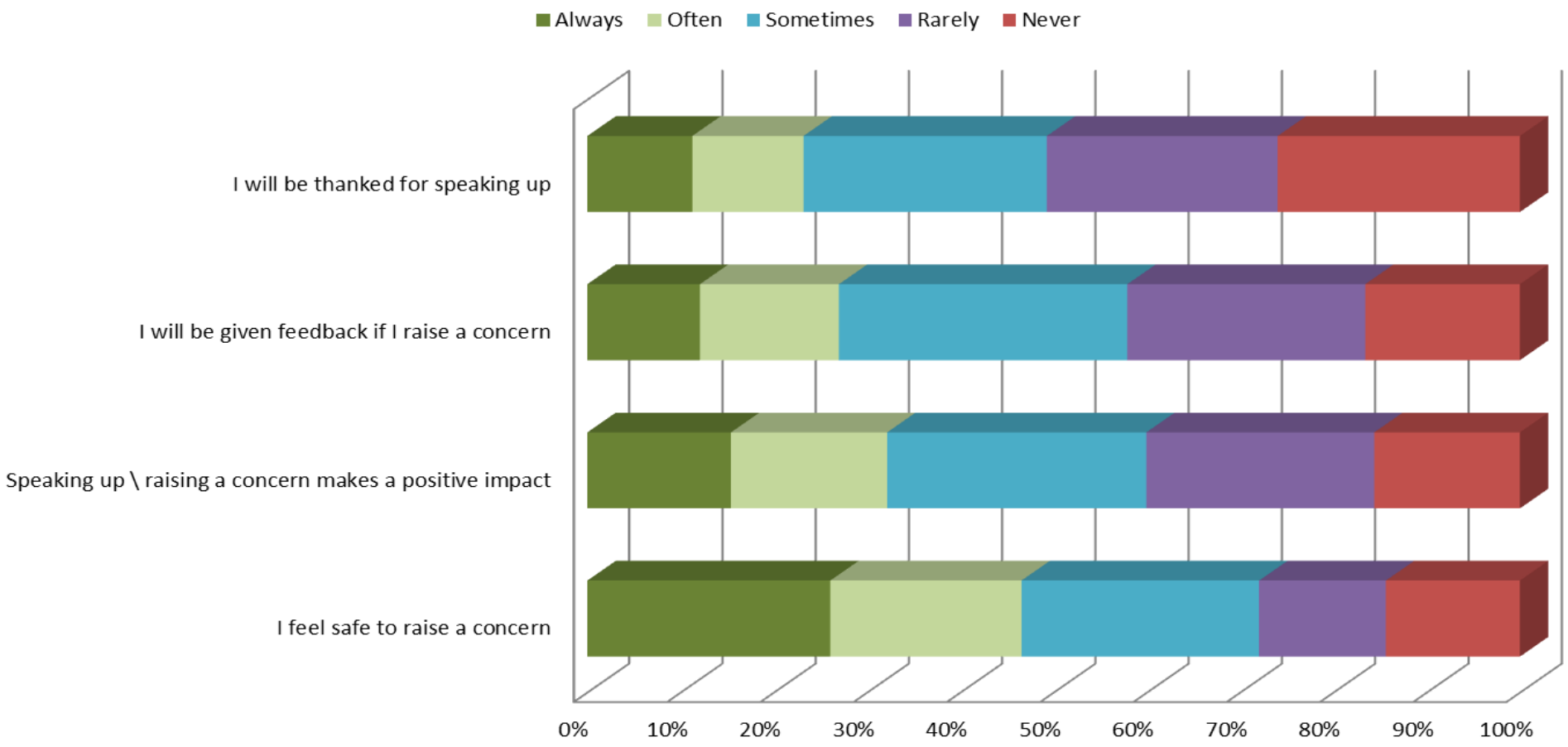
When Unity is launched in August over 5,500 colleagues will be using the electronic patient record on a daily basis. In order to prepare it is essential that you consider whether you will have to change the way you work when Unity is in place. The Unity Readiness Checklist is a guide for you and your 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.

Your feedback told us:

- **Teams are actively engaging with the EPR team in identifying how their working practices will need to change and how the implementation will effect their department.**
- **You are keen to ensure that informatics and Cerner staff are available during the go-live to support the deployment and eager to get hands on time with the new EPR to get a feel for how it looks and how it operates.**
- **Teams are concerned about ensuring that everyone has a login and sufficient end user training to be able to use the new EPR as well as deployment of all of the necessary computers\printers.**

Speak Up Day mood board results from all sites & Connect



	I feel safe to raise a concern	Speaking up \ raising a concern makes a positive impact	I will be given feedback if I raise a concern	I will be thanked for speaking up
Always	230	138	107	100
Often	181	150	132	106
Sometimes	225	249	274	232
Rarely	120	219	226	220
Never	127	140	147	231

SWB TeamTalk

TeamTalk Topic – May 2018: Kam Dhami

NHS
Sandwell and West Birmingham Hospitals
NHS Trust

Speaking Up – How will you encourage your teams to Speak Up?

We held our second Speak Up day on 16 May. Many colleagues took part by making new pledges and completed a short survey about confidence to speak up. As you can see (in the previous slide) the results of the poll carried out on Connect and on the stalls on Speak Up day your feedback is that more of you would like to be thanked for speaking up and you would also like to know the results of raising a concern.

In your teams please discuss:

1) What mechanisms do you have in place to enable colleagues to raise concerns?
2) How do you keep colleagues informed about what is being done about the issue they have raised?
3) What assurances do you have in place to ensure concerns raised are well received?
4) What further support do you need to ensure your team maintains a culture of openness and willingness to raise a concern?

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust action plan in response to

A review of the serious incident and patient safety governance processes at SWBH

Undertaken by NHS Improvement from December 2017 to March 2018

May 2018

Where EVERYONE Matters

Report ref:	Report section conclusions	Review Recommendations	Trust Response *(including action, owner and timescale)*
SERIOUS INCIDENT INVESTIATION PROCESS			
4.2.1	• SWBH and UHB email accounts are now linked so feedback to reporters is not missed • If an incident report is initially directed to an inappropriate department, this can be forwarded to a different department and investigation can continue as normal on the electronic system • Patient involvement in SI investigations has improved • Interviews are now used as part of all investigations to support the evidence-gathering phase (previously this had been focused on case note reviews) • Progress has been made in strengthening recommendations and learning from incidents, and in wider dissemination of learning, having taken advice from experts in large industrial organisations	1. SWBH have agreed to generate a situation report for the UHB oncology team specifying feedback from oncology-reported incidents during the past two calendar years. The review team understands that this was sent to Dr Andrew Toogood, Divisional Director, UHB, at the beginning of May 2018.	R1. The situation report has been sent to UHB and receipt acknowledged. **COMPLETED** **Executive Lead:** Kam Dhami **Completion Date:** April 2018
		2. Staff who report patient safety incidents or concerns should be offered an interview and engagement in any resultant investigation – even where they were not involved in the incident itself (whether an SI or not).	R2. This happens presently for Serious Incidents (SI), but the message will be reinforced that the corporate Patient Safety Team must ensure that the SI Lead Clinician engages and involves the incident reporter in their investigation. A similar process for Amber incidents, which are managed by the Clinical Groups, needs to be put in place. **Executive Lead:** Kam Dhami **Completion Date**: July 2018

Report ref:	Report section conclusions	Review Recommendations	Trust Response *(including action, owner and timescale)*
		3. A review of SWBH's Incident Reporting Policy, with input from relevant patient safety leads, governance leads and Executives, should be undertaken. A plan to support implementation of the revised policy should be developed.	R3. The current Incident Reporting Policy will be reviewed and revised, informed by a period of staff and patient consultation. An implementation plan will be developed to ensure the effective introduction of any proposed changes. **Executive Lead:** Kam Dhami **Completion Date:** September 2018
BOARD INVOLVEMENT WITH PATIENT SAFETY AND PATIENT SAFETY CULTURE			
4.2.2	• There is an evolving open and transparent safety culture • There are plans to identify any pockets of under-reporting by periodically checking reporting rates in each clinical area • Near-miss Never Events are reviewed • The patient safety committees have been reconfigured to provide higher levels of Board involvement; the Head of Quality from the CCG attends the Quality and Safety Committee • The Finance Director meaningfully supports patient safety initiatives, including funding for outpatient service expansion • PALS office has been moved to promote greater collaboration with the Governance	4. SWBH managers should arrange and monitor attendance at appropriate induction for all visiting members of staff. Content should include use of the local incident reporting system and details of their QI half-days.	R4. The revised Incident Reporting Policy will be communicated to colleagues through a variety of channels including a staff leaflet that will be issued to individuals with their payslip. This will also be provided to new starters as part of their induction pack. This leaflet will also be issued to visiting staff, along with the annual dates for the Quality Improvement Half Days. **Executive Lead:** Kam Dhami and Rachel Barlow **Completion Date:** September 2018
		5. SWBH leaders should agree and publish arrangements regarding support for visiting staff on how to raise safety concerns.	R5. A list of existing visiting staff will be established and a reminder issued to them about the numerous ways available to

Report ref:	Report section conclusions	Review Recommendations	Trust Response *(including action, owner and timescale)*
	and Complaints Departments • The *Purple Phone Project* is progressing		raise safety concerns. They will also receive the leaflet mentioned in R4. above launching the new Incident Reporting Policy (September 2018) **Executive Lead:** Rachel Barlow **Completion Date:** July 2018
		6. UHB oncologists should be encouraged to attend QI half-days at SWBH	R6. As per R4. above **Executive Lead:** Kam Dhami and Rachel Barlow **Completion Date:** September 2018
		7. UHB staff who visit SWBH should report any patient safety incidents there using the SWBH reporting channels rather than simply via their own MD.	R7. As per R4. **Executive Lead:** Kam Dhami and Rachel Barlow **Completion Date:** September 2018
		8. SWBH and UHB should agree, document and implement an action plan, which includes the above and other methods to improve the overall relationship between the two trusts to ensure patient care is optimised. The CEO of SWBH has stated following the interviews that SWBH is ready to make this commitment in writing	R8. The Trust will work with UHB colleagues to agree a shared action plan. **Executive Lead:** Toby Lewis **Completion Date:** July 2018

Report ref:	Report section conclusions	Review Recommendations	Trust Response *(including action, owner and timescale)*
CLINICAL AND OPERATIONAL ISSUES			
4.2.3	• A new Group Director of Imaging has been appointed • The backlog has been resolved and prioritisation of scheduling and reporting of radiology investigations is much improved • No CT or MRI scans are being reported by external contractors, or any oncology-related plain films • There is significantly improved recruitment of radiologists • New radiology flagging systems are in place • There are daily urgent MRI slots available for suspected spinal cord compression • The acute oncology service and chemotherapy unit continue to provide high quality care	9. It is imperative that cross-organisation plans are made and implemented for oncology patients presenting acutely to the Emergency Department at SWBH, to ensure that timely and appropriate specialist oncology input is available. This issue is being resolved by the Transitional Oversight Board, specialist commissioners and CCG commissioners	R9. The Trust will work with the Transitional Group and by the end of August will have audited Q1 performance. **Executive Lead:** Rachel Barlow **Completion Date:** September 2018
		10. A system should also be devised, documented and implemented which enables oncology-related patient information to be readily available throughout the day and night to staff at both sites.	R10. The Trust will work through as part of HIE how this can be accomplished in 2018. **Executive Lead:** Mark Reynolds **Completion Date:** December 2018
METASTATIC SPINAL CORD COMPRESSION			
4.2.4.	Urgent further work is required in this area and National Patient Safety Team expert support has been offered and accepted by SWBH	11. Focused investigation should be conducted into the recent cases of missed metastatic spinal cord compression, and specific support for this has been offered by the NHS Improvement Patient Safety Team to help determine the true root causes	R11. Verbal agreement has been reached with NHSI that for any future MSCC serious incidents we will seek their assistance in the investigation process. **COMPLETED** **Executive Lead:** Kam Dhami **Completion Date:** April 2018

INTEGRATED CARE (SANDWELL AND WESTERN BIRMINGHAM)

PARTNERSHIP INITIATION DOCUMENT

DRAFT FOR DISCUSSION

Purpose

To improve the health and wellbeing of the people in Sandwell and Western Birmingham.

Strategic Aims

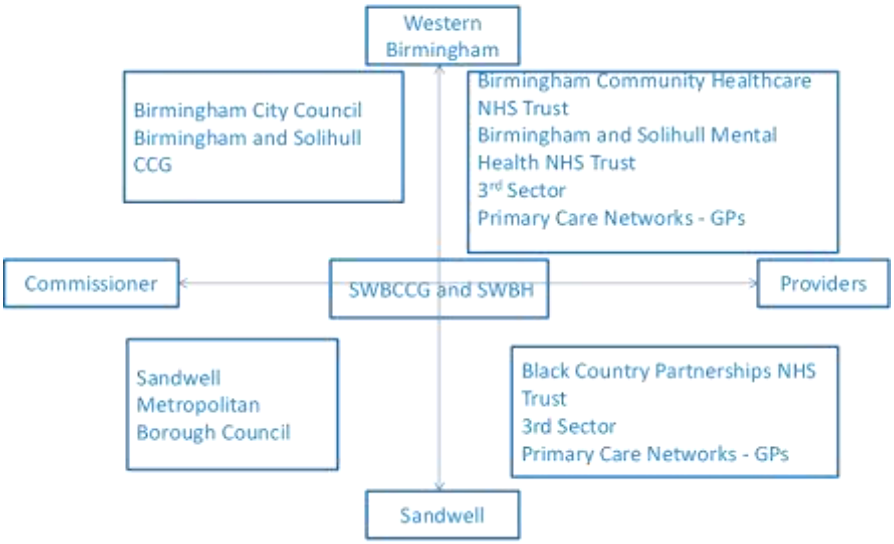
- To focus on the wider determinants of health and wellbeing including housing, employment, education and community safety.
- To achieve safe and sustainable acute services by 2022.
- To treat the whole person by integrating physical and mental health approaches.
- To bring together health and social care commissioning.
- To develop transformation, and reduce transactional, processes within the health and care system through a strategic approach to the commissioning and delivery of care; characterised by a focus on outcomes and experience, long term agreements and a move away from the annual contracting and PBR mechanisms in health.
- To support the integration of care through the use of common information and data systems and processes.
- To support individuals and their carers to live independently and to take responsibility of their own care through the personalisation of health and care wherever possible.

Programmes

The system is characterised by high levels of deprivation, a diverse population and poorer health and wellbeing outcomes in many cases than England as a whole. Whilst existing as a system sharing many key primary and secondary care resources, there are still two distinct geographies in Sandwell and Western Birmingham. The planned programmes of work reflect this.

In order to create a framework for integration the system with work through four programmes paired to reflect the two geographies. This will involve the development of joint commissioning arrangements and integrated provider partnerships in Western Birmingham and Sandwell. This is shown in the diagram below.

Relationship Map and Four Programmes



Partners have agreed there will be a fifth programme to ensure and enable safe and sustainable acute services. Details of this programme have yet to be agreed. There will also be a sixth programme addressing enabling areas of work such as workforce, IM&T, outcomes framework and metrics, and coordination across work areas.

Governance

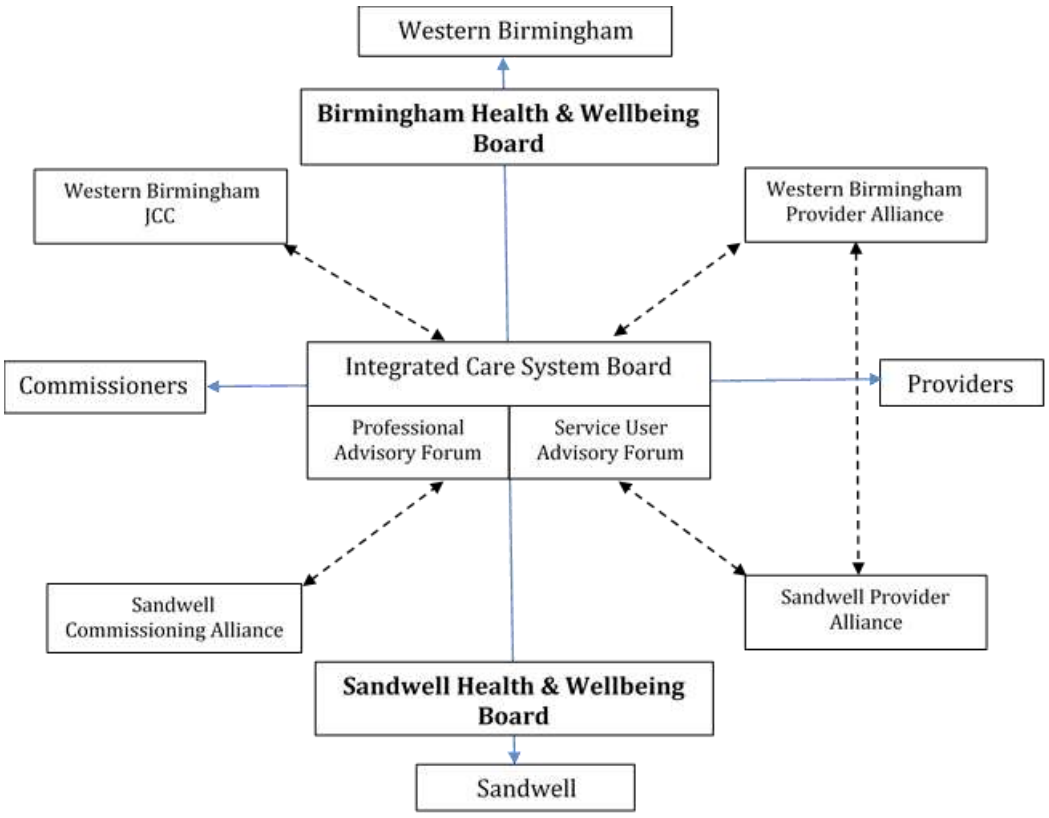
The Partnership will work through a decentralised approach, using existing governance mechanisms wherever possible to avoid the need for duplicate arrangements. It will still co-ordinate at a system level though to reduce unwarranted variation and to maintain viability and value for money.

In Western Birmingham this entails operating within the "Health Lives, Happy People" framework developed by the Birmingham and Solihull STP. In Sandwell it means operating within the Sandwell 2030 vision and the Black Country and Western Birmingham STP. Key relationships will be maintained with both systems through links with both STPs and both Health and Wellbeing Boards.

The Integration Partnership will therefore take responsibility for managing the boundary between these wider partnerships, ensuring the population benefit from both rather than falling between them. This is crucial given the population flows and common infrastructure shared by over 600,000 people in the Sandwell and Western Birmingham area.

The Chairs and Chief Executive/ Accountable Officer for the Sandwell & West Birmingham Hospitals NHS Trust and Sandwell & West Birmingham CCG will continue to meet informally on a weekly basis to sustain close working relationships and alignment. On a monthly basis the Chair and Vice Chair of the Professional Advisory Forum and the Service User Advisory Forum will join the "weekly forum" to form the formal Integrated Care System Board. The governance arrangements are shown in the diagram below.

Governance Arrangements



Distinct Approach and Ambition

Whilst operating in a decentralised way there are distinct values, approaches and ambitions that will characterise the Integration Partnership in Sandwell and Western Birmingham. These include:

- A focus on the first 1,000 days of life (to reduce adverse childhood experience and improve equity and life chances).
- A focus on later life (including integrated care for the frail elderly and end of life care).
- A determination to achieve outcomes in key areas that are in the upper quartile for comparable inner city/ urban areas in England.
- The development of shared health and care records and information systems to support the planning and delivery of care.
- The development of enabling approaches to workforce recruitment, training and development to support the transformation process.
- A focus on diversity and equality to reflect the community served.

These characteristics will be the lens through which the Integration Partnership will view plans and proposals.

1 June 2018

SANDWELL AND WEST BIRMINGHAM HOSPITAL NHS TRUST

Report to the Trust Board: 7th June 2018

Freedom to Speak Up Guardians: Update

1. In May 2016 the Trust appointed 10 Freedom to Speak Up Guardians from across the Trust's Clinical Groups and Corporate Directorate. The list below shows good representation across roles, gender and diversity.

Name	Job Title
Dermot Reilly	Clinical Practice Co-ordinator
Harpal Tiwana	Patient Administration Manager
Natasha Thompson	Medical Secretary
Rosie Auld	Head Orthoptist
Sandra Kennelly	Clinical Team Leader / Occupational Therapist
Rachel Clarke	Deputy Anticoagulant Services Manager
Susan Whalen	Consultant in Sexual Health
Anil Bhogal	Security Officer
Ian Galligan	Technical Supervisor, Medical Engineering

* One Guardian stepped down from the role when his medical rotation took him to another Trust

2. The role specification issued to the FTSU Guardians is based on national guidance. All of them have received tailor-made training commissioned by the Trust from Public Concern at Work, and some have attended external courses.

3. Since their appointment the Trust has worked with the FSTU Guardians to raise their profile across the organisation, as without this staff would not know of their existence. They have appeared in Heartbeat articles, a leaflet attached to payslips, videos played on the Staff Comms bulletin and attended corporate events such as the Leadership Conference. They FTSU Guardians have also front-lined the two Speak Up Days.

4. The nine FTSU Guardians hold a network meeting on a quarterly basis and invite the CEO, Director of Governance and Director of Communications to join the second half. That provides an opportunity for the Guardians to seek any support and assistance they require from the Executive.

5. The National Guardian's Office collects quarterly information on approaches made to each organisation's FSTU Guardians. After experiencing some difficulty in establishing the submission route, the FTSU Guardians are sending in this information, and were allowed to do so retrospectively for the Trust's 'missing' quarters.

   In 2017/18 between our nine Guardians six cases have resulted but looking at like-sized Trusts we are not alone in the low contacts, although many have significantly greater activity in their organisations.

6. Despite all the work that has been undertaken to raise the profile of the FTSU Guardians, the tiny number of approaches made across the year indicates the need for a better understanding of why staff are not contacting them. Ways to elicit this information from staff will be found to help find out why this is the case. Learning from other Trusts where such activity is higher is also planned over the next few months.

7. The review, revision and relaunch of the Speak Up Policy (currently called Whistleblowing) that is about to begin will provide the opportunity to reinforce the important role the FTSU Guardians play in supporting staff to raise their concerns.

8. Earlier in May the National Guardian's Office published guidance for NHS Trust Boards on Freedom to Speak Up. This guidance which has been produced jointly between the National Guardian's Office and NHS Improvement sets out expectations of Board and Board members in relation to Freedom to Speak Up. A self-assessment tool has also been produced and webinars are being arranged. Completing the self-review tool and developing an improvement action plan will help the Trust to further evidence its commitment to embedding speaking up.

9. In line with national guidance a report directly from the nine FTSU Guardians about their experience will be presented to the July Board.

10. The Trust is fortunate to have appointed such enthusiastic and committed FTSU Guardians. Work needs to continue to support staff to make the most of them to help raise their concerns.

Kam Dhami
Director of Governance

1st June 2018

Paper ref:	TB (06/18) 014 annex

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	CNST Maternity Rebate		
Sponsoring Executive	Paula Gardner, Chief Nurse		
Report Author	Rachel Carter, Group Director of Midwifery		
Meeting	Trust Board	**Date**	7th June 2018

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

NHS Resolution have provided opportunity for Maternity Services to be awarded a rebate of up to 10% of the CNST contribution upon confirmation by trust Boards that 100% compliance with 10 standards has been achieved. The standards were shared in January 2018 with further compliance information shared in April 2018. Supplementary information advised that, where 100% compliance cannot be evidenced, a proportion of the rebate may be awarded with opportunity for Trusts to then bid for funding to support future compliance where this has not yet been achieved. Compliance has been achieved in 9 out of the 10 criteria with robust supporting evidence. The standard that has not yet been achieved is Safety Action 8: "*Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?* "Having successfully bid for funds to support team members to receive 'train the trainer' 'PROMPT' training during 2017, once places for the Trust delegates to attend were secured (October 2017), the in-house faculty was developed and delivered its' first multi-professional maternity emergencies training session in February 2018. Monthly sessions have been facilitated thereafter; cohort size is maximum of 40 staff per session from across the multi-professional team. This, together with the multi-professional interactive fetal heart rate monitoring training and 'live skills drills' has seen a progressive level of compliance, working to achieve the 90% standard across all staff groups within the multi-professional team within 12 months of implementation. This is a scheme that was advised in January 2018 with new standards to demonstrate compliance.

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?]*

This is a scheme that was advised in January 2018 with new standards to demonstrate compliance.

4. Recommendation(s)

The Trust Board is asked to:

a. Acknowledge the self-assessment tool attached, with a view to the evidence being reviewed and accepted by the Trust Board for sign off and confirmation to NHS resolution. To submit to NHSI for proportionate rebate reflecting compliance with 9/10 actions and positive progress to compliance with outstanding.

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

Trust Risk Register		Risk Number(s): results acknowledgment						
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		

Board report on Sandwell & West Midlands Hospitals NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

SECTION A: Evidence of Trust's progress against 10 safety actions:

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	07.02.18 Access paperwork completed once released; submission to MBRRACE NPMRT implemented in practice for reviews for cases from January 2018 onwards (retrospective once access granted) *Evidence attached by link* **Action 1**	**YES**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Confirmation of submission in accordance with criteria *Evidence attached by link* **Action 2**	**YES**
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	Transitional Care of Babies in the Postnatal Ward area Guideline attached. Enhanced care babies info summarised per month January to April 2018 *Evidence attached by link* **Action 3**	**YES**
4). Can you demonstrate an effective system of medical workforce planning?	RCOG Self assessment tool completed- Compliant *Evidence attached by link* **Action 4**	**YES**

5). Can you demonstrate an effective system of midwifery workforce planning?	6 monthly Birthrate plus table top review completed November 2017- reported to Chief Nurse. NNU workforce review completed November 2017 – reported to Chief Nurse. Escalation Policy reflects supernumerary Band 7; revised escalation policy in draft and references use of birth-rate plus full and table top tool *Evidence attached by link* **Action 5**	**YES**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	Self-Assessment information and report Group review agenda re. maternity safety and perinatal mortality *Evidence attached by link* **Action 6**	**YES**
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	Co-production workshops and patient engagement, supported by Healthwatch Whose Shoes event: 28th March 2018 – outcome poster and press release *Evidence attached by link* **Action 7**	**YES**
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	CNST Local Training Record Form: • Skills Drills Programs • PROMPT training • Multi-Professional Live CTG review & training Progression evident to reach 90% across the multi-professional team: working	**In Progress; evidence of progress towards 100% compliance**

	towards achieving 2017/18 following launch of PROMPT training by the newly developed SWBH PROMPT faculty February 2018 *Evidence attached by link* **Action 8** **Actions to gain compliance outlined in Section B**	**during 2018/19**
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Group review agendas Safety Summit presentation and action plan Safety champion meetings National Collaborative driver diagram and outcome presentation *Evidence attached by link* ***Action 9***	**YES**
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	Evidence of referrals 2017/18 (NB. Patient identifiable information contained) *Evidence attached by link* **Action 10**	**YES**

Key

Compliant	**Partial compliance; plan progressing to achieve full compliance**	**Plan in development to achieve compliance**	**Non-compliant and no plan to achieve**

SECTION B: Further action required: Please refer to Action Plan for safer maternity, attached.

If the Trust is unable to demonstrate the required progress against any of the 10 actions, please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.

Safety Action Not Met	*Compliance issue*	*Action*	*Who Responsible*	*Compliance trajectory*
Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year	PROMPT training implemented following training (funded from NHSE training bid 2017/18 – delayed owing to lack of places for training). Faculty developed & in house courses commenced February 2018. Partial compliance reflected from skills drills, multi-professional CTG training and initial PROMPT training courses.	Aim to deliver 2 'live' clinical Obstetric skills drills per month Deliver planned in house rolling PROMPT courses as scheduled monthly Monthly monitoring/ compliance report reflecting PROMPT, skills drills and CTG training	Clinical Educators & Labour ward Lead Consultant Clinical Educators & PROMPT faculty Clinical Educators	*In progress* *evidence of compliance 31.03.19* *In progress- evidence of compliance 31.03.19* *In progress* *In progress- evidence of compliance 31.03.19*

SECTION C: Sign-off

……

For and on behalf of the Board of Sandwell and West Birmingham Hospitals NHS Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: **……..**

Date: **……..**

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

SECTION D: Appendices- Evidence files embedded in Self-assessment template (internal use: SWBH Trust Board assurance of evidence).

Paper ref:	TB (06/18) 014 annex

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Advocating for education and Quality improvement : Implementation of AEQUIP at SWBH		
Sponsoring Executive	Paula Gardner, Chief Nurse		
Report Author	Rachel Carter, Group Director of Midwifery		
Meeting	Trust Board	**Date**	7th June 2018

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

Statutory Supervision of Midwives ceased at the end of March 2017 following recommendations within the Morecombe Bay Report (2016).

In its' place, a new model has been developed known as A-EQUIP which is currently being implemented nationally, with local adaptation to ensure the required principles are met.

This paper outlines the situation at SWBH, delivery model and progressive implementation together with support required from the Trust to demonstrate commitment and achieve intended success.

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?]*

4. Recommendation(s)

The Trust Board is asked to:

a. Acknowledge the new role within maternity services and consider additional funding to support the role on the basis of evidence of quality and safety impact as reflected through the outcome measures.

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

Trust Risk Register		Risk Number(s): results acknowledgment					
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	

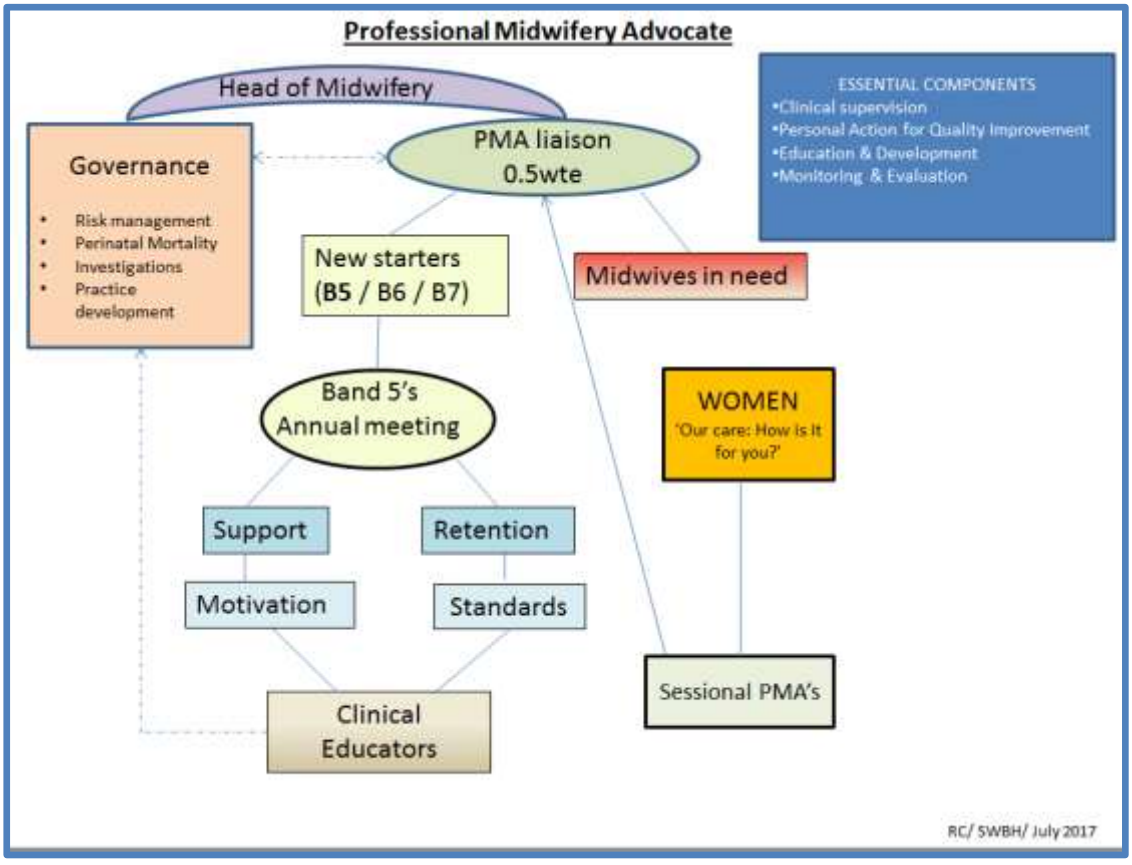
Background:

Professional development and support similar to clinical supervision has been available to midwives since 1902 through statutory supervision. In March 2017, Statutory Supervision of Midwives ceased following a review of the process after concerns regarding objectivity and transparency were identified during the review of maternity services at Morecombe Bay. It has since been replaced by a different model of clinical midwifery supervision: A-EQUIP which is detailed for inclusion as part of the National Variation for the NHS Standard Contract for 2018-19.

Implementation at SWBH began during 2017/18 when we secured funding for 5 ex-Supervisors of Midwives to complete the A-EQUIP bridging training course to become Professional Midwifery Advocates (PMA). The new model of supervision is employer led and non-regulatory with 4 essential components to be delivered to support a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for appraisal and professional revalidation" (NHSE, 2017). The 4 essential components are: clinical supervision, Personal action for quality improvement, education and development and monitoring and evaluation.

Each maternity service has developed a model to support implementation. With only 5 qualified PMA's in post, the implementation does not yet meet the desired model which would see an increased number of PMA's coordinated and supported by a lead PMA; funding would be required to achieve this.

SWBH Model:



The Head of Midwifery has worked with the 'ex-Supervisor's', EQAUIP pilot sites and engaged with local universities to develop a bespoke model, incorporating the essential components, to meet local need of our midwives and maternity services.

The model reflects the ambition, once successful recruitment and training has been completed, for a specific role of a PMA liaison midwife (0.5wte) to coordinate the activities of the sessional PMA's. To achieve this, funding would be required to ensure this does not impact on clinical hours; this is anticipated to form part of the quality plan 2018/19.

The model is designed to address issues identified regarding the need for additional support for midwives new to the Trust, those who are newly qualified and those who may have been involved with a clinical incident, or who have identified confidence or competence issues. Whilst the PMA's will report directly to the Head of Midwifery, there is a strong link with Governance and a key role identified for restorative supervision.

The SWBH model is unique in comparison to regional models, incorporating patient experience in the role with sessional PMA's allocated to daily visits with women and families to elicit key themes associated with their experience of our care (positive and concerns). This is not to replacing the role of the shift lead midwife, instead an objective view of immediate supportive measures that can be escalated to improve both, the experience of caring by the carers and also those for whom we care.

SWBH implementation:

The PMA's launched their role on 4th May 2018 to coincide with International Day of the Midwife celebrations. One of the 5 PMA's is now leaving the Trust therefore 3 places have been reserved for Midwives who are successful during selection process to begin their 'long course' training (as they will not have been Supervisors), with a plan for an additional 2 more PMA's to be trained each year.

At implementation, the model sees the PMA's fulfil their role on a sessional basis with 4 hours rostered cover over each of 4 days. This time has been funded by reallocation of the funding previously allocated for Statutory Supervision of Midwives together with supervision monies allocated by HEE against training. The activity will be captured through a monitoring tool which will be reported to the Head of Midwifery for impact and quality assessment and reported at Governance meetings.

A-EQUIP outcome measures have been developed by NHSE; these were shared at the end of April 2018 to ensure services have implemented the model and are adhering to the requirements of this new safety function across Maternity Services.

Future ambition:

There is joint ambition across the Local Maternity System for future development with the PMA's from each Trust working together to deliver the PMA function across the local area; this first requires all Trusts to have trained PMA's within each of the four services.

Paper ref:	TB (06/18) 015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Analysis of Mortality		
Sponsoring Executive	David Carruthers, Medical Director		
Report Author	Mumtaz Goolam		
Meeting	Trust Board	**Date**	7th June 2018

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

HSMR is outside the expected range for SWBHT, with site and weekday/weekend differences in mortality noted. To be able to address this rise in mortality rate it is important to:

1) Understand the influences of the way data is collected on mortality
    a. Identify and correct any data collection anomalies (coding and palliative care)
2) Identify where patient differences exist between site/time of week admitted
    a. are there demographic differences in patients based on site or day of week admitted
    b. are there differences in diagnostic groups based on site or day of week admitted

The Board is asked to note the information around palliative care coding and the initial analysis of mortality data. These data will be compared with disease groups that are part of the Quality Plan improvement process. Where other areas of concern are noted, these will be included in the QI process for the Quality Plan to improve amenable mortality.

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	x	Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

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

Trust Board May 2018

4. Recommendation(s)

The Trust Board is asked to:

a.	Note the initial work to identify patient differences in site and day of admission
b.	Approve the plans for progress in reduction of amenable mortality
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	

Progress report on amenable mortality June 2018

The attached report shows the data obtained on Trust mortality, comparing weekend and weekday demographic and disease specific mortality, which is summarised below. In addition progress in work around palliative care and coding progress.

1) Palliative care. There is incomplete coding of palliative care episodes at SWBHT noted and the potential impact of this on mortality data is being examined while the coding omissions are being identified.
    - Last 12 months' worth of patient care episodes will be retrospectively submitted to HES, with Palliative Care Codes updated.
        - Palliative care get data recorded for end of June 2018
        - We match, extract and submit to SUS by mid July 2018
        - SUS process by end of July 2018
        - So that HES can re-extract from SUS and process by end of August 2018

2) Coding. Recording of comorbidities and accurate recording of primary diagnosis is important both for mortality data but also for accurate costs for episodes of care.
    - A presentation on do's and don'ts is being prepared by coding department for dissemination to clinical staff. This can be provided to staff via CLE and directly to junior and consultant staff, with the best forum to be determined
    - There are links to the GIRFT process, income and quality plan
    - Other factors are to look at reducing use of signs and symptoms from episodes of care coded.

3) Demographic data (see report) shows no significant difference in age (mean 75) or sex ratio (50:50) of weekend v weekday patient characteristics
    - Need to look at data further to identify place of death to look at balance of community beds v acute hospital beds

4) RAMI mortality data for 2017 are summarised below, confirming the site and weekend v weekday differences.

Site	Weekday		Weekend	
	RAMI	Deaths Actual/expected	RAMI	Deaths Actual/expected
Sandwell	108.3	670/619	141.97	285/201
City	94.8	411/433	108.2	159/147
Trust	102.8	1081/1052	127.7	444/348

5) Diagnostic groups show that pneumonia, hip fracture and stroke have increased mortality rate compared with peer groups. These groups also have higher rate at the weekend compared with weekday. However, there is a fall over time with mortality from acute MI and fracture hip in weekdays.
    - This supports the approach of the quality plan to examine sepsis pathways initially (which will include pneumonia) and then to build on that with disease specific areas of stroke and hip fracture.
    - Leadership conference data to be examined to identify progress made already in disease specific areas and proposals from the clinical groups about areas to focus on.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

A Review of Weekend and Weekday Mortality in the 12 month data period, January 2017- December 2017 at SWBH NHS Trust

Position statement on Standardised Mortality Ratios for the Trust

Summary

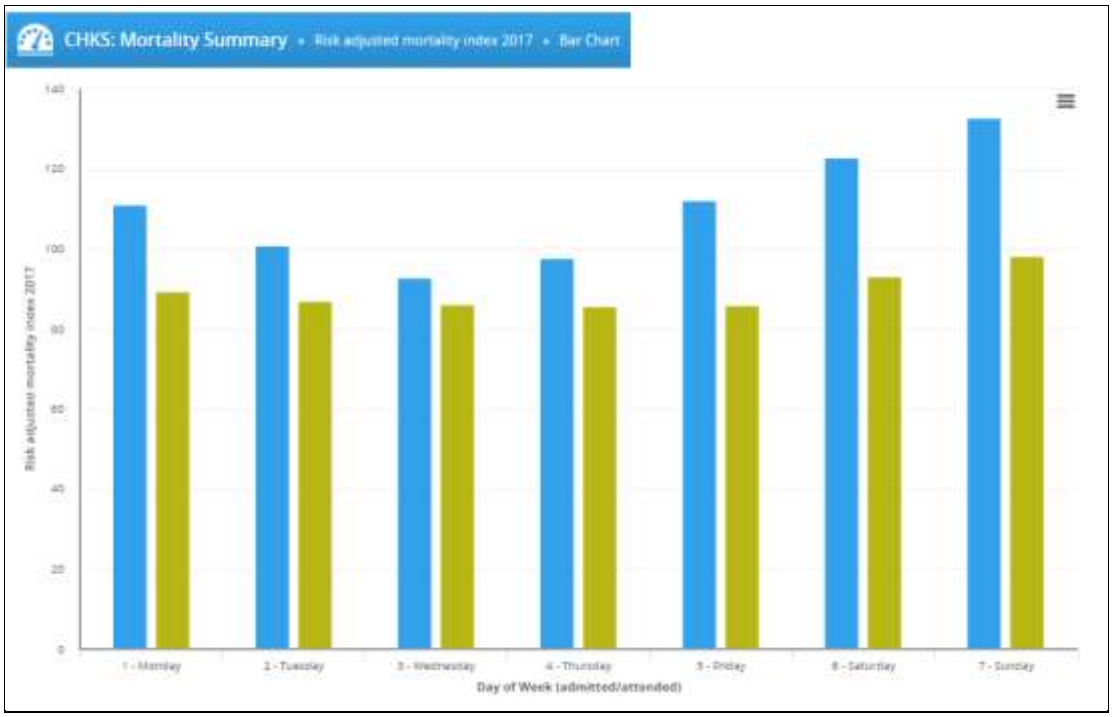
- A rising trend in standardised mortality ratios for the Trust Risk Adjusted Mortality Indicator (RAMI) & Hospital Standardised Mortality Ratio (HSMR)) have been reported in the Integrated Quality & Performance Report over recent months. This has also resulted in the Trust moving away from the top quartile of best performing Trusts.
- It was initially considered that the underreporting of when patients have received Palliative care and the effects of rebasing have contributed to this change in position. However this may contribute to a small percentage of the statistical rise. The significance of decreased Palliative care coding can also be attributed to the implementation of the Connected Palliative Care Hub, which has allowed patients to die in their Preferred Place of Care.
- The RAMI value for the latest 12 month cumulative period ending in December 2017 is 109. This is similar to the previous 12 month cumulative period value of 108. The Trust is now identified as an outlier as this is outside statistical confidence limits.
- The HSMR value for the latest 12 month cumulative period ending in December 2017 is 122.0. This is down from 106 for the previous 12 month cumulative period. The Trust is now identified as an outlier as the HSMR is also outside statistical confidence limits.
- The Trusts mortality review process which provides for a qualitative overview of the vast majority of deaths that occur in hospital, has not seen any significant change in the percentage of deaths initially classified by reviewers as being potentially preventable.
- The SHMI value for the Trust for the latest 12 month cumulative period (December 2016-November 2017) is 110 and this is also outside statistical confidence intervals.

Introduction

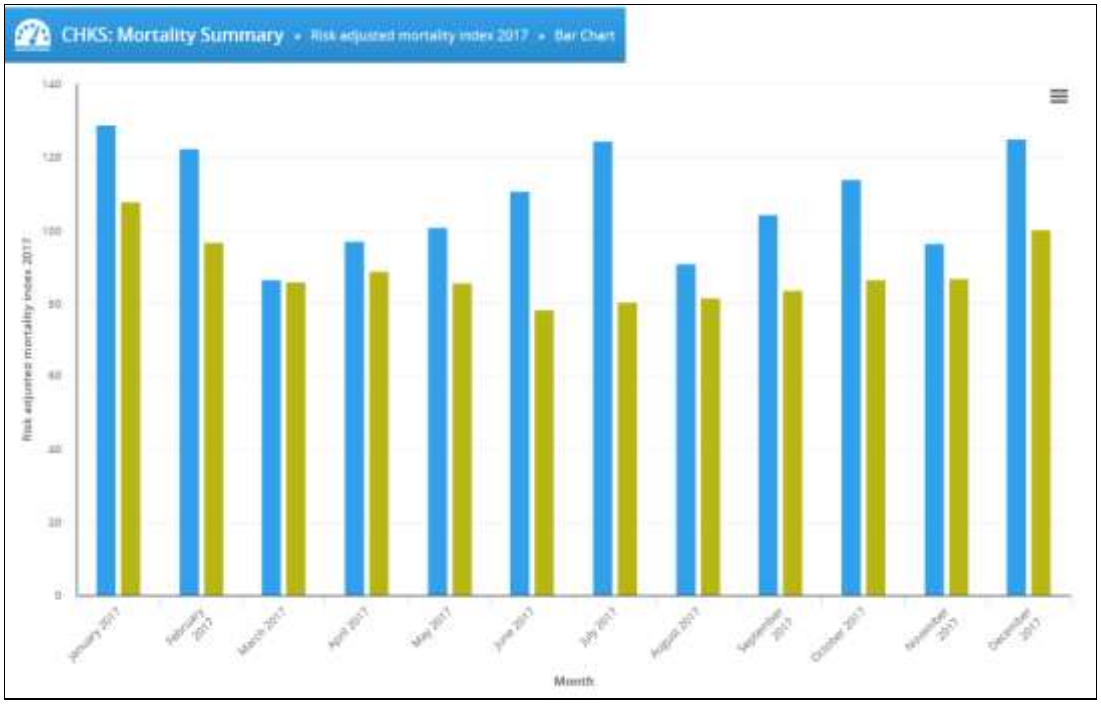
Over the recent months the Risk Adjusted Mortality Indicator (RAMI) reported for the Trust in the Integrated Quality & Performance Report (IPR) has shown a rising trend. The purpose of this report is to provide some further detail on the background to this increase. The insights analysed, have highlighted an upward trend primarily in the overall Weekend and Weekday mortality ratios, which will form the focus of this Report.

The Trust Weekend admissions reported in the Mortality Performance Report has largely shown a higher value in comparison to Weekday admissions for the last 12 consecutive months' cumulative data periods. This has been above the Peer Value for every day of the week (**Graph 1**) and also every month of the 12 month cumulative period, January 2017- December 2017 (**Graph 2**).

Graph 1- Weekend & Weekday RAMI values for the Trust reported in the Mortality Performance Report



Graph 2- Weekend & Weekday RAMI values for the Trust reported in the Mortality Performance Report (Monthly Values)



Standardised Mortality Ratios

Standardised mortality ratios (SMR's) including RAMI are methods of comparing mortality levels in different years, or for different sub-populations in the same year, while taking account of differences in population structure. The ratio is (observed) to (expected) deaths, multiplied conventionally by 100. Thus if mortality levels are higher in the population being studied than would be expected, then the value will be greater than 100.

The 'expected' number of deaths

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

Adjustments made for palliative care

Adjustments are made for when patients receive Palliative Care, but the extent of this is different across the indicators. For example, under RAMI patients coded as receiving palliative care (Z515) are excluded from the numerator, whilst for the HSMR adjustments are made for this.

Changes have been introduced to the RAMI indicator from December 2017. Following rebasing, the new RAMI methodology includes patients coded as receiving palliative care (Z515).

The 'observed' number of deaths

The observed deaths, the numerator, will be influenced by the quality of care given, i.e. the better the care, the fewer people will die. It will be influenced by place of death .i.e. if the end of life care is typically given in hospital, the numerator increases. Other factors such as how well a Trust manages the deteriorating, patient, sepsis and also how well it controls infections will be significant.

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

Source data for Standardised Mortality Ratios

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

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

Observed vs Expected Deaths- 2017

Weekend Mortality

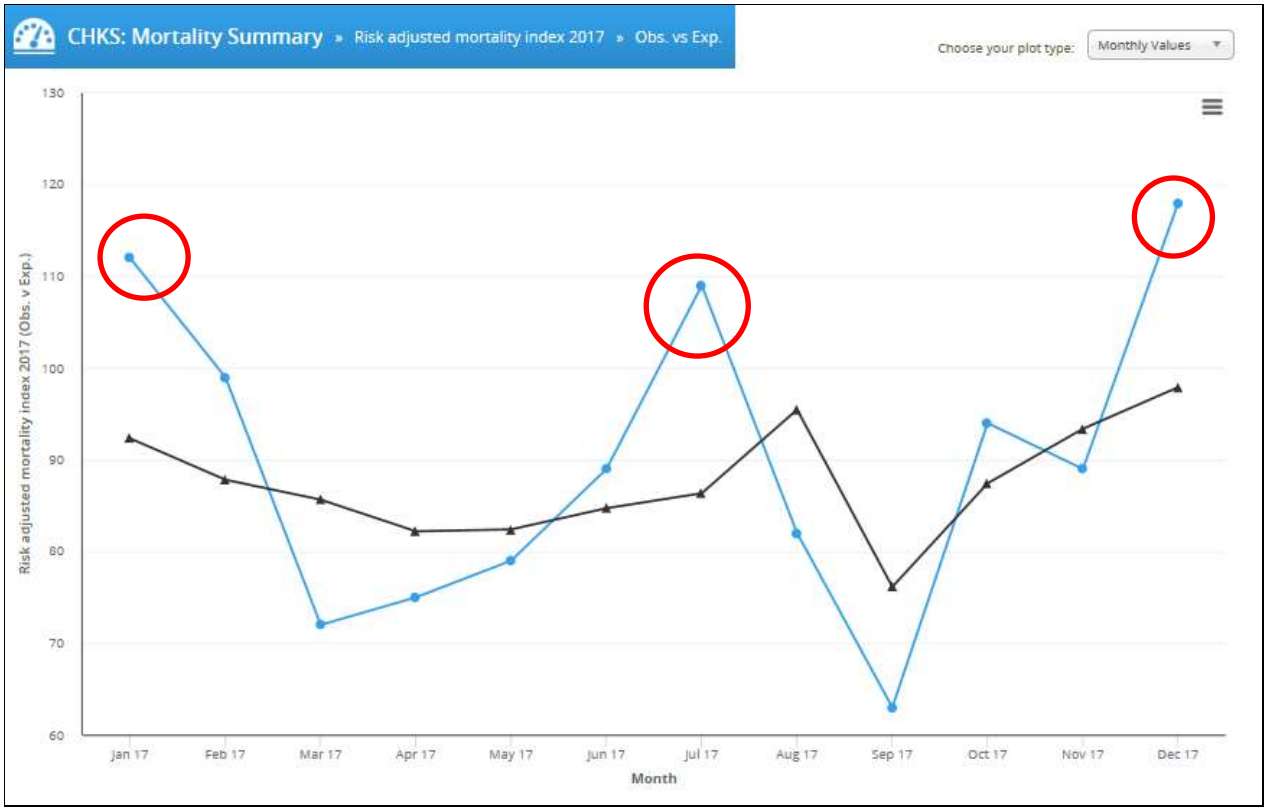
The Trust has consistently exceeded the observed (blue line)/ expected (black line) deaths in 2017 except in March 2017, where it was marginally below the expected number of deaths, i.e there were 28 observed deaths when 29.75 was expected, (**Graph 3**).

Graph 3

Weekday Mortality

The Trust position has been sporadic in relation to the observed / expected deaths in 2017. In January 2017, July 2017 and December 2017, the Trusts' observed deaths exceeded the expected number of deaths, in relation to the national average, (**Graph 4**).

Graph 4



Current position

Weekend mortality

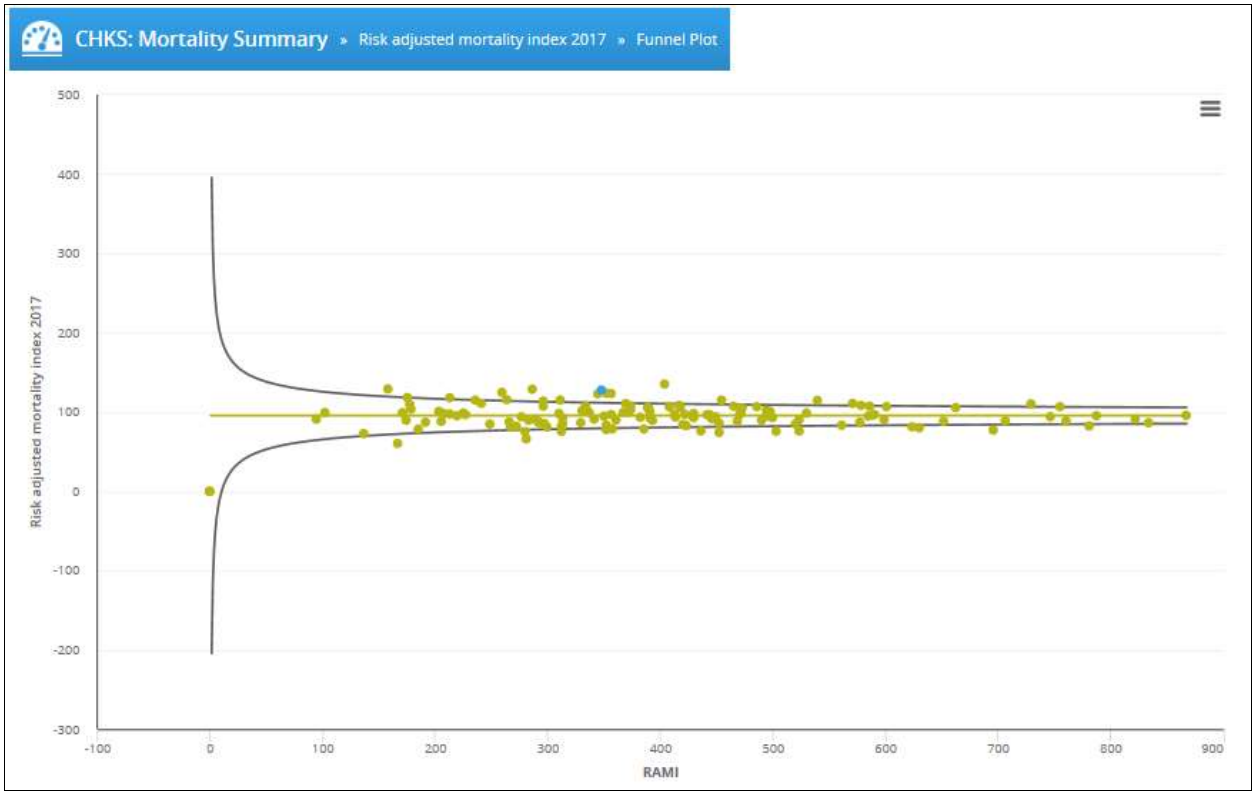
The Trust value for weekend mortality in the period January 2017 to December 2017 is 127.71 (Figure 1), outside statistical confidence limits (Figure 2) and above the Peer value of 95.55. There were 444 deaths when 348 were expected, calculating a total of 104 excess deaths.

Figure 1

CHKS: Mortality Summary » Risk adjusted mortality index 2017 » Overview

Description	Site Numerator	Site Denominator	Jan 17 - Dec 17	Jan 16 - Dec 16	Change	25th Percentile	Peer Value	75th Percentile	Performance	Alert
Risk adjusted mortality index 2017	444	348	127.71	132.46	-3.589%	87.02	95.55	105.41		
Weekend admission/attendance	444	348	127.71	132.46	-3.589%	87.02	95.55	105.41		
6 - Saturday	220	179	122.88	135.87	-9.561%	84.34	93.17	100.63		
7 - Sunday	224	169	132.83	128.65	3.247%	88.56	98.12	107.06		

Figure 2



City site

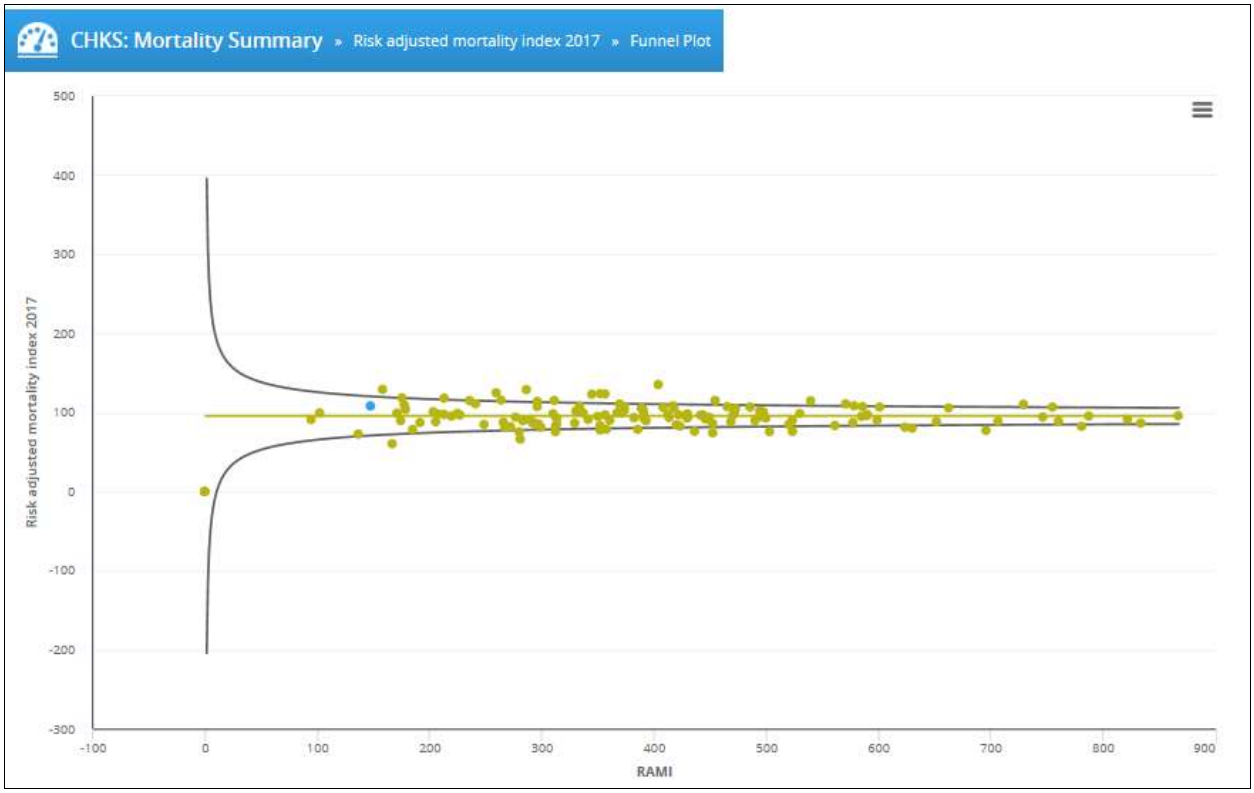
The City site value for weekend mortality in the period January 2017 to December 2017 is 108.21 (**Figure 3**), within statistical confidence limits (**Figure 4**) but above the Peer value of 95.55. There were 159 deaths when 147 were expected, calculating a total of 12 excess deaths.

Figure 3

CHKS: Mortality Summary » Risk adjusted mortality index 2017 » Overview

Description	Site Numerator	Site Denominator	Jan 17 - Dec 17	Jan 16 - Dec 16	Change	25th Percentile	Peer Value	75th Percentile	Performance	Alert
Risk adjusted mortality index 2017	159	147	108.21	139.64	-22.508%	87.02	95.55	105.41		
Weekend admission/attendance	159	147	108.21	139.64	-22.508%	87.02	95.55	105.41		
6 - Saturday	78	75	104.35	135.67	-23.090%	84.34	93.17	100.63		
7 - Sunday	81	72	112.22	144.15	-22.153%	88.56	98.12	107.06		

Figure 4

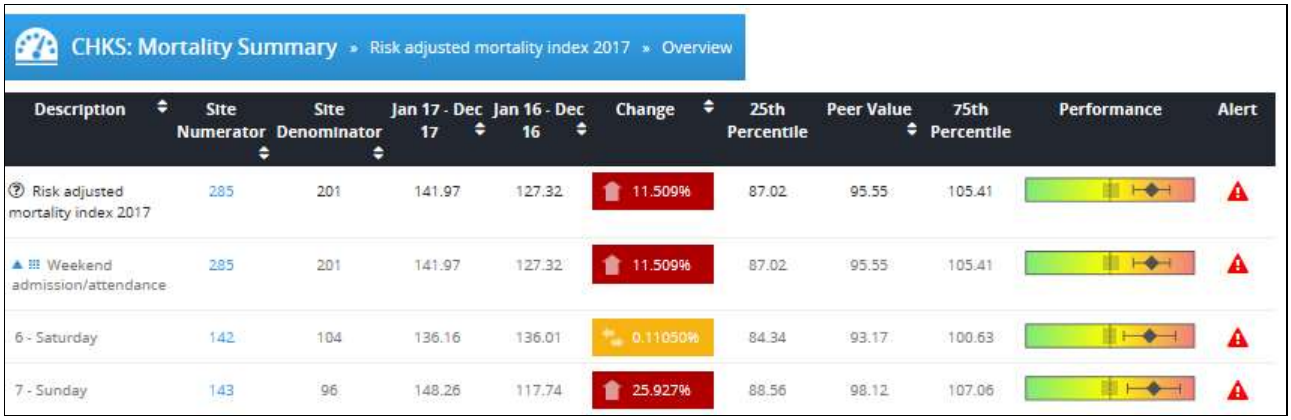


Sandwell site

(Note: The values included in the Sandwell site includes deaths at both Rowley Regis Hospital and Leasowes Intermediate Care Centre)

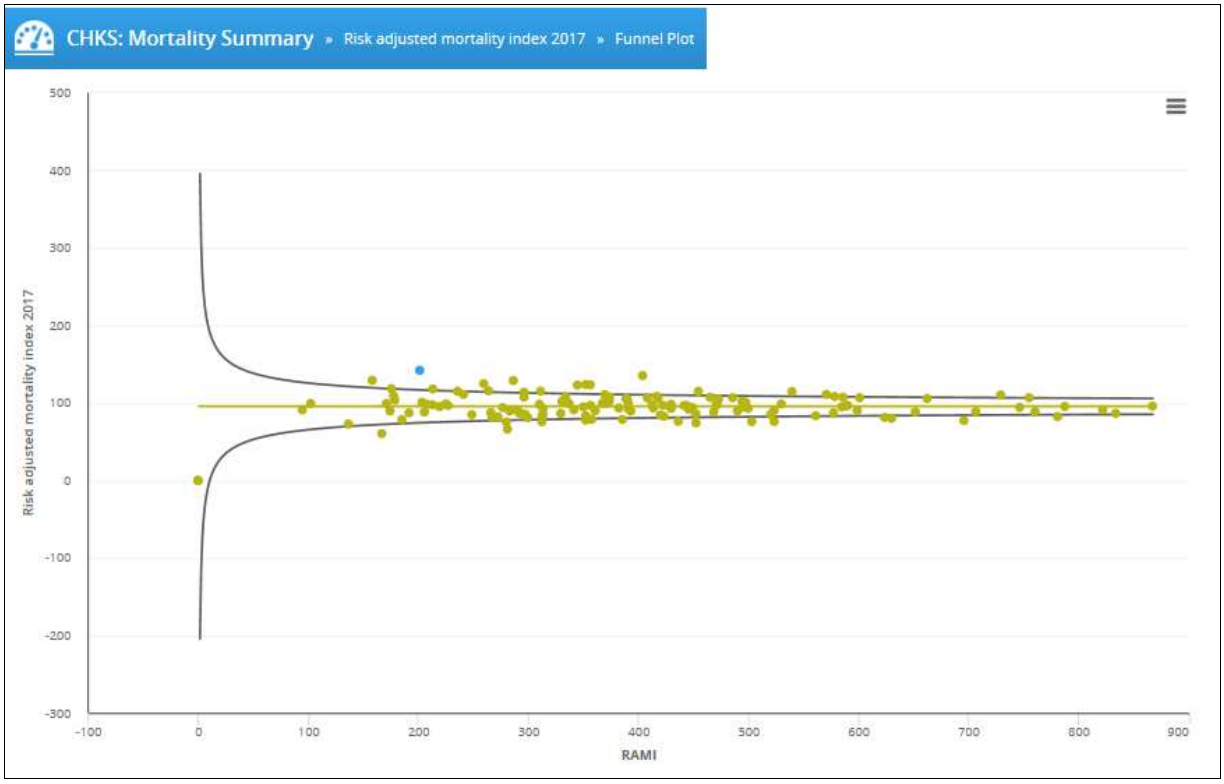
The Sandwell site value for weekend mortality in the period January 2017 to December 2017 is 141.97 (**Figure 5**), outside statistical confidence limits (**Figure 6**) and above the Peer value of 95.55. There were 285 deaths when 201 was expected, calculating a total of 84 excess deaths.

Figure 5



Description	Site Numerator	Site Denominator	Jan 17 - Dec 17	Jan 16 - Dec 16	Change	25th Percentile	Peer Value	75th Percentile	Performance	Alert
Risk adjusted mortality index 2017	285	201	141.97	127.32	11.509%	87.02	95.55	105.41		
Weekend admission/attendance	285	201	141.97	127.32	11.509%	87.02	95.55	105.41		
6 - Saturday	142	104	136.16	136.01	0.11050%	84.34	93.17	100.63		
7 - Sunday	143	96	148.26	117.74	25.927%	88.56	98.12	107.06		

Figure 6



Weekday Mortality

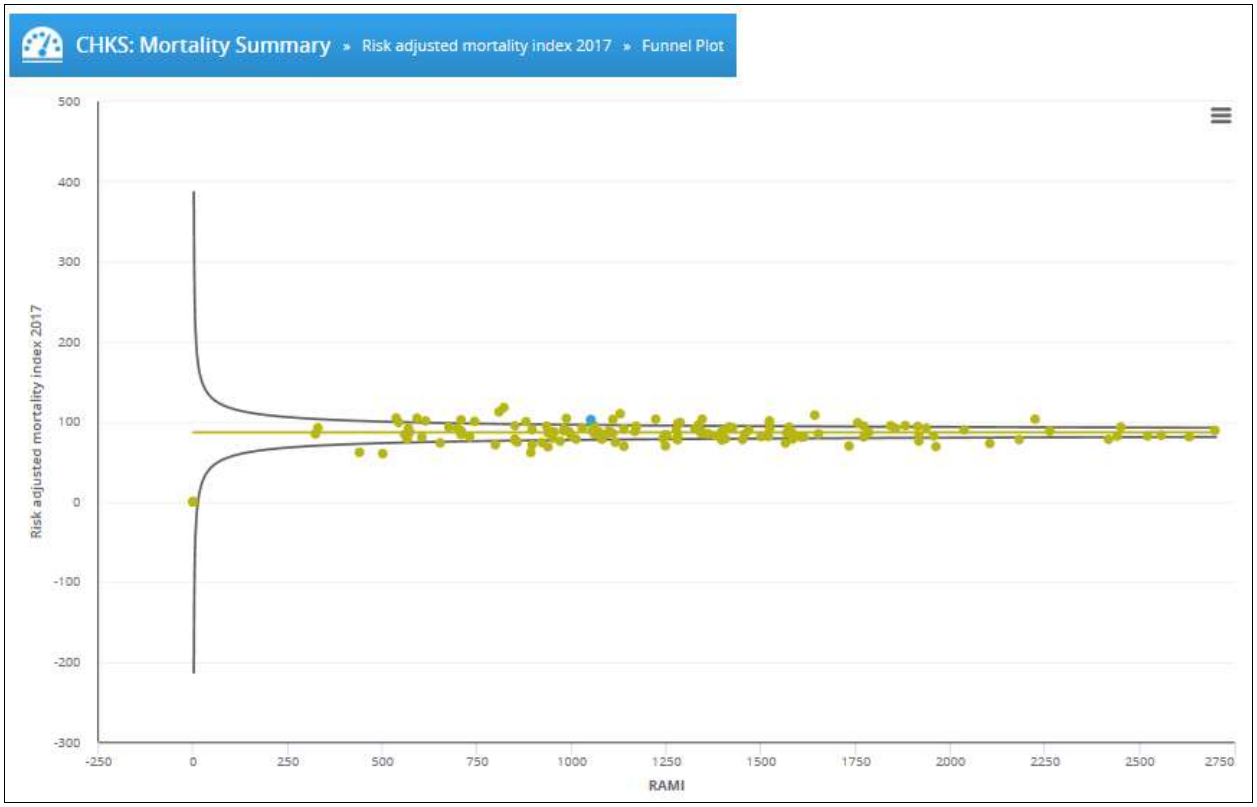
The Trust value for weekday mortality in the period January 2017 to December 2017 is 102.78 (**Figure 7**), marginally within statistical confidence limits (**Figure 8**), however above the Peer value of 86.77. There were 1081 deaths when 1052 were expected, calculating a total of 29 excess deaths.

Figure 7

CHKS: Mortality Summary » Risk adjusted mortality index 2017 » Overview

Description	Site Numerator	Site Denominator	Jan 17 - Dec 17	Jan 16 - Dec 16	Change	25th Percentile	Peer Value	75th Percentile	Performance	Alert
Risk adjusted mortality index 2017	1081	1052	102.78	114.31	-10.087%	79.70	86.77	93.44		
Weekday admission/attendance	1081	1052	102.78	114.31	-10.087%	79.70	86.77	93.44		
1 - Monday	231	208	111.02	108.99	1.8667%	81.80	89.45	97.45		
2 - Tuesday	213	211	100.83	117.62	-14.276%	79.91	86.88	95		
3 - Wednesday	196	211	92.91	113.96	-18.479%	78.30	86.07	93.38		
4 - Thursday	214	219	97.62	112.86	-13.506%	79.39	85.64	94.14		
5 - Friday	227	202	112.21	117.76	-4.715%	77.93	85.95	93.33		

Figure 8



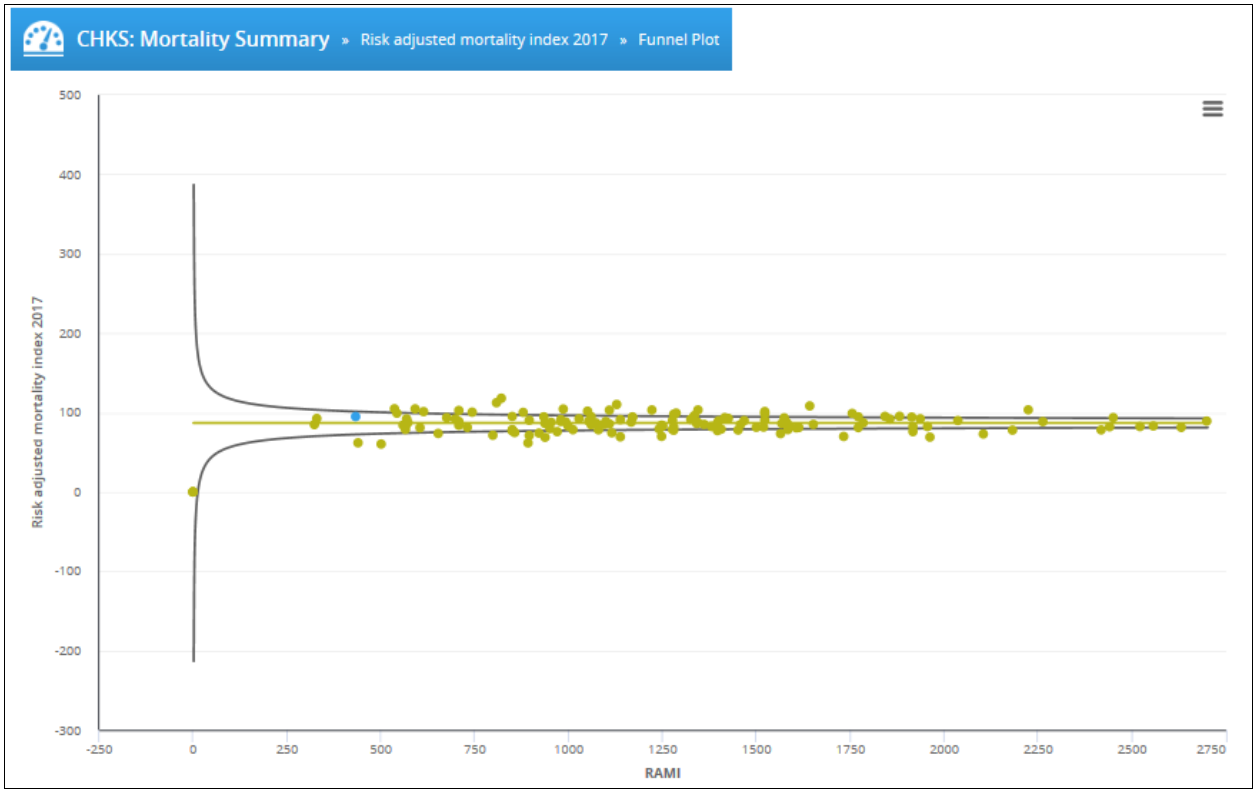
City site

The City site value for weekday mortality in the period January 2017 to December 2017 is 94.85 (**Figure 9**), within statistical confidence limits (**Figure 10**) but above the Peer value of 86.77. There were 411 deaths when 433 were expected, calculating a total of 22 excess deaths.

Figure 9

Description	Site Numerator	Site Denominator	Jan 17 - Dec 17	Jan 16 - Dec 16	Change	25th Percentile	Peer Value	75th Percentile	Performance	Alert
Risk adjusted mortality index 2017	411	433	94.85	106.86	-11.238%	79.70	86.77	93.44		
Weekday admission/attendance	411	433	94.85	106.86	-11.238%	79.70	86.77	93.44		

Figure 10



Sandwell site

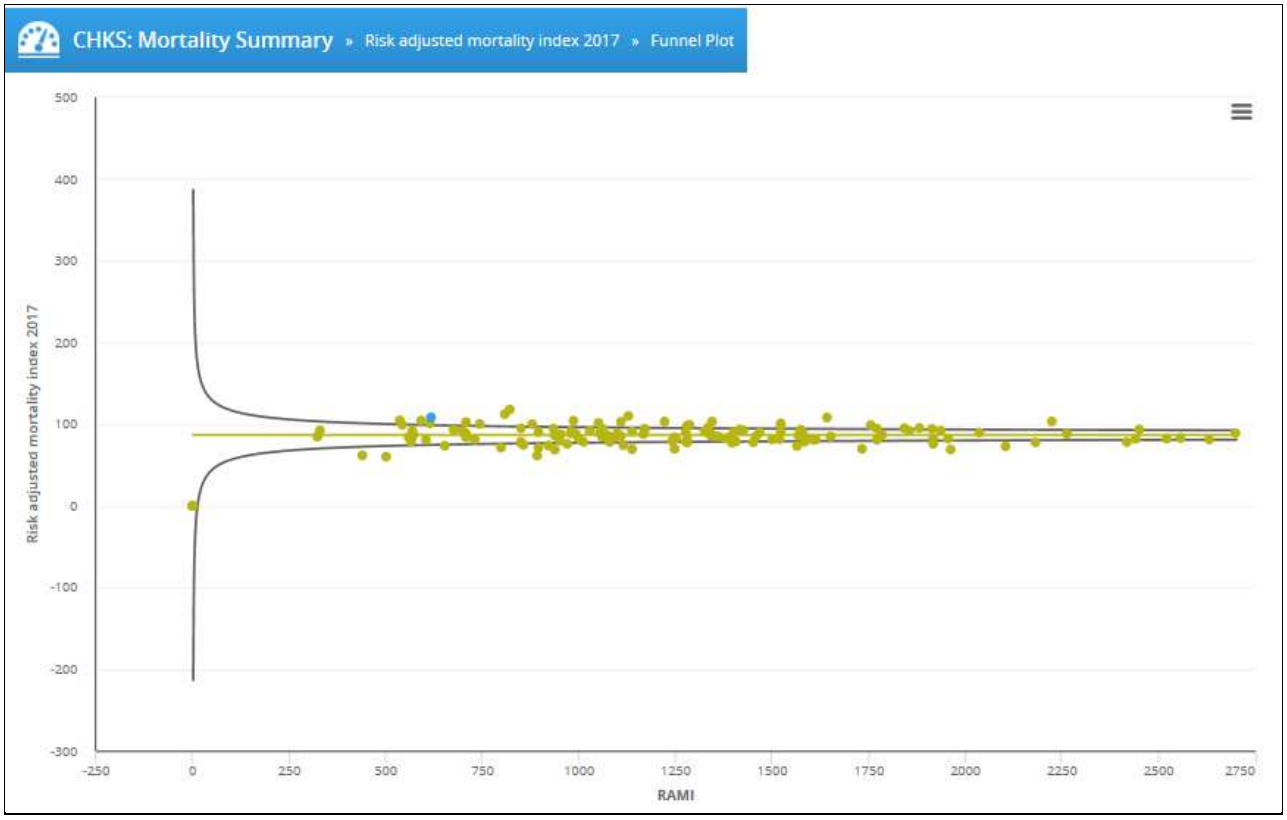
(Note: The values included in the Sandwell site includes deaths at both Rowley Regis Hospital and Leasowes Intermediate Care Centre)

The Sandwell site value for weekday mortality in the period January 2017 to December 2017 is 108.33 (**Figure 11**), outside statistical confidence limits (**Figure 12**) and above the Peer value of 86.77. There were 670 deaths when 619 was expected, calculating a total of 51 excess deaths.

Figure 11

Description	Site Numerator	Site Denominator	Jan 17 - Dec 17	Jan 16 - Dec 16	Change	25th Percentile	Peer Value	75th Percentile	Performance	Alert
Risk adjusted mortality index 2017	670	619	108.33	119.97	-9.709%	79.70	86.77	93.44		
Weekday admission/attendance	670	619	108.33	119.97	-9.709%	79.70	86.77	93.44		

Figure 12



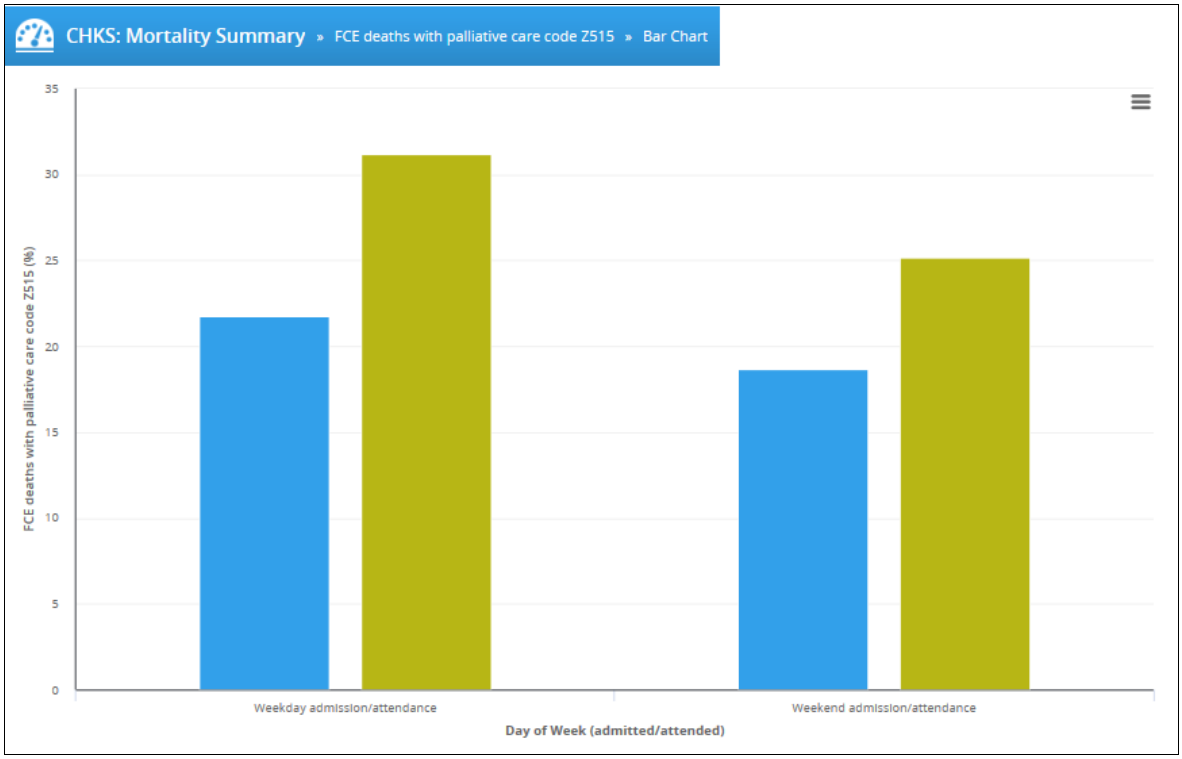
Findings

Palliative care coding trend

There has been a reduction in the percentage of patients coded as receiving palliative care who have died in the Trust over the last year. This reflects the drive for patients to receive this specialist care in their Preferred Place of Care other than in hospital. This has coincided with an increase in mortality ratios. There is however, currently joint working with the Head of Information and the Clinical Lead for Palliative to develop robust and accurate capture of Palliative care episodes' coding.

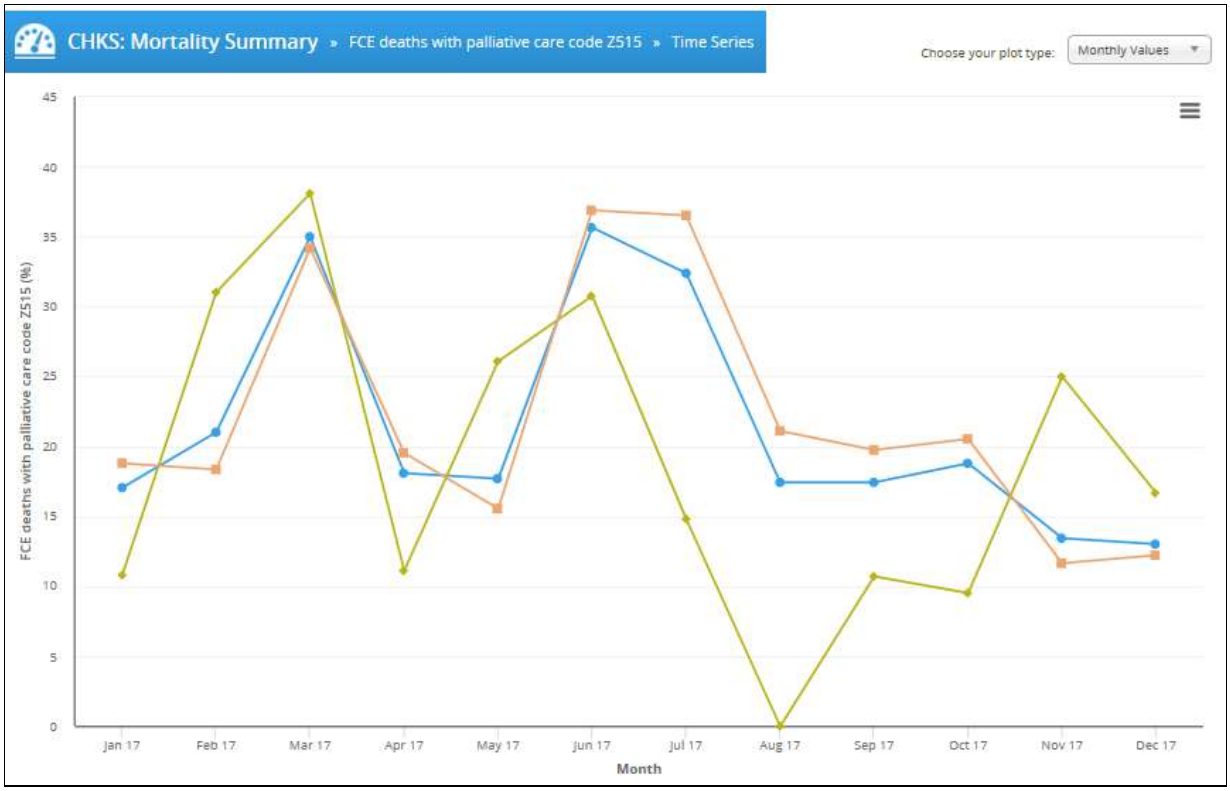
This trend is reflected in the data for the Trust which is shown in **Graph 5** below. The level of coding for the Trust (Blue Bar) is shown to be well below the level reported by peers (Green Bar).

Graph 5



Palliative care coding at the weekend is proportionally lower than in the week , as shown in **Graph 6-** (Green line- Weekend; Orange line- Weekday; Blue line- Site).

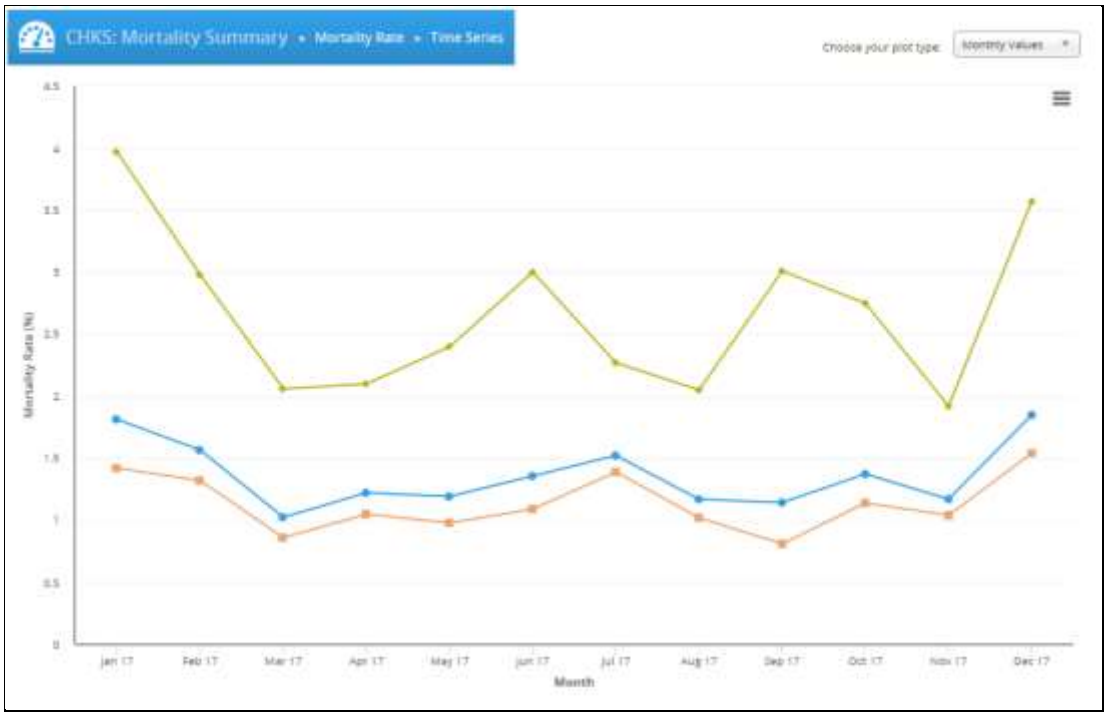
Graph 6 - Palliative care coding (Z515) for the Trust for the 12 month cumulative period ending in December 2017 for Weekend and Weekday admissions



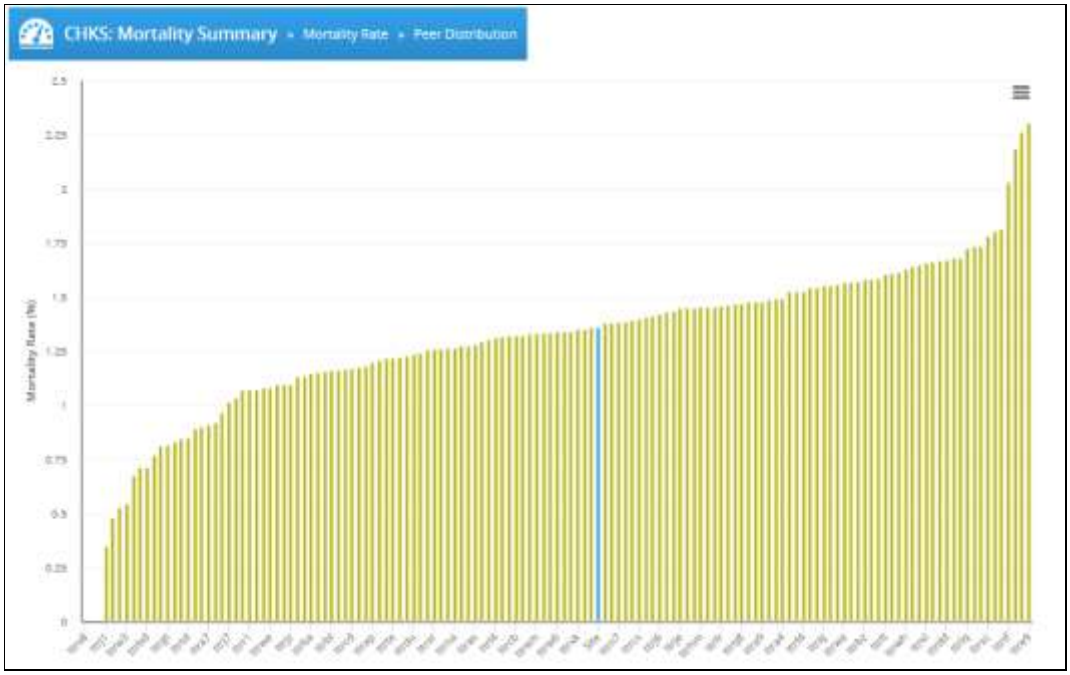
Crude mortality rate

Crude mortality rate amongst weekend admission has seen an upward trend (**Graph7**), but the Trusts position is in the mid quartile when shown in relation to peers (**Graph 8**), (Green line- Weekend; Orange line- Weekday; Blue line- Site).

Graph 7 - Crude mortality rate for Weekend and Weekday admissions in 2017



Graph 8 – Crude mortality rate for Weekend and Weekday admissions in 2017 in relation to Peers

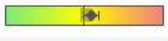


Mortality Dashboards

Weekend Admissions 2017

Description	Site Numerator	Site Denominator	Jan 17 - Dec 17	Jan 16 - Dec 16	Change	25th Percentile	Peer Value	75th Percentile	Performance	Alert
SHMI +	443	357	124.08	111.23	11.551%	97.47	104.31	111.18		Amber
Mortality Rate	444	16594	2.6757%	2.3652%	13.128%	1.9760%	2.2364%	2.7797%		-
Rate of Deaths in hospital within 30 days of elective surgery	0	1020	0%	0%	-%	0.06154%	0.05192%	0.16978%		-
Rate of Deaths in hospital within 30 days of Non elective surgery	30	1940	1.5464%	1.4844%	4.175%	1.0981%	1.5902%	1.9380%		-
% Deaths in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74	8	121	6.612%	7.634%	-13.389%	2.6316%	3.631%	5.333%		Amber
Rates of deaths in hospital within 30 days of emergency admission with a stroke	22	139	15.827%	4.202%	276.69%	11.111%	13.439%	16.058%		-
% Deaths in hospital within 30 days of emergency admission with a hip fracture (age 65 and over)	8	78	10.256%	6.579%	55.90%	3.636%	5.267%	6.796%		Amber
FCE deaths with palliative care code Z515	55	295	18.644%	11.397%	63.59%	17.280%	25.184%	30.155%		-
Sign and Symptoms as Primary Diagnosis (Episode 2)	333	2519	13.220%	13.465%	-1.8218%	8.244%	10.663%	12.244%		Amber
% Uncoded FCEs (Blank Primary Diagnosis)	0	20180	0%	0.014589%	-100%	0.08505%	0.7783%	0.4105%		-
Risk adjusted mortality index 2017	444	348	127.71	132.46	-3.589%	87.02	95.55	105.41		Red

Weekday Admissions 2017

Description	Site Numerator	Site Denominator	Included Spells	Jan 17 - Dec 17	Jan 16 - Dec 16	Change	25th Percentile	Peer Value	75th Percentile	Performance
SHMI +	1129	1082	38678	104.36	101.83	2.4784%	91.40	95.68	102.86	
Mortality Rate	1081	95255	-	1.1348%	1.1612%	-2.2657%	1.0110%	1.0820%	1.3334%	
Rate of Deaths in hospital within 30 days of elective surgery	4	22518	-	0.017764%	0.004310%	312.19%	0.017274%	0.03166%	0.038309%	
Rate of Deaths in hospital within 30 days of Non elective surgery	66	6201	-	1.0643%	1.2184%	-12.641%	1.0815%	1.3534%	1.5881%	
% Deaths in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74	11	353	-	3.1161%	5.678%	-45.12%	1.8519%	3.1104%	3.960%	
Rates of deaths in hospital within 30 days of emergency admission with a stroke	60	399	-	15.038%	13.144%	14.404%	10.651%	12.202%	14.634%	
% Deaths in hospital within 30 days of emergency admission with a hip fracture (age 65 and over)	13	209	-	6.220%	6.375%	-2.4222%	4.046%	5.003%	6.051%	
FCE deaths with palliative care code Z515	270	1241	-	21.757%	19.715%	10.356%	22.395%	31.192%	39.67%	
Sign and Symptoms as Primary Diagnosis (Episode 2)	2498	17528	-	14.251%	14.252%	-0.0031291%	7.943%	10.095%	11.278%	
% Uncoded FCEs (Blank Primary Diagnosis)	10	123535	-	0.008095%	0.03165%	-74.42%	0.06663%	0.6810%	0.3952%	
Risk adjusted mortality index 2017	1081	1052	96212	102.78	114.31	-10.087%	79.70	86.77	93.44	

Discussion from Mortality Dashboards

Crude mortality

The crude mortality rate for weekend admissions has increased slightly in comparison to 2016 and is above the peer value.

Crude mortality rates for weekday admissions have decreased slightly in 2017, but remain slightly above the peer value.

Mortality rates amongst specific Diagnoses Groups

In 2017 amongst weekend admissions deaths rates for patients admitted with a Stroke or Fractured Neck of Femur have shown a significant increase in comparison to 2016. This increase is also above the peer value. Death rates in patients with a Myocardial Infarction (MI), however has shown a decrease from 2016, although remaining above the peer value. This change can be attributed to the commissioning of a single site interventional Cardiology service. This is also consistent with the findings of the MINAP Annual Report 2017.

For weekday admissions there has been an increase in the death rate amongst patients admitted with Stroke, but a decrease in rate for patients admitted with a Fractured Neck of Femur or MI. All three diagnoses' categories however remain above the peer average.

Patient Characteristics

1) **Sex**

There is a marginal difference between both Male and Female admissions over both the Weekend and Weekdays, (**Table 1**). Note that there were the same number of neonatal deaths at Day 0, where the gender is undetermined.

Table 1

Day of Week Admitted	Male	Female	Other	Total
Weekend	218 (14%)	224 (15%)	2 (0.13%)	444
Weekday	543 (36%)	536 (35%)	2 (0.13%)	1081
Total (%)	761 (49.9%)	760 (49.8%)	4 (0.26%)	1525

2) **Age**

The age ranges were 0- 104 years old for Weekend admissions and 0-107 years old for Weekday admissions. The mean age for both Weekend and Weekday admissions were 75 years, (**Table 2**).

Table 2

Day of Week Admitted	Age Range	Mean
Weekend	0-104	75
Weekday	0-107	75

3) **Site**

63% of the total admissions for the Trust occurred at the Sandwell site, and 37% of admissions at the City site. Both Weekend admissions (19%) and Weekday admissions (44%) were higher at the Sandwell site.

Table 3

Day of Week Admitted	City Site	Sandwell Site	Total (%)
Weekend	159 (10%)	285 (19%)	444 (29%)
Weekday	411 (27%)	670 (44%)	1081 (71%)
Total (%)	570 (37%)	955 (63%)	1525

RAMI and CCS Diagnoses Groups

Table 7 – Top 3 CCS Diagnoses' Groups where the observed number of deaths most exceeds those expected for Weekend admissions for the 12 month cumulative period ending in December 2017

No.	Diagnostic Group (CCS)	Number of Spells	Expected number of deaths	Number of deaths	RAMI	Obs. - Exp.
1.	122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	522	74	84	113.29	10
2.	226- Fracture of Neck of Femur (Hip)	93	6	12	199.85	6
3.	109- Acute Cerebrovascular Disease	154	19.6	24	122.35	4.4

Table 8 – Top 3 CCS Diagnoses' Groups where the observed number of deaths most exceeds those expected for Weekday admissions for the 12 month cumulative period ending in December 2017

No.	Diagnostic Group (CCS)	Number of Spells	Expected number of deaths	Number of deaths	RAMI	Obs. - Exp.
1.	122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	1388	192	216	112.74	24
2.	109- Acute Cerebrovascular Disease	461	63	75	118.88	12
3.	129- Aspiration Pneumonitis; food/vomitus	129	26.7	36	135.08	9.3

122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)

Pneumonia remains the top diagnostic category for both Weekend and Weekday admissions, compared to the last analysis conducted in March 2018. There is currently a CQC Outlier Alert investigation into this diagnostic basket and a report will be submitted to the Care Quality Commission in June 2018. This is also being closely monitored the Trust Monthly Mortality Committee meeting and through national and local audit.

109 - Acute Cerebrovascular Disease

The data shows that the crude mortality rate has increased for both Weekend and Weekday admissions. The processes of care are closely monitored through participation in the Sentinel Stroke National Audit Project (SNNAP). There is also monthly scrutiny at the Stroke Action Group. As a result, assurance can be provided that any adverse trends will be detected and acted upon.

226- Fracture of Neck of Femur (Hip)

The data indicates that the crude mortality rate for this diagnosis basket has increased for Weekend admissions. Deaths related to Fractured Neck of Femur are being scrutinised at the Trust Monthly Mortality Committee, submission of data to the National Hip Fracture Database and a Corporate workstream is in place to monitor compliance with the Fractured Neck of Femur Pathway. Assurance of patient experience and outcomes is monitored through submission to the PROMS database, administered by NHS Digital.

129- Aspiration Pneumonitis; food/vomitus

The data indicates that the crude mortality rate for this diagnosis basket has increased for Weekday admissions. Deaths related to Aspiration Pneumonia are being scrutinised at the Trust Monthly Mortality Committee. Deaths of patients with Learning Disabilities are notified to the LeDeR programme. Aspiration Pneumonia in this group of patients has been highlighted as a contributing cause of premature mortality.

Conclusions

- There has recently been a rising trend in the values for mortality indicators for the Trust (RAMI) when examining a rolling 12 month cumulative period.
- The weekend RAMI values have also shown to be in excess of weekday values for the last 12 consecutive months cumulative data periods.
- The latest weekend RAMI value shows the Trust to be in the upper quartile in relation to peers.
- RAMI values are influenced by the levels of palliative care coding which have been decreasing for the Trust and which have been significantly lower than those reported by peers. This reflects a drive for patients to receive this specialist care in a place of their choice other than in hospital. Accuracy and consistency of coding practice is being reviewed by the Head of Information and Palliative Care lead.
- The data indicated a rise in the crude mortality rate. This is also reflected in peer values, albeit the percentage rate for the Trust for weekend admissions is above the peer rate.
- A review of the weekend and weekday mortality values indicates there is a slight variation between weekend and weekday admissions and perhaps a review of access to seven day services will provide further insight into this difference..
- A review of the top three CCS diagnoses groups where there has been the highest number of observed deaths for Weekend and Weekday admissions to the Trust, appear to be statistically similar except for the Fractured Neck of Femur deaths which show an increase on the Weekend. The Aspiration Pneumonitis diagnosis group has shown an increase in rates for Weekday admissions.
- The data indicated a rise in the crude mortality rate, particularly over the winter period, with a peaks in July 2017 for Weekday admissions and a consistent rise for Weekend admissions. This is also reflected in peer values, albeit the percentage rate for the Trust for weekend admissions is above the peer rate.
- A review of the Weekend and Weekday mortality dashboards indicate significant variation. Weekend admissions of patients admitted with a Stroke or Fractured Neck of Femur has increased in comparison to 2016, and is also above the Peer average. There are some changes in the mortality rates for patients admitted with a Stroke during the Week , with an increasing trend , which is above the peer average.
- The Sandwell site remains a statistical outlier for both Weekend and Weekday admissions.

Paper ref:	TB (06/18) 016

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**	7 June 2018

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

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.

The Board is directed to particularly focus on the robustness of plans to mitigate the IT infrastructure risks given the recent problems which disrupted clinical and operational delivery.

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.	consider, challenge and confirm the correct strategy has been adopted to keep potential significant risks under prudent control;
b.	**NOTE** the revision to **Risk 566**
c.	**NOTE** the updates to **Risk 3020, 3021 & 325**
d.	**NOTE** that **Risk 228** has been archived and replaced with **Risks 3109 & 3110.**
e.	**NOTE** the planned revision to two risks **1603 &1738** and,
f.	Advice on any further risk treatment required

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

Trust Risk Register		Risk Number(s): 566, 3020, 3021, 325, 228, 1603 & 1738					
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: 7 June 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 May 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 May Trust Board, three areas below have been discussed at May RMC and subsequently CLE;

2.3.1 **Risk 566 (Senior ED Medical staffing**) - **Appendix B** - This risk has been revised in light of changes that have occurred since the risk was first placed on the risk register and an updated risk assessment is being presented to the Trust Board to note the changes.

2.3.2 **Risk 3020 & 3021 (Midland Met) - Appendix C i & ii** – Both of these risks have been reviewed and updated by the Chief Executive Officer, to reflect the current situation and to provide an update on the progress against the further actions planned to reduce the probability and the severity of the risks materialising.

2.3.3 **Risk 325 (Cyber security) –** At the request of CLE, this risk is being re-visited by the Chief Executive Officer who will provide the Trust Board with a verbal update on the Trust's position against Cyber Security and the mitigating actions which are in place.

Risk No. 566	Risk No. 3020 & Risk 3021	Risk No. 325
There is a risk that the Trust will not be able to provide a viable rota at Consultant and Middle Grade level in ED, due to the reduction in the existing medical workforce and the difficulties in being able to recruit. This will result in delays in senior medical assessments, decision making regarding treatment and delays in referrals to specialist treatment pathways which may lead to compromising patient safety; affect patient outcomes and adverse publicity.	***3020*** *- 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.* ***3021*** *- 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.*	*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.*

2.3.4 **Risk 228 (IT Infrastructure) – Appendix E** – Again, at the request of CLE, this risk has been reassessed by the Chief Operating Officer & Deputy Director Informatics. Upon review it has been agreed that it is appropriate to archive this risk and to create two new risks, mentioned below, which are more applicable to the Trust's current IT Infrastructure.

2.3.5 **Risk 3109 (IT Infrastructure) – Appendix F** - Following archive of Risk 228, this risk has been included to reflect the Trust's current position on the IT Infrastructure and the mitigating actions which are in place to reduce the probability and the severity of the risk materialising.

2.3.6 **Risk 3110 (Technical Infrastructure) – Appendix G** - Following and archive of Risk 228, this risk has been included to reflect the Trust's current position on the Technical Infrastructure the mitigating actions which are in place to reduce the probability and the severity of the risk materialising.

Risk No. 228 (Archived)	Risk. 3109 (New)	Risk. 3110 (New)
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.	There is a risk that IT infrastructure service provision is inadequate Trust-wide, caused by the insufficient 24/7 workforce resilience, skills and changed governance processes, which results in planned and unplanned changes being made to the IT infrastructure. This can lead to loss of IT service provision to run clinical and non-	There is a risk that the technical infrastructure, Trust-wide, is neither robust nor subject to compliance against formal technical architecture and is therefore suboptimal. Combined with areas of legacy technology currently without a full plan to update or replace, there is an impact of loss of IT provision to run clinical and non-clinical services

Risk No. 228 (Archived)	Risk. 3109 (New)	Risk. 3110 (New)
	clinical services safely and effectively.	safely and effectively.

2.3.7 **Risk 1603 ((Trust's financial performance) –** This risk is currently being revised to include further mitigating actions for the 2018/19. The scoring of the risk is also being reviewed and will be updated to reflect the current position. The Director of Finance is reviewing this risk and the revised risk assessment will be presented at the June RMC and subsequently CLE and July Board.

2.3.8 **Risk 1738 (Ophthalmology)** – This risk has also been discussed at, and it has been agreed that there are 3 separate issues associated with this risk. The Group Director of Operations for Surgery is reviewing this risk and the revised risk assessment will be presented at the June RMC and subsequently CLE and July Board.

3. Recommendations

Trust Board is recommended to:

a) consider, challenge and confirm the correct strategy has been adopted to keep potential significant risks under prudent control;
b) **NOTE** the revision to **Risk 566**
c) **NOTE** the updates to **Risk 3020, 3021 & 325**
d) **NOTE** that **Risk 228** has been archived and replaced with **Risks 3109 & 3110.**
e) **NOTE** the planned revision to two risks **1603 &1738** and,
f) Advice on any further risk treatment required.

Refeth Mirza
Head of Risk Management

30 May 2018

TRUST RISK REGISTER - June 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. **(07/06/2018)** **3**-Embed Informatics implementation and change activities in Group PMOs and production planning **(07/06/2018)** **4**-Agree and implement super user and business change approaches and review and re-establish project governance **COMPLETED**	1x2=2	29/06/2018	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***	29/06/2018	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 - (29/06**/2018)** Contingency bed plan is agreed in October for winter - L5 to be opened in November.**(31/12/2017) - COMPLETED**	1x4=4	29/06/2018	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**-Complete rollout of Windows 7. **(31/05/2018)** **3**-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)** **4**-Achieve Cyber Security Essentials **(31/03/2018) - COMPLETED** **5**-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** **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)
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 majority of cases that present at BMEC ED	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)

TRUST RISK REGISTER - June 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
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***	30/06/2018	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. **(29/06/2018)** **4 -** revise weekly LOS and bed closure trajectory exceptional weather condition impact on bed base **(29/06/2018)**	4x3=12	30/06/2018	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***	29/06/2018	3x3=9	**Lack of assurance on 18 week process.** **1**-Data quality process to be audited - Monthly audits **(29/06/2018)** **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. Rollout for Clinical staff will be between June - August 18. **(30/08/2018)** **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	30/08/2018	Live (With Actions)
1603 22/01?2016	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)
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***	31/05/2018	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. (**31/05/2018)**	1x4=4	31/05/2018	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***	31/05/2018	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. **(31/05/2018)**	3x4=12	31/05/2018	Monitor (Tolerate)

TRUST RISK REGISTER - June 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
566 17/10/2017	Medicine And Emergency Care	Accident & Emergency (S)	There is a risk that the Trust will not be able to provide a viable rota at Consultant and Middle Grade level in ED, due to the reduction in the existing medical workforce and the difficulties in being able to recruit. This will result in delays in senior medical assessments, decision making regarding treatment and delays in referrals to specialist treatment pathways which may lead to	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	4x5=20	**Vacancies in senior medical staff in ED.** **1.** Recruitment ongoing with marketing of new hospital **(31/07/2018)** **2.** CESR middle grade training programme to be implemented as a "grow your own" workforce strategy **(31/07/2018)** **3.** Development of an overarching recruitment strategy for all ED clinical staff **(31/07/2018)**	3x4=12	**31/07/2018**	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***	08/06/2018/ 2018	4x4=16	**1.** complete clinical analysis of options and makes choices by the end of July on our preferred option (working group and CLE undertaken detailed work. now need to finalise locations and sequence and confirm nature of retained ED function at SGH) - **(29/06/2018)** **2.** Detailed costing incorporated into STP and other plans to meet costs to be incurred in executing any City based option (assuming zero cost to Homes England delay, price both IT infrastructure and physical estate costs from bringing wards back into use) - **(08/06/2018)** **3.** Complete analysis of interim site reconfiguration options if Midland Met delayed to 2022 - **(15/06/2018)** **4.** Establish agreed approach to land release with Homes England - **(16/04/2018) - COMPLETED** **5.** Price new estate and IT investments required for interim reconfiguration - (**16/04/2018) - COMPLETED**	4x3=12	29/06/2018	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***	15/06/2018	4x4=16	**1.** Working alongside HMG ensure we understand who has to do what as THC wraps up- (16/06/2018) **2.** local assessment of cost of delay to be completed and then use upcoming EWC to finalise due diligence on that work - (14/06/2018) **3.** Complete option appraisal & assist Board and DHSC and HMG in choosing between options A, B and C - **13/04/2018 - COMPLETED** **4.** Finish analysis of contract remedies available under standard PF2 contract - **13/04/2018 - COMPLETED**	4x3=12	16/06/2018	Live (With Actions)

TRUST RISK REGISTER - June 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
3109 01/06/2018	Medical Director Office	Informatics(C)	There is a risk that IT infrastructure service provision is inadequate Trust-wide, caused by the insufficient 24/7 workforce resilience, skills and change governance processes, which results in planned and unplanned changes being made to the IT infrastructure leading to loss of IT service provision to run clinical and non clinical services safely and effectively.	4x5=20	24/7 on call IT support in place but with variable skills and competence change control processes documented but compliance variable	Mark Reynolds ***Rachel Barlow***	08/06/2018	4x5=20	**Inadequate IT Infrasructure service provision trustwide.** **1.** Assess skills gaps and design workforce plan to ensure sustainable high quality service internally or with 3rd party support **(31/07/2018)** **2.** Implement operational / executive led change control process **(29/06/2018)** **3.** Design 24/7 iT support proposal to mitigate immediate support risk **(15/06/2018)** **4.** Secure external professional expert capacity to mitigate immediate risk **(14/06/2018)** **5. All staff meeting to engage and communicate new ways of working (08/06/2018)** **6.** Implement full change freeze with only changes to be authorized though new change control process **(04/06/2018)**	2x3= 6	31/07/2018	Live (With Actions)
3110 01/06/2018	Medical Director Office	Informatics(C)	There is a risk that the technical infrastructure, Trust-wide is not robust nor subject to compliance against formal technical architecture and is therefore suboptimal. Combined with areas of legacy technology currently without a full plan to update or replace, there is an impact of loss of IT provision to run clinical and non clinical services safely and effectively	4x5=20	IT infrastructure plan is documented and reports to CLE through the Digital Committee (but has slippage on delivery dates)	Mark Reynolds ***Rachel Barlow***	01/07/2018	4x5=20	**Inadequate technical infrastructure trustwide.** **1.** Map infrastructure components to organizational services and ensure comprehensive monitoring and early warning alert process for critical IT infrastructure and impact at clinical / non clinical service level **(31/07/2018)** **2.** With industry expertise advise fully document technical architecture **(31/07/2018)** **3.** Ensure change process is documented and auditable **(31/07/2018)** **4.** Document a robust IT infrastructure plan with well defined scope, delivery milestones and measurable outcomes signed off via digital committee **(31/07/2018)** **5.** Implement clinical group and directorate impact reporting **(29/06/2018)**	3x3=9	31/07/2018	Live (With Actions)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Assessment

Risk Number: 566		**Status:**	*Live (With Actions)*
Site:	Sandwell General Hospital	**Department:**	Accident & Emergency (S)
Clin. Grp / Corp Dir:	Medicine & Emergency Care	**Owner:**	Michelle Harris
Directorate:	Emergency And Acute Medicine	**Assessor:**	Michelle Harris
Specialty:	Emergency Medicine	**RR Level:**	Clinical Group/Corporate Direc
Risk monitored by:	Trust Board		

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
There is a risk that the Trust will not be able to provide a viable rota at Consultant and Middle Grade level in ED, due to the reduction in the existing medical workforce and the difficulties in being able to recruit. This will result in delays in senior medical assessments, decision making regarding treatment and delays in referrals to specialist treatment pathways which may lead to compromising patient safety; affect patient outcomes and adverse publicity.	To assess and resolve the risk of reduced medical cover in the ED's through inability to substantively recruit to vacant posts and staff retention, particularly at Middle Grade on the Sandwell Site.	Potential harm to patients due to the deficit in senior medical staff availability to 'manage' the Emergency Departments safely.

Existing Controls:

1	Recruitment campaign through local networks, national adverts, head-hunters and international recruitment expertise.	Staff
2	Robust forward look on rotas are being monitored through leadership team reliance on locums and shifts are filled with locums.	Staff
3	Leadership development and mentorship programme in place to support staff development.	Staff

Actions:

1	Recruitment ongoing with marketing of new hospital. PROGRESS: Being reviewed in light of build delay. Recruitment Partnership with Remedian for Middle Grades - 6 appointments secured and are in training. Date Entered : 31/05/2018 13:32 Entered By : Refeth MIRZA ---------- In progress Date Entered : 29/10/2015 18:36 Entered By : Mariola Smallman	31/07/2018	Open	PREM PREM
2	CESR middle grade training programme to be implemented as a "grow your own" workforce strategy. PROGRESS: Programme designed and funding now agreed Date Entered : 31/05/2018 13:33 Entered By : Refeth MIRZA ---------- Allocated to Dr Wani and Dr Elangbam Date Entered : 22/05/2017 13:34 Entered By : Tajinder Virk-Dhugga	31/07/2018	Open	Elizabeth Miller
3	Development of an overarching recruitment strategy for all ED clinical	31/07/2018	Open	Elizabeth Miller

Risk Assessment

staff.
PROGRESS: New Hospital model agreed but now being reviewed in light of new hospital build delay.

Date Entered : 31/05/2018 13:34
Entered By : Refeth MIRZA

Review Dates:

Last Review Date: 19/01/2018 **Next Review Date:** 18/02/2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Assessment

Risk Number: 3020		**Status:**	*Live (With Actions)*
Site:	Midland Metropolitan Hospital	**Department:**	Midland Metropolitan Project
Clin. Grp / Corp Dir:	Estates & New Hospital Project	**Owner:**	Toby Lewis
Directorate:	Midland Metropolitan Project	**Assessor:**	Kamaljeet Dhami
Specialty:	Management	**RR Level:**	Clinical Group/Corporate Direc
Risk monitored by:	Trust Board		

Initial Risk	Current Risk	Target Risk
Severity (4) x Likehood (4) = 16 Red	Severity (4) x Likehood (4) = 16 Red	Severity (4) x Likehood (3) = 12 Amber

Risk Type: Clinical Care/Treatment **Risk Sub-Type:** Delay

Risk Statement	Scope	Hazard
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.	Future of organization, stability of finances, and sustainability of acute clinical services	Patients, staff, physical environment, service delivery, contract security and retention

Existing Controls:

1	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	Policy/Procedure/System

Actions:

1	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	15/06/2018	Open	Rachel Barlow
2	establish agreed approach to land release with Homes England	16/04/2018	Closed	Alan Kenny
3	non retained estate investment has been grounded in 2018-2019 move	16/04/2018	Closed	Alan Kenny
4	assuming zero cost to Homes England delay, price both IT infrastructure and physical estate costs from bringing wards back into use	08/06/2018	Open	Mark Reynolds
5	working group and CLE undertaken detailed work. now need to finalise locations and sequence and confirm nature of retained ED function at SGH	29/06/2018	Open	David Carruthers

Review Dates:

Last Review Date: / / **Next Review Date:** / /

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Assessment

Risk Number:	**3021**	**Status:**	***Live (With Actions)***
Site:	Midland Metropolitan Hospital	**Department:**	Midland Metropolitan Project
Clin. Grp / Corp Dir:	Estates & New Hospital Project	**Owner:**	Antony Waite
Directorate:	Midland Metropolitan Project	**Assessor:**	Toby Lewis
Specialty:	Management	**RR Level:**	Clinical Group/Corporate Direc
Risk monitored by:	Trust Board		

Initial Risk	Current Risk	Target Risk
Severity (4) x Likehood (5) = 20 Red	Severity (4) x Likehood (4) = 16 Red	Severity (3) x Likehood (4) = 12 Amber

Risk Type: Legal/Regulation Breach **Risk Sub-Type:** Regulation Breach

Risk Statement	Scope	Hazard
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	financial impact on this project, and all other projects which may compete with this for funds	money, workforce, leadership bandwidth

Existing Controls:

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

Actions:

1	assists Board and DHSC and HMG in choosing between options A, B and C	13/04/2018	Closed	Antony Waite
2	finish analysis of contract remedies available under standard PF2 contract	13/04/2018	Closed	Toby Lewis
3	Working alongside HMG ensure we understand who has to do what as THC wraps up	16/06/2018	Open	Alan Kenny
4	local assessment of cost of delay to be completed and then use upcoming EWC to finalise due diligence on that work	14/06/2018	Open	Antony Waite

Review Dates:

Last Review Date: / / **Next Review Date:** / /

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Assessment

Risk Number: 228		**Status:**	*Live (With Actions)*
Site:	City Hospital	**Department:**	Informatics(C)
Clin. Grp / Corp Dir:	Medical Director Office	**Owner:**	Dean Harris
Directorate:	Informatics	**Assessor:**	Steven Lane
Specialty:	IT Infrastructure	**RR Level:**	Directorate
Risk monitored by:	Trust Board		

Initial Risk	Current Risk	Target Risk
Severity (4) x Likehood (3) = 12 Amber	Severity (3) x Likehood (3) = 9 Amber	Severity (1) x Likehood (1) = 1 Green

Risk Type: Informatics **Risk Sub-Type:** IT Hardware - Clinical System Failure / Issue

Risk Statement	Scope	Hazard
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.	Information systems not flexible to support clinical activity redesign- limitations iCM & iPM and ebms- operational rather than clinical tool	Operational performance is hindered by inadequate or failing IT infrastructure, which could result in harm to patient, and failure to deliver against strategic objectives could result in increased financial risk

Existing Controls:

1	Approved Business Case in place for Infrastructure Stabilisation programme (approved by Trust Board June 2015)	Contingency/Emergency Arrangem
2	Specialist technical resources engaged (both direct and via supplier model) to deliver key activities	Policy/Procedure/System
3	Informatics has undergone organisational review and restructure to support delivery of key transformational activities	Policy/Procedure/System
4	Informatics governance structures and delivery mechanisms have been initiated to support of transformational activities	Policy/Procedure/System

Actions:

1	Stabilisation of all aspects of the local IT infrastructure will be completed end March 2017. The replacement of PCs, printers, monitors, etc., and upgrade of the network is conducted in parallel. PROGRESS: PC estate now stable. Further work required for network, storage, compute and wifi. Contractors will join in October to resolve by Xmas. Date Entered : 16/10/2017 08:29 Entered By : Mark Reynolds ---------- 80% of the work was completed by December 2016 Date Entered : 29/09/2017 10:48 Entered By : Laura Mcquilkin ---------- As of end April approximately 3,400 PCs have been replaced or upgraded with 1,600 remaining. Network work has been completed at the Community sites. The next period will focus on: - Infrastructure security hardening - Improvements to performance and resilience of servers - Further work on improving network resilience and configuration. Date Entered : 16/05/2017 17:10 Entered By : Mark Reynolds ----------	31/12/2017	Closed	Dean Harris

Risk Assessment

As of 15th December 2016 approximately 1,800 PCs have been replaced and the network has been upgraded in Sandwell and Rowley plus cabling is complete in City. Works will continue throughout 2017 with the aim of this becoming business as usual from the end of March

Date Entered : 15/12/2016 11:43
Entered By : Mark Reynolds

2	Establish infrastructure plan and track progress	30/12/2017	Closed	Dean Harris
3	Standardise network config to resolve performance issues	30/04/2018	Closed	John Borland
4	Migrate SAN storage and close EVA	30/04/2018	Closed	John Borland
5	Migrate VMs from VMware to Hyper-V	31/03/2018	Closed	John Borland
6	See plan	14/05/2018	Open	John Borland

Review Dates:

Last Review Date: 14/05/2018 **Next Review Date:** 12/08/2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Assessment

Risk Number:	**3109**	**Status:**	***Live (With Actions)***
Site:	Sandwell General Hospital	**Department:**	Informatics (S)
Clin. Grp / Corp Dir:	Corporate Operations	**Owner:**	Mark Reynolds
Directorate:	Informatics	**Assessor:**	Rachel Barlow
Specialty:	IT Infrastructure	**RR Level:**	Clinical Group/Corporate Direc
Risk monitored by:	Risk Management Committee		

Initial Risk	Current Risk	Target Risk
Severity (5) x Likehood (4) = 20 Red	Severity (5) x Likehood (4) = 20 Red	Severity (3) x Likehood (2) = 6 Yellow

Risk Type: Informatics **Risk Sub-Type:** IT Hardware - Clinical System Failure / Issue

Risk Statement	Scope	Hazard
There is a risk that IT infrastructure service provision is inadequate Trust-wide, caused by the insufficient 24/7 workforce resilience, skills and change governance processes, which results in planned and unplanned changes being made to the IT infrastructure leading to loss of IT service provision to run clinical and non clinical services safely and effectively	The scope of the risk includes: - workforce resilience in terms of capacity and skills - inadequate change control processes - lack of reporting of services available and impact at group and directorate level	Hazards include: - the ability to provide full clinical service provision is compromised with inadequate clinical IT system availability - cancellation or delay in clinical care - impact on mandated performance targets - loss of income - reputational damage internally and externally

Existing Controls:

1	24/7 on call IT support in place but with variable skills and competence	Policy/Procedure/System
2	change control processes documented but compliance variable	Policy/Procedure/System

Actions:

1	implement operational / executive led change control process	29/06/2018	Open	Rachel Barlow
2	implement full change freeze with only changes to be authorized though new change control process.	04/06/2018	Open	Toby Lewis
3	all staff meeting to engage and communicate new ways of working	07/06/2018	Open	Toby Lewis
4	secure external professional expert capacity to mitigate immediate risk	14/06/2018	Open	Toby Lewis
5	assess skills gaps and design workforce plan to ensure sustainable high quality service internally or with 3rd party support	31/07/2018	Open	Mark Reynolds
6	No Action recorded for this risk.	01/07/2018	Closed	Mark Reynolds
7	design 24/7 iT support proposal to mitigate immediate support risk	15/06/2018	Open	Mark Reynolds

Review Dates:

Last Review Date: / / **Next Review Date:** / /

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Assessment

Risk Number: 3110		**Status:**	*Live (With Actions)*
Site:	Sandwell General Hospital	**Department:**	Informatics (S)
Clin. Grp / Corp Dir:	Corporate Operations	**Owner:**	Mark Reynolds
Directorate:	Informatics	**Assessor:**	Rachel Barlow
Specialty:	IT Infrastructure	**RR Level:**	Clinical Group/Corporate Direc
Risk monitored by:	Risk Management Committee		

Initial Risk	Current Risk	Target Risk
Severity (4) x Likehood (5) = 20 Red	Severity (5) x Likehood (4) = 20 Red	Severity (3) x Likehood (3) = 9 Amber

Risk Type: Informatics **Risk Sub-Type:** IT Hardware - Clinical System Failure / Issue

Risk Statement	Scope	Hazard
There is a risk that the technical infrastructure, Trust-wide is not robust nor subject to compliance against formal technical architecture and is therefore suboptimal. Combined with areas of legacy technology currently without a full plan to update or replace, there is an impact of loss of IT provision to run clinical and non clinical services safely and effectively	The scope of the risk assessment includes: - understanding of current technical architecture - documentation of changes and maintenance to the IT technical architecture - delays to delivery of the infrastructure programme - insufficient architecture design and planning skills - legacy equipment without replacement plan / dates	Hazards include; - cancellation or delay in clinical care - impact on mandated performance targets - loss of income - reputational damage internally and externally

Existing Controls:

1	IT infrastructure plan is documented and reports to CLE through the Digital Committee (but has slippage on delivery dates)	Policy/Procedure/System

Actions:

1	Map infrastructure components to organizational services and ensure comprehensive monitoring and early warning alert process for critical IT infrastructure and impact at clinical / non clinical service level	31/07/2018	Open	Mark Reynolds
2	With industry expertise advise fully document technical architecture	31/07/2018	Open	Mark Reynolds
3	Ensure change process is documented and auditable	31/07/2018	Open	Mark Reynolds
4	Document a robust IT infrastructure plan with well defined scope, delivery milestones and measurable outcomes signed off via digital committee	31/07/2018	Open	Mark Reynolds
5	implement clinical group and directorate impact reporting	29/06/2018	Open	Mark Reynolds

Review Dates:

Last Review Date: / / **Next Review Date:** / /

Paper ref:	TB (06/18) 017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Results Acknowledgement		
Sponsoring Executive	David Carruthers, Medical Director		
Report Author	David Carruthers, Medical Director		
Meeting	Trust Board	**Date**	7th June 2018

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

Results acknowledgement and action on those reports is important for patient safety and quality of care. There will be a change in process with the introduction of UNITY where all results (radiology and pathology) will require authorisation. Efficient safe systems need to be in place for result endorsement.

The Board is asked to consider the three different time points raised in the report, the actions taken to date and the work that will need to be done over the coming weeks to prepare for new electronic patient record systems and to help identify other areas of concern and potential risk.

1) Current process for results acknowledgement
2) Transitional arrangements and potential risks
3) Results management in UNITY

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	x	Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

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

CLE May 29th 2018

4. Recommendation(s)

The Trust Board is asked to:

a.	Consider the current and future risk around non-compliance with results endorsement
b.	Note the ongoing work to identify and minimise risks to maintain safe patient care
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		

Results Acknowledgement

Recent SI reports have identified where delays or unacknowledged reports have contributed to patient harm. There are 3 main areas that are being looked at for safe management of results for both Radiology and Pathology reports.

a) Current Processes

The Trust policy on results management (2011) highlights the need for departments to have SOPs for acknowledgement and acting on results. An email has been sent to all medical staff about the importance of personal and team approach to results acknowledgement (Appendix 1) and review of local processes has been a part of the last QIHD event within the Shared Learning Topic and was discussed by some but not all specialty areas in the prior QIHD with completion of an audit tool to highlight to staff areas where local change in practice may be needed. Feedback from these meetings is being collated to confirm that specialties have agreed processes for radiology review if not using the results acknowledgement functionality of CDA

Between and within individual departments there is not a consistent approach to radiology results acknowledgement and this needs further investigation. It may relate to the number of reports allocated to individuals from inpatients that have already been acted on by the team at the point of care and may not have been directly under the individuals care. It is important to note that results with significant pathology are also emailed to the ordering clinician as an additional safety check, and in the cases of MSCC, the report is phoned through (to the RMO if needed for admission)

One recent Coroner case where a failure to look at blood results contributed to a poor outcome has been addressed by process change in A&E (appendix 2).

b) Transition phase between now and Unity

Work is being done to identify risks that may occur around the time of change over to Unity. This relates to the effect on results and orders not currently undertaken/available and is not exclusive to the list below:

i. Investigations reported but not acknowledged at time of go-live
ii. Investigations undertaken but not reported at the time of go-live
iii. Investigations ordered but not undertaken at time of go-live
iv. Investigations pre-booked at a point in time in the future (3, 6 month delay) but not undertaken
v. Investigations ordered on paper and not yet done

These questions are currently being asked of how the relationship between new and existing systems will cope and how dual running of CDA and Unity may mitigate this risk.

c) Future State with Unity

The message centre within Unity will require all results of investigations undertaken to be acknowledged by effective use of the application and will require clear departmental processes to stop the risk of flooding the system with unacknowledged results.

- The situation will differ between outpatient and inpatient results. The former can be more regulated with results coming to the individual clinician ordering the test within a dedicated outpatient message centre. Clarification will be needed over:
    - test results ordered by CNS in clinic
    - those results where patients attend at regular intervals for monitoring tests.

- Use of 'pools' for results can allow for cover while individuals are on leave.

- For inpatients, many investigation results will be acknowledged on ward rounds and by junior staff from within the individual patient record, thus removing them from the message centre. Effective team working will be required for this to occur effectively. Any other reports should appear in message centre for the team or individual who is currently looking after the patient as identified by Unity.

- A&E will need a system to make sure that outstanding blood reports are seen prior to a patients discharge or are followed up within an accepted time frame after the patient has left the department.

- Radiology reporting that acknowledges XRs taken without providing a report (e.g. orthopaedics) with need review to reduce un-needed report acknowledgement

In summary, the importance of correct management of pathology and radiology results has been highlighted to all medical staff with differences in approach identified with respect to radiology reports (remembering that flagged reports of significantly pathology are also emailed to the ordering clinician). Work will need to be done to make sure that prior to go-live, procedures are safe for the transition phase and that departmental policy will be established for on-going results management.

Appendix 1

Dear Colleagues,

The shared learning topic this month at the QIHD meetings will be around specific patient safety issues – one of which you may have discussed last month (results acknowledgement).The other 2 areas reflect areas where serious incidents have been investigated in relation to head injuries and metastatic spinal cord compression (MSCC). Both have updated Trust pathways coming out soon to reflect new guidance and any issues from the incidents. These will be available shortly.

Due to the patient safety issue around these areas I thought it appropriate to ask you to think about these area before your QIHD meeting and to review and discuss the updated pathways when they are published.
In summary:

1) Head injury
    a. the new policy has an updated assessment proforma to be used for patients presenting through A+E and also those who have falls on the wards with head injuries.
    b. it reflects new guidance for when to image the neck, whether or not they are symptomatic, the impact of use of anticoagulants on decisions to scan, the timing of follow up scans in admitted patients who do not improve (over 24 hours) or who have fluctuating conscious level (urgent repeat scan needed) and information to be given to head injury patients on discharge.
2) MSCC
    a. the new policy aims to reduce the risk to those presenting with or considered at risk of developing MSCC.
    b. the need for urgent scans, clear communication about scan results, early commencement of therapy and appropriate referrals are stressed.
3) Results Acknowledgement
    a. please reflect on your own and your teams approach to reviewing results – pathology, imaging and others.
    b. it is important that the results of any test you request are reviewed in a timely fashion and are acted on. Radiology assist with 'red flags' for those images with significant findings that you will be acknowledging and acting on via CDA. Local departmental policies should be in place already for blood and other test result review, including when colleagues change shift, are on leave or have left the Trust.
    c. The audit tool that reflects the 2011 policy for results acknowledgement is attached to help with reflection on your own systems and later discussion at your QIHD.

The process for results acknowledgement in Unity will be an important part of the new ways of working to reduce risk from missed investigations and there will also be more on this in the near future.

Appendix 1

Results Acknowledgement Audit April 2018

Action for radiology reports	Y/N	If no, then plan/comment to address

Action for blood test results	Y/N	If no, then plan/comment to address
Process in place to have in-patient blood tests checked while patient on ward?		
Process in place to follow-up test results returning after patient discharged from hospital		
Process in place to review micro results after in-patient episode		
Process in place to review blood tests after OPA		
Process in place to review delayed tests after OPA (e.g. immunology)		
Process in place to review micro results after OPA		
Results for day case work considered and plan in place for review		
All radiology request are made electronically via iCM		
All radiology requests are linked to the correct/current clinical episode on iCM to make sure the report comes back to you as the requesting clinician		
The electronic acknowledgement system is used within CDA (iCM username section)		
The electronic acknowledgement system is used within CDA (specialty section) to check for reports not linked to your iCM username (e.g. from juniors, paper requests)		
Process in place to have in-patient radiology reports within CDA checked and acknowledged		
Reports intended for other clinicians are redirected as appropriate		

Appendix 1

Red flagged results are acknowledged, actioned and documented		

General points	Y/N	If no, then plan/comment to address
A process is in place for results review of colleagues on leave (clear delegation)		
When a colleague has left the trust that there is clear delegation for any outstanding or future results acknowledgement (via specialty section)		
Any other points/safety issues you would like to raise?		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Results Endorsement within Unity

Subject	Results Endorsement within Unity v2.1
Date	29/5/2018
Owner	Ash Sharma

The acknowledgement of patient test results has been a longstanding risk for the Trust. With the launch of Unity EPR comes an opportunity to ensure a robust system is in place to allow clinicians to acknowledge all pathology and imaging results performed on their patients. This therefore fills a gap within our legacy EPR systems. Within Unity the patient's electronic medical record (PowerChart) will be the main route whereby all test results on inpatients and outpatients can be viewed and acknowledged (endorsed). Those tests requested from within Unity (solicited requests), known as Orders, will be returned to the patient's record and posted to the requesting clinician's inbox within Message Centre. This is a repository for results to be endorsed and acts as a back up in case the results return after the patient has left or been discharged.

Key Decisions:

Which clinicians should be able to order requests in their own name rather than the responsible consultant? The decision should be based upon who will most likely review the result.

The recommendation is that clinicians order in their own name in all areas. This corresponds with both the Cerner recommendation and that from the Royal Colleges which recommend that all doctors should take responsibility for the results that are associated with the requests they make for tests and investigations. Many health professionals run their own clinics, order tests and manage their own groups of patients independent of medical consultants. Certain Nurse practitioners including Hospital at Night staff would therefore require access to the results endorsement facility within Unity.

In Cerner terms the clinician indicator is set to **'ON'** for all clinicians and this has the support of Unity Senior Sponsors and Cerner.

What pools should be set up for Message Centre (noting that in the wards and ED results will most likely be acknowledged through the patient's chart?

The recommendation is:

- Location pools for:
    - ED
    - Maternity

- Consultant pools for other areas.

What is the best route to maintain Message Centre Lists? Whilst staff can elect to join a list changes in Consultant must be made by the Informatics department.

A process needs to be developed to ensure the maintenance of Message Centre lists, especially when clinicians leave the Trust or move on rotation. It should include the monitoring of results endorsement to ensure this is done in a timely fashion or escalated

through management. The Informatics department can only be allowed to close an account once a clinician's results list has been fully endorsed or handed over to another clinician.

Introduction

There are a number of key decisions that need to be made by the Trust relating to the acknowledgement of test results. These decisions will impact on the workflows, their adoption and practices of clinical staff who request and need to regularly acknowledge (endorse) results that are returned against the original request in the patient's record.

These key decisions need to be made in recognition of clinical working practices that support the greater emphasis in the NHS on team working and shared ownership of responsibility for clinical decisions being made through the team when it comes to delivering patient care.

The main implication of this for the EPR is that junior doctor's work is established around a shift system and team working which results in a consultant having a much larger team of junior doctors looking after their patients. Also consultants work more collaboratively when providing care for their patients. It is this that sets the challenge for supporting the 'Results to Endorse' process and particularly the Message Centre set up. The design needs to meet the often complex workflow of multiple users 'touching' the same patient and patients moving through multiple care venues under the care of multiple clinicians during a single encounter with the care service.

Some Trusts have a blanket policy of requiring all results to be endorsed while others leave it to the lead clinicians to decide which results should be endorsed. The EPR provides a set of tools that support a comprehensive results endorsement process and audit to meet the different required workflows.

Message Centre

This standard option from Cerner offers a backup system to endorse results by clinicians when they are not patient-facing such as after an outpatient visit or following a discharge from hospital. The main features within Message Centre that will support the results endorsement process are:

- Inbox, this is specific to the user e.g. Consultant (Dr Jones) and is set up for all users
- Pools, these are set up so that results return to the Consultant in charge of the patient and his/her pool (i.e. current Lead Clinician's team) at the time the results return to the EPR. Members of the care team managing the patient's care can opt into and out of a pool at any time.
    - A hierarchy is followed until a pool is found for the result :
        - Consultant pool
        - Specialty pool
        - Location pool
    - Unity will 'post the message' going down the hierarchy until it finds the pool selected for the result. A consultant can have only one pool for their results
    - An ED location pool can be set up for City and Sandwell ED areas as consultants working here do not manage patients elsewhere in the hospital and will not be part of a consultant or specialty based pool
    - Assessment areas (AMU/SAU/Critical Care) cannot have a location pool as consultants working in these areas also manage patients elsewhere in the hospital and cannot be part of two pools
- Proxy, the Inbox of the user can be given to a designated other user by way of proxy for a given period of time, e.g. to cover annual leave. Important to note that a user's Inbox can have a proxy taken by a User at any time e.g. in the event of an unscheduled period of absence.

- Purging, the messages within a user's Inbox can be purged; this is a system setting and should only be considered where the management of the user's inbox has been problematic resulting in a large backlog of messages (results). Important to note that results will always remain in the patients' medical record viewable in the Results View.

Cerner's recommended design relating to pools is to have Consultant based pools with the exception of discrete functional departments such as A&E, where a location based pool makes more sense. However other designs are possible relating to pools, E.g. Speciality pools, Inpatient versus Outpatient pools, these type of pools **cannot co-exist** with a consultant based pool and their management creates difficulties which relate to the volume of messages and management thereof of returning results to these type of pools

Message Centre has a wider scope in handling documents relating to patient care and forwarding discussions or referrals that take place between clinicians. Referrals can be made to:

- A pooled service (comprising a pool of clinicians receiving referrals to a service)
- A named clinician

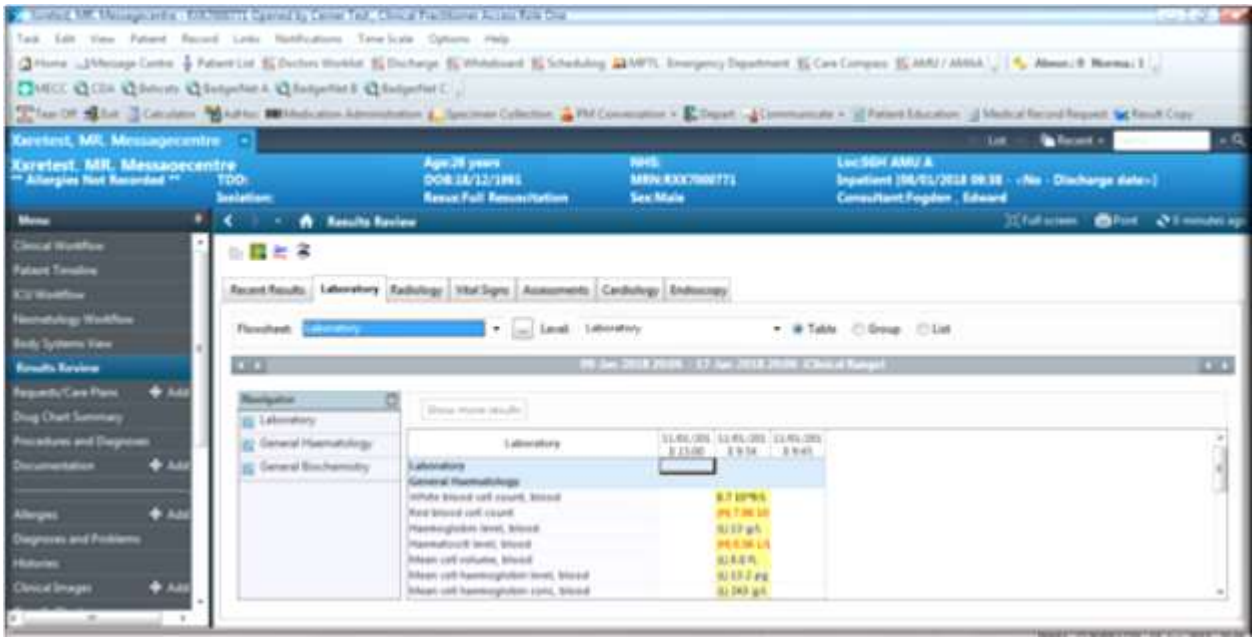
A standard operating procedure for using Message Centre to handle in house referrals will be drawn up between the Trust and Cerner (see separate document)

Locum Doctors

As the Trust utilises locum medical staff from time to time who will be requesting tests and investigations for their patients it is recommended that the Clinician Indicator be set '**ON**' for this group of staff. However, to avoid creating a backlog of work, all doctors leaving the Trust should be advised that their Message Centre Inbox be 'cleared' before HR processes are completed.

Viewing and Endorsing Results

Results are visible within the results tab in PowerChart. This displays the patient's current and historic results.



Results can be endorsed in two ways:

- **PowerChart** - For the requesting clinician, their results will appear in yellow in PowerChart ready to be endorsed. For other clinicians, they can view results which need endorsing by clicking the “Endorse Results” button.
- **Message Centre** –A list of your unendorsed results in the results endorsement home screen. Results in ‘Bold’ denote unread results. Abnormal results are displayed in the abnormal section.

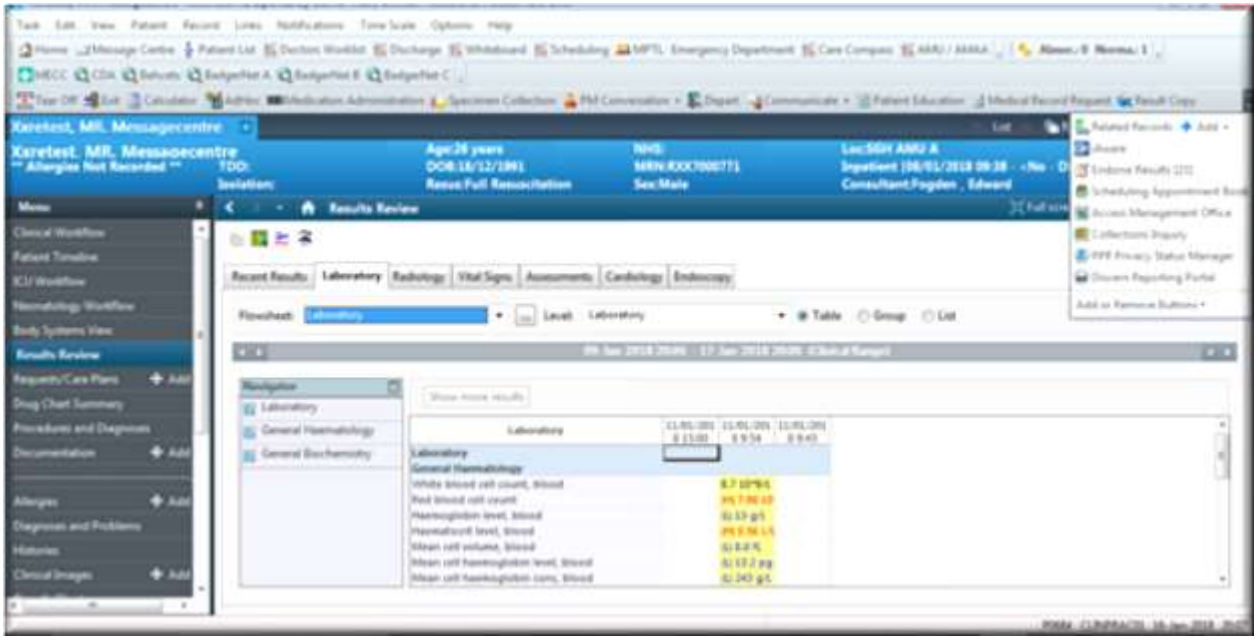
Unsolicited Results

These are results that can be stored and viewed from within the patient’s PowerChart record eg some cardiology and endoscopy results but are not associated with an order requested from within Unity. Hence these results cannot be endorsed from the patient’s chart nor will they populate Message Centre.

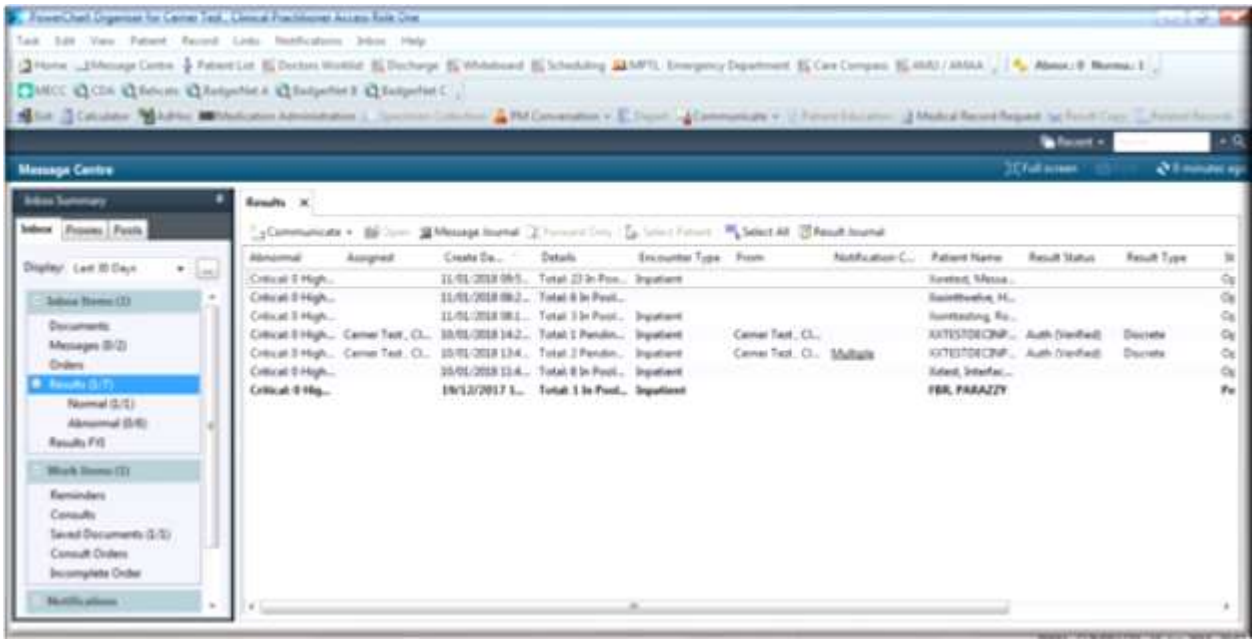
A full list of unsolicited results will be drawn up to provide an SOP on how best we should manage them and ensure they are acknowledged in a safe and timely manner

Test results arriving from outside the Trust are also classed by Unity as ‘unsolicited’ but a function exists (Single Document Capture) that allows external paper results to be scanned into Unity and a message can be forwarded via Message Centre to the relevant clinician that an external document has been received. This will be a manual process that can be allocated to the secretary who scans the document.

PowerChart:



Message Centre:



Implementation Decisions

Set out below is a table that set out the benefits and dis-benefits of the Message Centre design considerations:

Message Centre Design	Description	Benefit	Dis-Benefit
Inbox	Standard built for all users	N/A	N/A
Consultant Pool	Results return to the pool of the Consultant under whom the patient is (i.e. current Lead Clinician) under at the time the results return to the EPR	• Recommended by Cerner based on the experiences of the Cerner clients • Focus on the lead consultant management of patients and associated decisions • Pools are manageable by the Consultant and his/her team • Safety aspect relating to completing the endorsement of the result and subsequent actions by the consultant team	• Rotating junior doctors will have to opt in and out of these pools • Junior doctors may need to opt into a number of pools at any one time

		• Easier to police and gain adoption	
Location Pool	Results returned to the pool in the location the patient is currently e.g. A&E at the time the results return to the EPR	• Recommended by Cerner based on the experiences of the Cerner clients • Pool is focused on the discrete area e.g. A&E • Pool is managed by the care teams within the discrete area and supports the workflow and decision making process • Safety aspect relating to the endorsement of the result and subsequent action by the care teams • Easier to police and gain adoption	• Setting up location pools for areas that are not discrete e.g. Oncology unit can result in the pool becoming quickly unmanageable • None discrete areas managed by multiple specialties creates confusion and become unmanageable • To the above point, this increases the number of messages being forwarded for review and management
Speciality Pool	Results return to the pool of the speciality under whom the patient is under at the time the results return to the EPR	• None Cerner recommendation • Smaller services e.g. Dermatology can discretely manage their results (where there exist a small number of consultants who share patients quite freely)	• Management can become problematic because of the volume of results returning to this type of pool • Continuity of endorsement of results can become compromised resulting in safety issues • Large number of messages end up being forwarded onto the consultant • To the above point this leads to delay in endorsement and actions • **Cannot co-exist**

			with a Consultant pool • Difficult to police and gain adoption
Encounter Specific Pool	Results return to the pool of the encounter e.g. Outpatient which the request was made	• Smaller services e.g. Dermatology with single venue (encounters e.g. outpatient) can discretely manage their results	• Main stream services will be unamenable with significant volumes of results returned • The lack safety will be a significant feature and negate this option • Large volume of results will get forwarded on to the consultant's inbox • Policing this becomes impossible
Clinical Indicator **ON**	With the user's CERNER account setup enabled, the clinician will be able to requests under their own name	• Jr Doctors & SpR: Bypasses the need to select the consultant the test is being placed on behalf of. This would mimic the process as is currently done with i.CM. • Each doctor will have their own pool which they can manage themselves and would not have to opt. IN/OUT of consultant pools to acknowledge a result. This would make management accountability simpler	• Can become unwieldy as there will be a huge number of MC mailboxes. • High turnover of Jr Docs will make the task of removing mailboxes with results still awaiting acknowledgement more difficult to manage.
Clinical Indicator **OFF**	With the user's CERNER	• Fewer mailboxes to manage as a	• Introduce an additional step for

	account disabled, the clinician will have to requests on behalf of a consultant	trust. • Responsibility lies with the consultant / department as opposed to individuals clinicians. • More suitable to be used by short term locum doctors	Jr Drs and SpR in have to select the consultant which the request is being placed under. It will also introduce the risk of select the wrong consultant from the dropdown list which will cause the result to appear in under the wrong mailbox.

Paper ref:	TB (06/18) 018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Patient Handover / Staff Exit SOP and Implementation		
Sponsoring Executive	Rachel Barlow, Chief Operating Officer		
Report Author	Liam Kennedy, Deputy Chief Operating Officer		
Meeting	Trust Board	**Date**	7th June

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

The outstanding issue of the IT system not forwarding results named to an alternative professional following departure from the Trust of the previously named lead, is linked to the results acknowledgement risk (risk 370). Historical administration of clinical staff starting and leaving the organisation on the patient administration systems or clinical administration systems has not always been accurate not timely. Historical administration practice in relation to clinic template management has been inadequate at times and previously not been consistently applied, resulting in clinic templates being available to book that no longer operationally run as a routine clinic and therefore available to use to set up adhoc capacity. This is not an exclusive issue to this Trust but is unequivocally not the administration standard we aspire to. There is no auditable process in place for assuring handover of care in progress between clinician's leaving and taking over care as new starters or clinical successors. This can result in a number of issues:

- Patients booked into clinics under the right speciality but the wrong consultant on the PAS system
- Results acknowledgment system not forwarding results named to alternative professional following departure from the Trust of the previously named lead and results remaining unacknowledged
- Inaccurate consultants patient attribution data

In terms of an indication of scale, the number of patients currently booked to outpatient appointments under consultants who have left the Trust is 5. The scale on unacknowledged results is higher than this.

Mitigation plans of this historical issue includes:

- Standard operating procedures for starters (including locums) and leavers on all clinical administration systems
- A patient level checklist to be signed off by the outgoing member of staff and operational manager to assure safe administration / handover
- Automatic closure of empty unused clinic capacity to avoid misuse

New processes will be designed and implemented from the end of June. Assurance will be submitted to the Executive Quality Committee. Internal audit will review in Q3 to provide assurance of systems and processes in place.

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?]*

4. Recommendation(s)

The Trust Board is asked to:

a. Discuss mitigation, assurance plans and timelines

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

Trust Risk Register		Risk Number(s): results acknowledgment 370						
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		

The following report provides background information on the focuses on the three key issues highlighted above and outlines the process that have been put in place to mitigate these issues going forward.

Background:
All clinics in the organisation are built in IPM our Patient administration System (PAS). When a clinic is built an accountable clinician is required, so that we know who to attribute the patients to. Recently a profroma was introduced that when a clinic is established there is a 12 month standard cut off period. This means that after 12 months with no activity the clinic is removed. Before that clinics were established with no end date. Also when a clinician leaves the organisation or retires there is and end date form that should be completed. However, this no failsafe mechanism for linking this with their clinics and therefore clinics can remain open under their name.

Issue 1: Patients booked into clinics under the right speciality but the wrong consultant on the PAS system

Currently there are 3362 clinics that have no end date, created before the introduction of the new 12 month cut off period. Of these 3022 have had no activity recorded against them in the 2018 calendar year (2018). There are 6 clinics that are built under retired consultants, 1 of which still has activity attributed to it. The remaining 5 have been closed down as of the 30/05/18.

The remaining one has 5 patients and is a pre-op clinic that will be cancelled and patients re-allocated to the correct consultant who is allocated onto that clinic on the same date and time.

The proposal is that we initiate a rule that closes all clinics down that have not had activity booked into them for a 3 month period. This would mean that of the 3362 clinics above there would only be a residual 346 clinics that would need to be reviewed by groups to decide if the clinics are correctly set up against the right clinician and allocate an appropriate end date. This will be completed over the next 4 weeks to ensure we have a completely clean clinic build.
To ensure a sustainable grip and control on clinics, all clinics that have no clinical activity after 3 months will be closed to avoid misuse of clinic templates. A mechanism for reconciling retiring and leaving consultants against any clinics open under their authority also needs to be implemented. A SOP is under development (appendix 1) for this, which clearly outlines the need for the clinical groups to complete an end date form and a failsafe monthly reconciliation put in place.

Issue 2: Results acknowledgment system not forwarding results named to alternative professional following departure from the Trust of the previously named lead and results remaining unacknowledged.

A standard operating procedure for clinical accountable staff leavers and completion of clinical handover will be established for both substantive and locum staff which will include consultants, CNS's, allied health professionals and independent practitioners. Leavers should have a named person responsible for accepting handover and future attribution of care for all patients who have an open episode of care. This should cover a minimum of 3 months to ensure:

- Sign off clinical letters and cross checking with outstanding pathology post clinic.
- Review of radiology or other diagnostic test results which may be up to 12 weeks post OP appointment.

- Handover of patients booked on waiting lists waiting for treatment
- The SOP includes an end to end reconciliation to ensure handover has taken place and assurance is via the Directorate team

In Unity there will also be a 'pooled' approach to results acknowledgement and clinic letters where groups of staff from within an area will be able to view results not just the requesting clinician to ensure that no results are missed. Primarily the requesting clinician will be able to view the results, so regardless of what the clinic name is but then additionally the clinician who is named on that clinic will also be able to review. This set up is to allow, junior doctors and consultants to view each other's results.

Issue 3: Inaccurate consultant's patient attribution data impacting on demand and capacity planning

This is important in understanding the efficiency and throughput of a clinic and individual consultants for job planning and demand capacity modelling. The mitigations above to ensure patient safety will mean that this issue will also be resolved.

Appendix 1: High level information to be included in the SOP which will be ratified by Planned Care Board and CLE prior to Board approval.

SOP to include:

- Implementation and audit of the 3 month auto closure of clinics
- Implementation of monthly reconciliation report about leavers and retiring clinicians against the clinic builds and all clinical systems.
- A checklist will be created to ensure all clinical and administrative handover is completed, including but not limited too; transfer of f/ups, clinic letters, results, complaints and clinic templates
- All clinics set up with a maximum 12 month end date, for annual review with anything not active for a minimum of 3 months closed
- All groups to complete an end date form as part of the leavers checklist
- Quick reference guide for clinic admin team of how to complete end date procedure will support new processes

Paper ref:	TB (06/18) 019

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	CQC Improvement Plan: BMEC response and delivery		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author	Kam Dhami, Director of Governance		
Meeting	Trust Board	**Date**	7th June 2018

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

This paper focuses on the CQC Improvement Plan actions relating to BMEC, specifically those that remain outstanding. It is suggested that the Board

- Seeks a way forward on the outstanding paediatric out-of-hours risk for children;
- Explores the robustness of the action plan delivery presented
- Tests the governance arrangements put in place by the Group to comply with the CQC Inspection requirements.

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?]*

CLE 29th May 2018

4. Recommendation(s)

The Trust Board is asked to:

a.	**NOTE** the progress made with the outstanding CQC Improvement Plan actions in BMEC and seek **ASSURANCE** that the adequacy of the governance arrangements introduced to maintain a 'Good' rating

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

Trust Risk Register		Risk Number(s): 1738						
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 HOSPITAL NHS TRUST

Report to the Trust Board: 7th June 2018

CQC Improvement Plan: BMEC response and delivery

1. Introduction

1.1 As part of the Trust's CQC re-inspection in March 2017 the Birmingham and Midland Eye Centre (BMEC) was included for the first time. The Inspectors decided to review and report on BMEC as part of Surgery rather than separately, within this it also covered the emergency department, children and young people, outpatients and urgency and emergency care.

1.2 The Inspection report was published in October 2017 and rated Surgery as 'Good', an improved position since the previous visit in 2014. The 'Good' rating also resulted for BMEC.

1.3 In response to a view that the rating may have been different if BMEC had been inspected alone, this paper reports on BMEC's response to the CQC inspection findings and the governance arrangements in place within the Group to maintain, and improve, on their current 'Good' rating at the next inspection which is likely to happen later this year.

2. Improvement Plan actions: progress achieved

2.1 At the Board last month an update was presented that showed a number of outstanding actions that should have been completed by March 2018. Assurance was provided by the Surgery Group that that work was in hand to close these out. The current position against each action is listed below:

a. **Age appropriate facilities are provided with a separation of adult and children waiting and treatment areas** – The photograph in Appendix 1 captures compliance.

b. **Privacy and dignity issued in the BMEC Orthoptics area**. Plans are in place to use screens to separate the two stations which will avoid direct 'view' but will not address the concerns about 'overhearing'. This is a temporary plan because a long term solution involves some structural change in the area and will take time.

c. **Signage** – improved signage that meets the requirements of the patient group are in place. Appendix 1

d. **Mandatory training**. Compliance levels are presently at 94%, if the 'floating' Registrars and visiting surgeons are excluded. Checks their mandatory training status is being followed up with their employers.

e. **Appraisal of Trust employed doctors.** The appraisals have been carried out or have a date scheduled.

2.2 The timeliness and appropriateness of treatment for children under 3 years of age, who attend the ED at BMEC, remains an issue to due to limited availability OOH of specialist paediatric ophthalmologists and/or the availability of a paediatric anaesthetist. Conversations with external partners have taken place but the issue remains unresolved and continues to feature on the Trust Risk Register.

3. Moving forward

3.1 All other actions within the CQC Improvement Plan for BMEC have been declared by the Group as achieved. Validation work is now underway to check that the areas of concern found by the Inspectors in March 2017 have been properly addressed. This will be completed by August 2018.

3.2 The appointment of a new Group Director, Siten Roy, and new Group Director of Nursing, Diane Eltringham, has resulted in a renewed focus on the Improvement Plan in BMEC. The governance arrangements put in place by the Group can be found in Appendix 2.

4. Recommendations

The Board is asked to:

4.1 **NOTE** the progress made with the outstanding CQC Improvement Plan actions in BMEC and seek **ASSURANCE** that the adequacy of the governance arrangements introduced to maintain a 'Good' rating

Kam Dhami
Director of Governance

1st June 2018

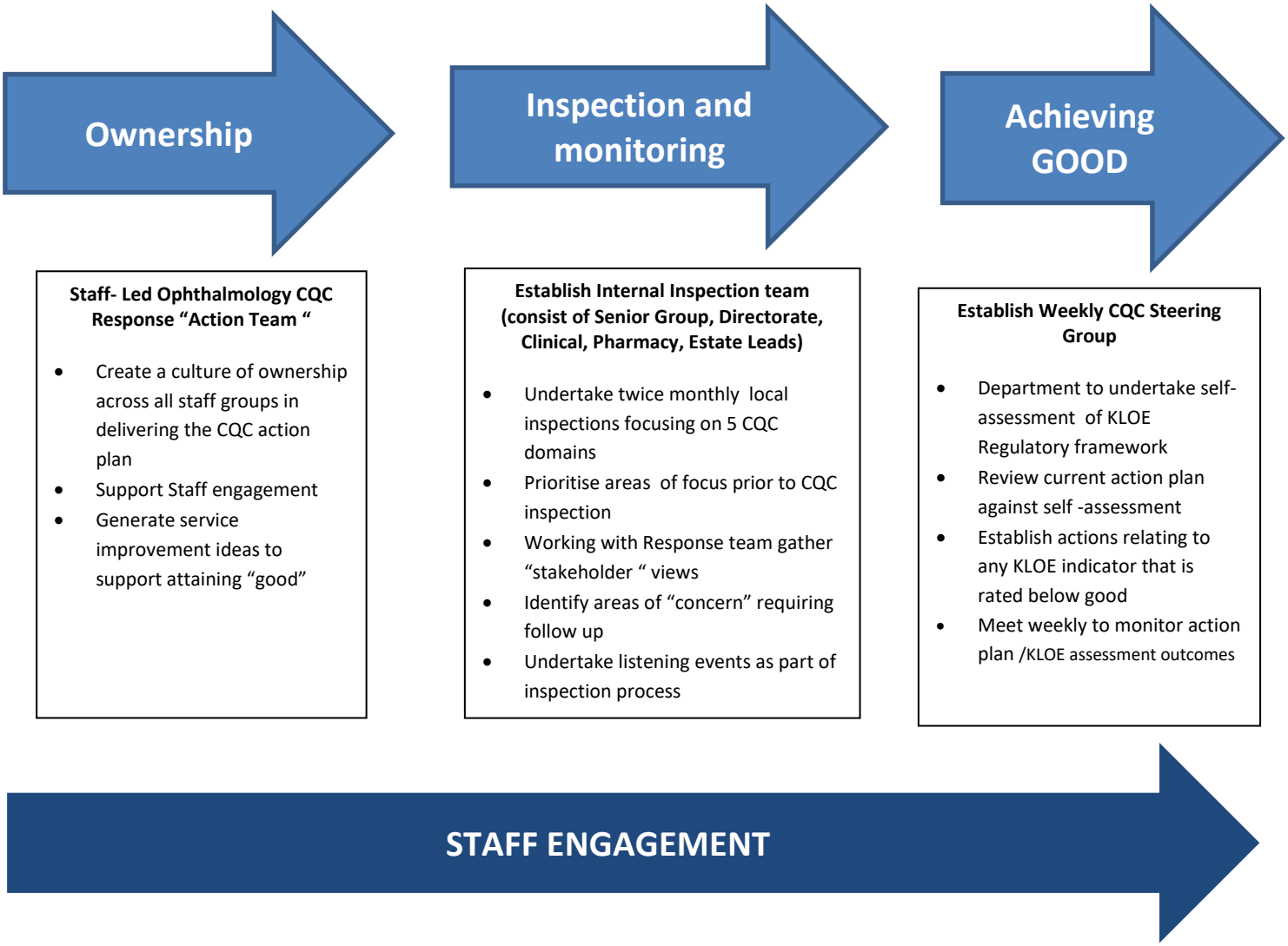
Appendix 1

A suitable waiting area for children and young people in BMEC ED

Improved signage in BMEC

Appendix 2

Surgery Group CQC Governance Arrangements



Staff Engagement Plan

- Develop communication strategy
- Undertake CQC briefing sessions with all groups of staff
- Listening Events with Senior Group and Directorate Leads
- Establish Service CQC pack for Individual Ophthalmology services

Paper ref:	TB (06/18) 020

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Unity Implementation – December 2018		
Sponsoring Executive	Rachel Barlow, Chief Operating Officer		
Report Author	Rachel Barlow, Chief Operating Officer Dean Harris, Deputy Director of IT		
Meeting	Trust Board	Date	7th June 2018

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

This Unity Implementation update covers the following aspects regarding implementation for discussion:

- Key milestones to a 'go live' in August, noting a full delivery plan to stabilise and optimise usage of UNITY to a specified level by December will be considered by the June Digital Committee.
- Organisational readiness and gateways/ milestones
- Walkthroughs summary
- Training status
- Dress rehearsal scope
- Risk, issues, hazard and change request status
- Infrastructure and IT performance to enable a safe 'go live'.

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?]*

Monthly update to Trust Board and CLE.

4. Recommendation(s)

The Board is asked to:

a.	Discuss progress in last month and forward milestone and assurance on mitigation of risk, issues and hazards.
b.	Readiness and preparedness status.
c.	Likelihood of go-live date scheduled after August 2018 but within the calendar year.

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

Trust Risk Register	x	Risk Number(s): 3109, 3110						
Board Assurance Framework	x	Risk Number(s): BAF1						
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 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. A full delivery plan including a post go-live plan to December will be available for Digital Board in June.

This paper provides the Trust Board with an update on:

- Key milestones to a 'go-live' in August, noting a full delivery plan to stabilise and optimise usage of UNITY to a specified level by December will be considered by the June Digital Committee.
- Organisational readiness and gateways/ milestones
- Walkthrough summary
- Training status
- Dress rehearsal scope
- Risk, issues, hazard and change request status
- Infrastructure and IT performance to enable a safe 'go -live'.

2 Implementation Plan (Plan and Gateways)

There are two stages for the successful delivery and use of Unity; Implementation followed by Adoption and Optimisation. Due to the delay in the UNITY programme, a detailed end to end integrated technical and operational delivery programme has been a deficit. A detailed integrated technical and operational delivery plan for a 'go-live' in August is in development and 95% complete at the time of writing. The aim is to have this completed by the end of May. A delivery plan to optimise usage of UNITY to a specified level by December will be considered by the June Digital Committee. The key milestones for an August go live are:

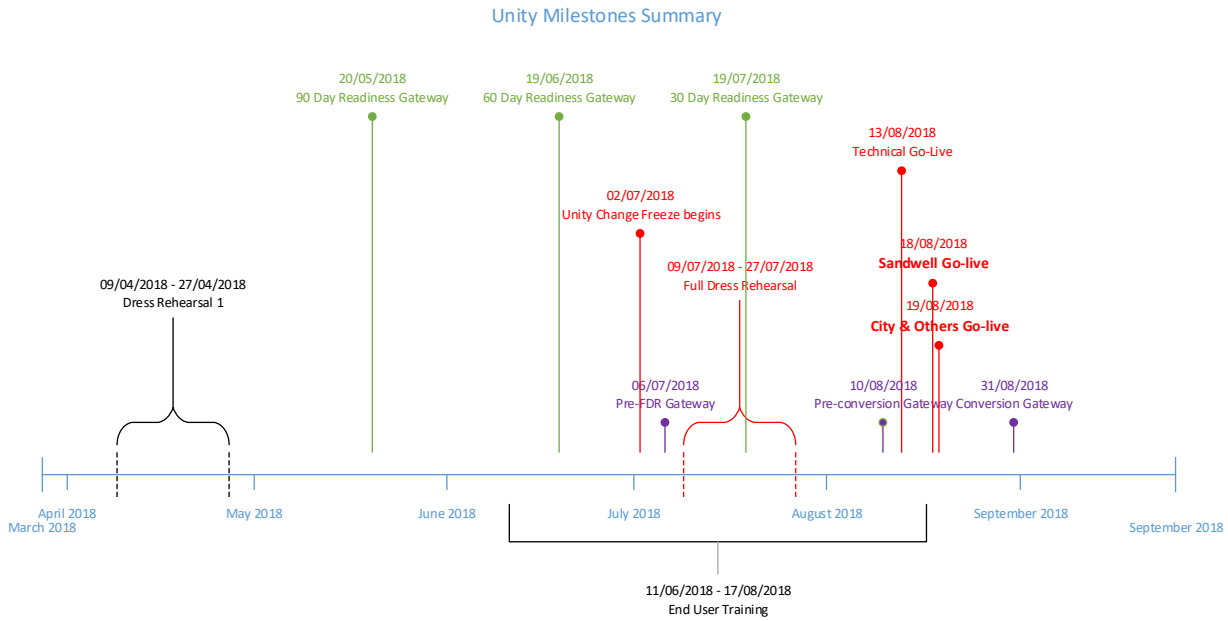


Figure 1 - Unity August Summary Timeline

The key difference from earlier published iterations of these milestones is that technical go-live was arranged for three weeks before the operational go live (Cutover), this has now been reduced to one week before. The reasoning for this was to enable an extra two weeks for activity in the programme before the Full Dress Rehearsal to ensure that this will be successful and a true representation of the final solution that will be implemented. The reduction in the interval between technical and operational go-live does not increase the risk profile of these activities.

The plan highlights two forms of gateway; the Readiness Gateways are advisory and give assurance on the preparedness of the organisation is being managed and measured. All other gateways are mandatory and should be considered as hard stops therefore must be successfully passed. 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. The key dates for mandatory gateways are:

Mandatory Gateway	**Main criteria**	**Deadline**
Pre-FDR Gateway	Champion training complete FDR procedure and resources approved QRG and videos approved and published Statutory and operational reports are tested and available Disaster Recovery processes agreed and documented. No system issues or outages Testing is complete	06/07/2018
Pre-Conversion	End user training on track Issues from Full Dress Rehearsal worked through Clinical Safety Case and Clinical Authority to Deploy approved Cerner team resourced No system outages or issues Sufficient end user devices Statutory and operational reporting in place 724 business continuity solution installed and tested	10/08/2018
Conversion Gateway	Normal operational performance No outstanding priority 1 or 2 issues No high or very high risks issues or hazards Confirm quality and safety has not been affected End use training is routine Debrief report finalised and published	31/08/2018
Readiness Gateways		
90 Day	System access – most staff have basic I T skills End user training – staff identified and most rostered for training IT equipment completion audit in progress Digital champions prepared and some trained Engagement and communications in place to some extent	20/05/2018
60 Day	System access – most staff have basic I T skills Some staff have network log in and unity log in End user training – all staff identified and all staff are rostered for training.	19/06/2018

	Some have completed and passed competency IT equipment completed and installation in progress Digital champions prepared and some trained Engagement and comms in place to a large extent How we will work – understood to some extent Business as usual – bank / agency arrangements understood for unity Go live planning rosters completed to some extent	
30 Day	System access – all staff have basic I T skills Most staff have network log in and unity log in End user training – most staff have been trained and passed competency IT equipment all in place and tested Engagement and comms fully completed How we will work – understood to a large extent Business as usual – business continuity plan updated and tested Go live planning rosters completed to a large extent Reference guides and patient information ready to a large extent	19/07/2018

2.1 90-Day Gateway

The 90-day gateway was due on the 20/05/2018 and can be found in Appendix A. The approved gateway criterion was met with the only exception related to End User Training. The red status is against "Colleagues rostered to attend training". The training schedule is still not released, Issue 442 has been raised in respect of this. There was a failure in the training governance group which has led to a delay in this area and the Chief Nurse has now been appointed as the Executive lead to ensure swift remediation. The specifics of this issue are covered under section 2.4.

2.2 Pre-FDR Gateway

The Trust's next formal mandatory gateway will be the Pre-FDR and is due on the 6th July 2018. The Trust has to meet the entire criterion to enter into Full Dress Rehearsal (FDR). There are 31 measures; current progress against these is Green (6), Amber (18) and Red (7). The current red status activities are summarised below and those aspects highlighted **bold** do not yet have full mitigation plans:

KEY STAGE CRITERIA	OWNER
Is End User Training on track or an approved remediation plan in place?	Paula Gardner
Are all Cerner and Client resources available for FDR and the Cut-over?	Dean Harris
Have all **workflows**, including those with **printers** and devices been defined, approved and tested?	Louise Brown
Has the Printers and Devices DCW been completed, the data uploaded into Unity, a roll-out plan agreed and the implementation of the plan roll-out on-target?	Sarah Cooke
Have all statutory, operational and management **reports** required for Go Live been produced and is the Trust satisfied that they have been fully tested?	Dave Baker
Have the **Policies, Procedures** & Work Instructions been produced and approved by the Organisation?	Dean Harris
Has all of the infrastructure work required for Go Live been completed e.g. reliable **Wi-Fi** in wards, ports in theatres (Phase 2 pre-requisite) and wards etc.?	Mark Reynolds

The pre-FDR gateway criteria do not but should include mitigation of all red hazards. The gateway criteria is now being reviewed to include the mitigation of high or unacceptable risks, issues and hazards to align with the necessary completion of SOPs, workflows and training materials to inform a safe implementation.

The gateway criteria are being monitored weekly for progress updates and will be reported to the Unity Implementation Committee for governance.

2.3 Walkthroughs

2.3.1 Scope

The remit of the walkthroughs taking place during April and May 2018 has been to provide an opportunity to review the current workflows walking through Unity using scenarios. This approach aimed to clarify the accuracy of the workflow and obtain clinical and operational sign-off. It was anticipated that further risks, issues, hazards and change requests would be identified during this process. There were 18 walkthroughs identified, 78% (14) have been carried out successfully, 5% (1) the CAPMAN walk through has been extended and phased over 3 sessions to complete thoroughly and is due to be completed on 6.6.18. 17% (3) have been unsuccessful; the unsuccessful were Inpatients, Regular Day Attenders and MDTs. The 3 failed walkthroughs will be completed by 3rd week of June.

2.3.2 Outcomes

The success of the walkthroughs has been variable but has in all cases provided opportunities to highlight items which require resolution prior to go live, and those which are able to be deferred for review post go live. All walkthroughs were seen as a positive engagement experience. The walk-throughs generated 33 Risks or Issues, 13 Clinical Hazards and 21 Change Requests.

2.4 Training

The issue (442) rating related to training has been escalated to 25. Unity training has to date included the successful Digital Champions and Early Adopters, the next large scale activity is to deliver End User Training (EUT). There are issues with the current governance structure and project leadership, which was been overseen by the Unity Training Steering Group which has been assessed as non-functional due to issues such as non-quorate meetings and gross slippage from key milestone dates. This has been escalated through via the Integrated Governance Group and the Chief Nurse will take over the leadership of Unity training. There is an immediate need to ensure that the scheduling of training is undertaken, or this will become a barrier to go-live; a workshop week last week designed the mitigation approach which will be considered at Unity Implementation Committee on the 4th June and will likely result in regrading of the risk. The key elements of the plan are summarised below:

- Course sign off – sign off teams have been agreed with named workstream lead, operational and clinical leads. Courses will be formally signed off and reported to the Training Committee by 22nd June. A quality assurance methodology will be considered of peer trainer testing in order to quality assure the content and delivery of a full course.
- Scheduling of training is over a 10 week plan. This gives 120% capacity against the number of staff requiring training, therefore providing contingency training capacity.

- Booking approach – will be via connect and be role specific. Learning form PDR booking, there will also be localised support for teams to book, onto courses, with trainers deployed into clinical areas to support booking.
- Competency assessment – will be devolved to local managers to record and oversee with their teams. Competency statistics will be tracked through the readies surveys.
- A communications plan needs to be agreed and deployed.

The scheduled date to commence EUT is the 11th June 2018 and completes on the 17th August on the current deployment schedule. If there was to be a delay in go live, the delay time would be optimised by deploying trainers to provide road shows through the play domain and introduce the play domain to clinical teams. The play domain that allows end user experimental and familiarisation will be made available on the 18th June 2018.

The in-person training will be complemented by an e-learning offer delivered by a 3rd party company based on our Trust requirements. This facility will be used for training temporary staff such as Locums.

2.5 Full Dress Rehearsal

2.5.1 Scope

The final scope of the Full Dress Rehearsal (FDR) will be signed doff at the next digital committee. The current work proposes:

- Complete data Migration
- Successful Interface integration
- New Patient journey's throughout the organisation. Areas include:
  - Emergency departments (Sandwell, City & BMEC)
  - Inpatient Wards (Assessment, Base, community, BMEC)
  - Outpatient Clinics
  - Theatres
  - MDT meeting
- Existing Patient Journey's (2 wards)
- Inpatient Transcription (2 wards)
- Full Service desk facility
- Command & Control structure in place

2.5.2 Timeline and outputs

Technical Full Dress Rehearsal will be for a week beginning on July 9th 2018. Operational Full Dress Rehearsal will be for a week beginning on July 16th 2018. The outputs from FDR will be:

- Completion of Patient Journey checklist for each area
- Completion of transcription on inpatients (2 wards)
- KPI's completed by each location lead throughout the event.
- Helpdesk dashboard of number of issues/severity/closures etc
- Network and device test check list for each area.
- Complete list of Unity, statutory and operational reports produced
- Lights on report dashboard tested

2.5.3 Resources

Below are the numbers of resources which will be required for the FDR. These will be allocated by their respective clinical groups.

JUNIOR DOCTOR	NURSE/CNS	THERAPIST	HCA	MIDWIFE	WARD CLERK	TOTAL PER AREA
51	51	27	31	3	33	196

3 Risk, Issue, Hazard and change request summary status

3.1.1 Risks

There are currently 5 very high risks and 8 high risks to the programme; this represents an increase of 3 very high and 2 high in the last month. Overall in the period since the walkthroughs have commenced there has been an additional 12 risks.

EPR PROJECT	VERY HIGH	HIGH	MEDIUM	LOW
Open	5	8	51	22
Closed	13	29	111	27
Total	**18**	**37**	**162**	**49**

RISK ID	RISKS	TRUST SCORE	RESIDUAL SCORE
186	ED Reports	25	4
426	Cancer Services Histology Requests	25	8
431	Reduction in therapy service during end user training and cutover	25	4
370	Endorsement of Results	22	8
441	No demonstration of Unity Blood Transfusion Process	20	TBD
445	Device loss could threaten go-live	20	4
349	Single Document Capture Workflow is not defined	16	6
416	Inconsistencies with content for EPMA-pharmacy	16	6
437	Recording 'WELLs' score	16	6
352	Floor walker cutover support not adequate to ensure patient safety	15	4
405	Business Continuity Plans	15	6
432	Potential unsafe/inappropriate patient discharge due to inaccurate use of the discharge checklist AHP readiness option.	15	6
433	Loss of key patient clinical documentation due to saved documents not being signed	15	8

3.1.2 Issues

There are currently 3 very high and 5 high issues to the programme; this represents an increase of 2 very high and 1 high over the last month. Overall in the period since the walkthroughs have commenced there has been an additional 10 issues. The Clinical Safety Officer has been appointed in May which has closed a very high risk and enables the Trust to meet a future gateway criteria.

EPR Project	Very High	High	Medium	Low
Open	3	5	21	8
Closed	9	28	71	13
Total	**12**	**33**	**92**	**21**

Issue ID	Issues	Trust Score	Residual Score
442	Training Schedule Release	25	6
446	Unity Reporting workstream position is unclear	25	6
362	Inability to print labels at bedside poses risk of incorrect sample labelling	20	10
429	Ordercomms Printing - General	20	4
381	Lack of clearly defined process for ECG capture	16	6
383	Citrix Receiver Version 4.9 Upgrade	16	6
409	Medcon interface for Cardiology Orders	16	6
425	No evidence of operational mitigation within hazard controls	16	4

3.1.3 Clinical hazards

There number of Clinical Hazards has increased to 56 from 47 following the completion of the walkthroughs. The due diligence review has led to a reclassification of many of the hazards resulting in the highest proportion now rated as unacceptable or undesirable. The main changes related to training and business change. The impact of this on the pre-FDR gateway is being assessed and the outcome will be advised to the Digital Committee in June. The table below gives the summary information regarding the rating of the open and closed hazards. Hazards are monitored weekly in the current governance arrangements.

Hazard rating	Archived	Closed	Open	Grand Total
Acceptable (1-3)		1	1	2
Tolerable (4-6)		5	8	13
Unacceptable (15-25)		2	23	25
Undesirable (8-12)	1	3	24	28
Grand Total	**1**	**11**	**56**	**68**

4 Infrastructure

There are recognised issues with the Trust IT infrastructure and more recently significant outages in some areas that could potentially affect the success of the Unity adoption and cutover. There is a significant and understandable 'trust' issue from our staff based on poor user experience that we must address. The necessary operational and clinical effort to manage business continuity in IT outages is detracting from progressing the Unity programme. A period of stability on the IT infrastructure is essential. A change freeze has been put in place and new change control processes for essential work which are operationally led with clinical and technical support are being established. 2 new risks 3109 and 3110 are for consideration on the Trust risk register.

Explicitly and directly related to the Unity deployment rather than the wider infrastructure the following must be completed:

- Commissioning of the City Hospital Cerner network link due to be completed by 14th June 2018.
- The resolution to Issue 383 - Incompatibility of Citrix software versions; which at the time of writing is now has a mitigation solution but timelines to complete are yet to be confirmed.

5 Summary and Conclusions

The Trust Board are asked to receive this update as a work in progress. The programme still faces significant challenges however the redefined planning of activities, engagement with the organisation through Dress Rehearsal 1 and Walkthroughs plus the new governance structure is proving successful in Clinical Group engagement and oversight of this programme and the associated risks and delivery challenges which is reviewed monthly at MPA, CLE and Digital Committee.

The Trust Board are asked to discuss:

- Progress in last month and forward milestones
- Assurance on mitigation of risk, issues and hazards
- Readiness and preparedness status
- Likelihood of go-live date scheduled after August 2018 but within the calendar year

6 Appendices

6.1 Appendix A – Readiness Gateway Tracker

CHECK	90 DAYS	60 DAYS	30 DAYS	CUTOVER
SYSTEM ACCESS				
Basic IT skills confidence is good	Most	Most	All	
Colleagues have network logins	Some	Some	Most	All
Colleagues can login to Unity	None	Some	Most	All
END USER TRAINING				
Colleagues identified	Most	All		
Colleagues rostered to attend training	Most	All		
Colleagues trained & competency passed	N/A	Some	Most	All
IT EQUIPMENT				
Completion of IT equipment audit	In Progress	Completed		
Wi-Fi checked	In Progress	Completed		
Appropriate hardware installed	In Progress	In Progress	Completed	
Bedside Medical Device Integration installed (Critical Care, Neonates & Theatres)	In Progress	In Progress	Completed	
DIGITAL CHAMPIONS				
Digital Champions identified	All			
Digital Champions released for preparation activities	All			
Digital Champions trained	Some	Most	All	
Digital Champions rostered (supernumerary) for go-live		Most	All	
ENGAGEMENT & COMMUNICATION				
Unity discussed at team/departmental meetings	To Some Extent	To A Large Extent	Fully	
Unity team have visited department	To Some Extent	To A Large Extent	Fully	
Staff newsletters & information on display	To Some Extent	To A Large Extent	Fully	
HOW WE WILL WORK				
Every staff member understands the benefits of Unity	N/A	To Some Extent	To A Large Extent	Fully

Staff participated in Full Dress Rehearsal	N/A	N/A	Fully	
New processes understood	N/A	To Some Extent	To A Large Extent	Fully
Staff have practiced new processes	N/A	To Some Extent	To A Large Extent	Fully
BUSINESS AS USUAL				
Staff able to access and maintain iPM Lorenzo	N/A	To Some Extent	To A Large Extent	Fully
Obsolete paper work identified and removed	N/A	N/A	N/A	To Some Extent
Business continuity plan updated	N/A	N/A	Fully	All
IT support arrangements & fault reporting understood	To Some Extent	To A Large Extent	Fully	All
Unity access protocols for bank & agency staff understood	N/A	To Some Extent	To A Large Extent	Fully
GO LIVE PLANNING				
Adequate staff rostered to cover the go live period	N/A	To Some Extent	To A Large Extent	Fully
Local go live activities and processes understood	N/A	To Some Extent	To A Large Extent	Fully
Reference guides and cutover help understood	N/A	To Some Extent	To A Large Extent	Fully
Patient information available	N/A	To Some Extent	To A Large Extent	Fully

Paper ref:	TB (06/18) 021

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Quality Plan Implementation		
Sponsoring Executive	David Carruthers, Medical Director		
Report Author	David Carruthers, Medical Director		
Meeting	Trust Board	**Date**	7th June 2018

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

The Quality Plan aims to place SWBHT in the top 20% of comparable Trusts in the UK for patient outcomes. The scope and aims of the plan were relaunched at the recent leadership conference and the output from the group work and discussions will inform the approach that will be taken.

The Board is asked to consider the planned approach to delivery of the quality plan, with the initial focus on 6 clinical areas previously felt to be contributing to poorer outcomes in the Trust than expected. This work will run in parallel with other work examining Trust mortality rates.

A quality improvement approach with involvement of junior medical staff and clinical service managers to generate their ideas and enthusiasm in improving care will be used with support from the Improvement Team.

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	x	Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

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

Quality and Safety Committee May 25th 2018

4. Recommendation(s)

The Trust Board is asked to:

a.	Note and approve the plan for project launch
b.	Be aware of overlap with project work on amenable mortality
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	

Quality Plan Implementation

The Quality Plan was developed 2-3 years ago with clinician engagement, identifying areas where improvements in care could improve patient outcomes and place SWBHT in the top 20% of Trust performance across the country.

The same clinical structure and aims are to be maintained in the re-launch of the plan and this was presented at the May Leadership Conference. The initial focus will be around the 'Big Six' areas identified from mortality data suggesting higher death rates than comparable Trusts.

Much has already been done in these clinical areas to improve care but using a quality improvement project approach, with support from the Improvement Team and engagement with junior medical staff, we hope to build on this further.

- The Six initial areas for study will be Sepsis, Hospital Acquires VTE, MI, Stroke, Hip fracture and high risk abdominal surgery. Other areas identified in the quality plan will be developed at a slower pace with additional QI work done where needed from issues identified from current mortality data and SI investigations.

- Baseline data will be brought up to date to define the standards to base the QI work on. The outcomes may be around Mortality or other outcome data (such as completion of Sepsis 6 within 1 hour).

- A project lead will be identified for each stream of work and approaches learnt from the safety plan will be considered.

- Junior Medical and Service Management staff will be engaged in QI projects to address the areas of each stream of work, with support and training in QI work provided by the Improvement team. This form of 'Corporate Sponsored QI Project' will hopefully be attractive to trainees and will use their skills and involvement in clinical care in the relevant areas to take things forward.

<u>Specifics needed:</u>

- Team and roles of individuals
- Baseline data
- Project outline
- Identification of areas to focus on from baseline data
- Definition of patient pathway
- Clear outcome definitions
- Improvement plan and actions

- GANTT chart for each project area to confirm progress against actions using Single Improvement methodology

Next steps:

- Review information from Group work at Leadership Conference
- Identify project leads
- Define scope of individual projects
- Engage junior staff
- Oversight and support from Improvement Team
- Be responsive to new data to identify 'little rocks' projects

First project launch will be sepsis – with the general project outline and specific approach for sepsis shown below having discussed with Improvement team. Aim is to have first project role out ready to go in 4 weeks and then to build on that approach with other general and disease specific projects.

Quality Plan – Approach to Project Deployment with a focus on sepsis

Following a pause in the deployment of the Quality Plan, a refocusing of effort is underway. Building on feedback from workshop sessions at the recent Leadership Conference, the approach to the relaunch of the Quality Plan is described below.

Aim of the Quality Plan

To produce measurable, patient meaningful, outcomes, to improve on these continuously and to do so with an ambition that puts us amongst the best organisations in the NHS.

Project Approach

Following the successful deployment of the Safety Plan, a similar approach will be used in the deployment of the Quality Plan, that is, a project approach that encompasses:

- Small scale pilots with a "top-down-meets-bottom-up" alignment of priorities and tasks
- Rapid PDSA
- Data driven
- Visual Management in clinical areas
- Fast (good) decisions
- Effective communication and engagement with staff and patients
- Exec oversight in PMO

Principal focus areas

The two initial areas of focus are Sepsis and Hospital acquired venous thromboembolism. The Sepsis Project will kick off first with a four week lead time into deployment. In this four week period the objective is to initiate three project workstreams

- Neutropenic Sepsis
- Sepsis presenting on admission
- Sepsis develop in The Trust

Key Performance Indicators

KPIs will be developed as part of the four week initiation period and are likely to be in the areas of

- Reduction in deaths related to Sepsis
- Reduced length of stay
- Reduced ITU admission
- Reduced renal impairment as a result of sepsis
- Improvement in identification of sepsis indicators
- Improved deployment of deployment of Sepsis 6 Bundle

Project Team Structure

The Sepsis project is led by Roger Stedman and Helen Cope. Resources will be identified from Junior Doctors, Nursing Staff and colleagues from support services and corporate functions. This will be enabled by a Trust-wide engagement activity on the Sepsis Improvement Project and by enabling involvement in the project to feature in individuals' PDR and personal objectives. Input from colleagues at the recent Leadership Conference has indicated a number of different engagement strategies that can be used.

Building on success and learning

Following a successful four week deployment of the Sepsis project, a similar approach will be used to kick off the hospital acquired venous thromboembolism project.

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Quality Plan

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Background - Our 2020 Vision

"The aim of the Quality Plan is to produce measurable, patient meaningful outcomes, to improve on these continuously, and to do so with an ambition that puts us amongst the best organisations in the NHS"

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Learning from the Safety Plan

- Top-Down + Bottom-Up = Buy In
- Small scale pilots, Rapid PDSA, Data, Visual Management, Fast (good) decisions
- Huddles = no meetings and few emails
- Visible senior leadership

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A quality plan - A large-scale programme

Reduce deaths in hospital from: • Sepsis • Hospital Acquired Venous Thromboembolism • Stroke • Acute Myocardial Infarction • Fractured Neck of Femur • High Risk Abdominal Surgery
Improve outcomes for cancer patients
Reduce unplanned readmissions
Save people's eye-sight
Improve screening uptake
Reduce stillbirths and deaths in the first week of life
End of life care – choice over place of death
We will reduce lost days of school
Patients will report that their health is better following treatment with us
Improve mental health care for patients

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Areas of initial focus – The Big Six

Sepsis	Bugs
Hospital acquired venous thromboem	Clots
Stroke	Heads
Acute myocardial infarction	Hearts
Fractured neck of femur	Hips
High risk abdominal surgery	Tummies

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Moving forward with purpose and pace

- Project groups, one for each of The Big Six
- Emulate the Safety Plan (embrace PDSA, love the data, swift decision-making)
- Engage junior medical staff and specialty management
- Improvement Team support

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Moving forward with purpose and pace

- The "Little Rocks" approach
- Mortality data and outcomes from Serious Incident investigation will identify Quality Improvement opportunities outside of The Big Six
- These will become "Little Rocks" Quality Improvement projects
  - Same PDSA approach
  - Smaller scale
  - Shorter duration
  - Faster improvement

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Four Workshops – bed-holding groups

- Medicine & Emergency Care
  Women's & Child Health
  Primary Care, Community and Therapies
  Surgical Services
  Joined by other colleagues
- Tables in each room with one of the quality plan goals and a table on engagement and support – Choose your table

Key questions include:

- What have you done to improve outcomes in the past year?
- What more could be done? And what should be the focus?
- How would you measure improvement?

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Paper ref:	TB (06/18) 022

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Strategic Board Assurance Framework		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author	Clare Dooley, Head of Corporate Governance		
Meeting	Trust Board	**Date**	7th June 2018

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

The latest review/progress of actions and identification of gaps against the two year Strategic Board Assurance Framework was completed in May 2018. High risks (red rated) include:

- IT Infrastructure residual concerns
- Development of alliance-wide model for paediatric eye care services
- Monitoring Cost Improvement Plans throughout 2018/19
- Excess costs and service reconfiguration due to Midland Met construction delay
- Development of an Integrated Care System funding model
- Roll out of apprenticeship/training Levy
- Quantifying the boundary impact of cross area / out of area patients
- System-wide approach to non-PBR controls

The BAF will be routinely taken to committees for further discussion (as listed on the BAF).

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	x	Estates Plan	x
Financial Plan	x	Digital Plan	x	Other *[specify in the paper]*	

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

Trust Board February 2018

4. Recommendation(s)

The Trust Board is asked to:

a.	**DISCUSS** the mitigating information provided by Executive Leads and level of assurance on controls / gaps.
b.	**AGREE** the Strategic BAF must be considered at all relevant sub-committee meetings throughout 2018/19 (as listed).
c.	**RECEIVE** 2018/19 Q1 update report at August 2018 Trust Board meeting.

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

Strategic Board Assurance Framework: 2017/19

Progress report as at period ending May 2018

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
MR	BAF1	MPA	Digital Plan	There is a risk that our **infrastructure** does not support 365 day 24/7 uptime for key systems, resulting in a resort to paper back up, and a loss of confidence by users. This then reduces use and data completeness militating against the quality and efficiency gains we are seeking.	• The absence of an Infrastructure scorecard **Actions** 1. Include an infrastructure scorecard in the Informatics monthly report.	The scorecard on performance was delivered and provides some overview of approach. But red remedy by end of March missed and position deteriorating in Q1.	**Actions taken as outlined but did not deliver performance as required.** **New plan now urgently required to address and closeout residual concerns.**	Q1	R

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
PG	**BAF2**	**Q&S**	**Safety Plan**	There is a risk that we are unable to deliver consistent safety checks inside the first 24 hours because **staff turnover and temporary staffing** use mean that our wards are not staffed by individuals sufficiently familiar with our 'approach'. This exposes patients to risk of sub optimal care.	• External comparison • Assurance that data can be replicated in Cerner **<u>Actions</u>** 1. Gap analysis completed - Work with Cerner EPR team to ensure input data can be replicated and output / outcome reporting in place	1. Vacancy Gap is reducing significantly and the Safety Plan process is well embedded, such that the risk is minimal. This can be demonstrated by improving compliance rates. Project closure planned for end Jan with ongoing monitoring embedded in Group Governance processes.	**Safety checks continue with minimal outstanding checks in all groups. This is triangulated with the consistency of care checks in Medicine and PCCT. Recruitment continues into all clinical vacancies. Recruitment Fairs regularly attended by Senior Nursing staff. Other options are being explored to ensure we fill our vacancy factor to minimise this risk.**	**Q4**	**G**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
DC	BAF3	Q&S	Quality Plan	There is a risk that the Trust is unable to reduce **amenable mortality** to the timescale set out in our plans because we do not identify interventions of sufficient heft to alter outcomes.	• No quantifiable plan to respond to amenable mortality and track progress. **Actions** 1. Through LfD programme identify all deaths amenable to prevention – and their causes 2. Continue to pursue improvements of the delivery of preventive care in diagnoses of known preventable mortality – specifically – Sepsis, VTE, AMI, Stroke, #NOF, High risk abdominal surgery 3. Re-launch mortality improvement plans 4. Track relevant care inputs through GPOs	1. 7/12 Medical Examiners appointed with plan to start in February. Repeat advert out last week in January for additional medical examiner recruitment. Structured Judgment Reviewers to be appointed after working patterns for medical examiners fully established. 2. Currently reviewing Quality Plan and drafting KPIs to be monitored through Executive Quality Committee. For new MD to pick this up over next 2 months 3. Re launch scheduled for after quality plan reviewed 4. Scheduled following relaunch on Quality Plan.	**1. Medical Examiners to start at Sandwell site May 2018. Once processes established for the role to re-advertise for MES to work at City.** **2. Quality Plan relaunched May 2018 at Leadership Conference, using a Quality Improvement approach.** **3. Mortality improvement Q1 projects to work in parallel with main items for Quality Plan.** **4. Relaunch will be done as outputs from Quality Plans develop.**	**Q4** **Q4** **Q4** **Q4**	G A A A

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
DC	**BAF4**	**Q&S**	**Quality Plan**	The first-time CQC inspection may deem that BMEC is not fit to continue to provide a safe, high quality care in its current form, particularly to children on an emergency basis, leading to the Trust **losing 20% of its outpatient income** thus putting at risk the financial viability of SWBH.	• Agreement lacking across whole system in West Midlands in how to provide paediatric eye care **<u>Actions</u>** 1. Engage with BCH and NHSE Specialised Commissioning to agree and provide regional leadership in agreeing a regional solution to the children's emergency eye surgery problem. 2. Deliver a regional paediatric eye medical on-call rota 3. Engage with Spec Comm in overseeing a solution.	BCH have confirmed that they cannot support the preferred model and as such we need to consider regulatory resolution.	**For routine Paediatric eye cases there has been a Consultant appointment to work with the current post holder.** **For out of hours work there is still no local agreement for cover of paediatric urgent cases. Adult ophthalmologists will provide urgent care until over night with support from paediatric trained anaesthetist.** **Continuity engagement with specialised commissioners needed for provision of regional on-call service.**	**Q4**	**R**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
TW	**BAF5**	**FIC**	**Finance Plan**	There is a risk that our necessary level of **cost reduction** plans are not achieved in full or on time, compromising our ability to invest in essential revenue developments and inter-dependent capital projects.	• Lack of assurance on the sufficiency of our plan to achieve cost reduction **<u>Actions</u>** 1. Opportunity assessment against external benchmarks including specifically New Model Hospital underpinning multi-year & specific CIP plans 2. Ensure necessary and sufficient capacity & capability to deliver scale of improvement required	1. Plausible opportunity to deliver scale of necessary cost & margin improvement identified. Subject to on-going validation and milestone planning to determine realistic scale & pace of delivery. Options for non-recurrent and other measures to close any residual gap to be determined.0. 2. Coherent programme structure in place and with key personnel assigned to each work-stream. Re-alignment of PMO on-going. Executive prioritization of near term management agenda done & second tier resources being re-aligned accordingly. Residual capacity & capability assessment including use of subject matter experts to be determined.	**1. Re 2018.19 plan £28m of £37m cost & margin improvement plans in place & assessed as credible and deliverable. Balance of £9m together with mitigation for delivery risk to be secured from plausible N/R measures which total c£20m.** **2. Strengthened formal CIP governance with executive board & underpinning 2nd tier steering group. PMO continues to develop to support discipline in devolved scheme level delivery. Use of subject matter experts remains in view & is in place on case by case basis. Key procurement work-stream now supported by strengthened BCA function.**	**Q4** End Q1 for confirmed primary route to 2018/19 balance. **Q4** Keep in view	**R** **A**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
							Prospective new leadership with effective from 1 September. Group capacity & capability kept in view – positive recruitment evident to senior roles but challenging operational context remains.		
					3. Align trust CIP to commissioner QIPP programmes to confirm coherence and credible route to collective cost reduction	3. Coherent programme includes specific QIPP work-stream. Common definition and understanding of QIPP vs CIP agreed with SWBCCG.	**3. Common definition and basis for triangulation of CIP & QIPP agreed. Credible & complementary QIPP programme remains to be identified & agreed. CCG scope for mitigation through moderated investment or use of reserves remains to be confirmed.**	**Q4** End Q1 for primary route to QIPP delivery	A

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
					4. Secure market opportunities to drive financial margin gain.	4. Detailed market share analysis done & repatriation opportunity identified. Specific work-stream in place with SWBCCG to influence & secure GP alignment with that endeavor.	**4. Market share analysis done & identifying c£67m of top line opportunity [vs c£16m margin requirement]. Initial schedule of 3rd party CCG contracts identified for potential re-alignment.**	**Q4** End Q2 to confirm route to 2019/20 income & margin	A
					5. Secure system support for impact of Midland Met delay & remediation costs such that not borne by trust [or local health economy]	5. Working with THC and key stakeholders to determine and secure best solution to Midland Met delivery. Includes assessment of cost implications and dialogue as to source of any required funding support.	**5. End to end plan to secure build-out of Midland Met and to address any near term service re-configuration consequent on delay remains to be agreed with stakeholders. Similarly funding source for cost impact.**	**Ongoing** Q1 urgency to confirm way forwards, indicative costs & funding and mobilise in line with plan.	R

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
TW	**BAF6**	**FIC**	**Finance Plan**	There is a risk that our necessary level of **cash remediation** plans are not achieved in full or on time, compromising our ability to invest in essential revenue developments and inter-dependent capital projects. [*Note that a key assumption underpinning the cash remediation plan is delivery of year on year P&L results to plan and on a re-current, cash backed basis. The risk to that assumption is dealt with discretely at BAF4]*	• Lack of assurance on the sufficiency of our plan to achieve sufficient cash remediation **<u>Actions</u>** 1. Refresh LTFM to confirm scale of cash remediation required and consistent with level 2 SOF financial sustainability rating 2. Opportunity assessment & confirmation including external benchmarks for working capital management	1. On-going as part of 2018-20 annual plan process. High-level 5 year capital / cash / loans model indicates base case scenario with plausible route to cash remediation and capex funded from internally generated funds. Modest near term revenue loans required reflecting 'take-off' profile of CIP. Downside case indicates requirement for capital and revenue loan support. 2. Remediation reliant on STF recovery which depends on P&L delivery [see BAF 5], gains from commercialisation of fixed assets [specific CIP work-stream] and recovery of extant receivables. Creditor days stretched & currently at sustainable level.	1. **2017.18 year ended with c£10m cash surplus to plan.** 2. **Forward medium term plan indicates capex remains affordable subject to year on year P&L delivery & PSF being secured at c£10m p.a.**	**Q4** 2017.18 plan delivered. Requires ongoing year on year delivery	A A

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
					3. Ensure necessary and sufficient capacity & capability to deliver scale of improvement required 4. Secure borrowing necessary to bridge any financial gap	3. Deputy DoF in place & which has released time for ADoF [compliance] to focus necessary time on cash remediation. 4. Requirement for loans managed to now fall into new financial year. On-going dialogue with NHSI suggests access to required revenue loans should be achieveable. Capital loans would be subject to a more involved ITFF process.	3. **Capacity & capability assessment remains in view and is subject to post year-end review.** 4. **No loans required in 2017.18 which was better than plan.** **Key issue is sourcing funding for cost impact of Midland Met delay. Any shortfall in funding would require adverse capex moderation and likely significant loan finance. Ongoing dialogue with DHSC & NHSI.**	**Complete** Keep in view **Ongoing**	A R

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
TW	**BAF7**	**FIC**	**Finance Plan**	The risk that changes from a **PBR system** to non-PBR system produces an income stream less sensitised to volume and complexity and our demand exceeds planned supply driving unsustainable cost and consequent financial imbalance in the organisation.	• Under-developed understanding of service line capacity, cost behavior & profitability • Absence of a preferred Trust or agreed system approach to non-PBR **<u>Actions</u>** 1. Develop BIU capability to include fit for purpose service line insight for improvement 2. Develop & secure alternative funding & contracting mechanism to drive the right long term system behaviours	1. Work in progress. Model Hospital data and KLOEs reviewed together with NHSI regional lead director and initial triangulation with local intelligence undertaken. Framework for service-line assessment of financial, operational and service standards in development. Performance & costing team now aligned to information team 2. System review concluded and emergent ACS model to underpin drive for aligned action and real change. Encouraging dialogue with SWBCCG continues. Remains to be translated into action and tested in anger. CCG timetable for development of ACS contracting / commercial model unrealistic. Foreseeable that conclusion of 2018.19 contract will run to March 2018.	1. **Performance & costing team now aligned to information team and with development programme under new Director of Partnerships & Innovation.** 2. **Emergent ICS model with SWBCCG. No significant work done to date on alternative funding models to underpin 'place based' and 'outcome oriented' approach to integrated commissioning & delivery arrangements.**	**Ongoing** **Q4** End Q2 for prospective development & implement for 2019.20 financial year. Interim progress through re-alignment of 3rd party contracts	A R

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
RG	**BAF8**	**People & OD Committee**	**People Plan**	There is a risk that **labour supply** does not match our demand for high quality staff, because of low training numbers or overseas options for students, and therefore we are unable to sustain key services at satisfactory staffing levels resulting in poorer outcomes, delayed delivery or service closures.	• Non-existence of a future workforce supply model that reflects new roles and ways of working • No influence over international recruitment policy • Lack of workforce plan across the region including retirement and education profile **<u>Actions</u>** 1. Refreshed workforce plan on regional basis	STP workstream is generating two regional workforce reports. A) the number of gaps in delivery for the next 5 years B) one off workforce planning report including retirement, age profile across the STP inclusive of primary care	**Local workforce action board (LWAB) undertaking regular regional workforce planning, but not to the detail that was previously provided. Significant work has started on planning apprenticeship numbers and working practices for the region, but other roles including nursing and junior doctors remains a key risk** **The People and OD Board committee considered the Long Term Workforce Model at its March meeting, and supported a plan to refresh the Trust's approach to workforce planning, including the Midland Met impact, in Q1 and Q2 of the new financial year. This remains a live issue that is being considered at both People and OD and Executive Quality Committees on a regular basis.**	**Q1**	**A**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
							Clinical groups have been asked to develop and submit individual workforce needs and plans, to link to the TNA and investment in learning and development. This will be expanded during Q1 and Q2 for executive review. It remains a key risk for the Trust.		

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
RG	BAF9	People & OD Committee	Education Learning and Develop-ment	There is a risk that we do not invest precisely enough to improve sufficiently the **skill base of our staff** and as a result our altering staffing levels may not be appropriate for the care we are trying to provide.	• Skills audits of staff in other professions • Inclusion of newly emerging roles through levy in training needs analysis **<u>Actions</u>** 1. Involvement of groups in TNA 2. Integration of levy planning across region	1. Clinical groups have been engaged in TNA through the group reviews. Director of OD has written to all consultant colleagues outlining the new process for training spend. Consideration is being given to allocating training money to corporate priorities (e.g. ED and critical care) before the allocation of training monies for 2018/19. 2. SWBH is taking part in STP wide planning group to ensure that the design and implementation of new roles is fully embedded within the Trust. This is inclusive of nursing associates and nursing degree apprentice roles.	The Trust has protected the training spend for this financial year, and all groups received allocated monies early in the year, to invest in the skills of their teams. The executive also agreed additional investment in the CESR programme to support skills development and retention in ED medical workforce. The trust also launched and supported the development and funding of a nursing skills escalator, which will roll out fully in 2018/19. The Levy has not been rolled out in the timeframe promised by national bodies, in particular the nursing apprenticeship is still not ready and in place. The Trust should consider sponsoring nurses and their fees if this continues in to the new financial year. Although a lot of good work has been done, this remains a key risk for the Trust.	**Q1** **Q1**	**A** **R**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
RB	BAF10	MPA	Estates Plan	There is a risk that we are unable to deliver the full change programme by July 2019 resulting in stranded services and stranded costs for disused but not yet decommissioned estate. This would compromise our ability to deliver **seven day multi professional services** because locational alignment is not achieved concurrently.	• Market pressure on the use of temporary staff (Plan A) becomes unsustainable and a Plan B is required **Actions** 1. Estates development group chaired by COO to be established to oversee integrated delivery programme (estates & clinical service delivery[Q3]	1. Estates development group chaired by COO established.	**The collapse of Carillion has delayed the completion of Midland Metropolitan Hospital. In Q4 an initial clinical risk assessment was completed.**	-	G
					2. Form integrated programme office and effective governance by Q4 2018	2. Due to the collapse of Carillion the programme to move to Midland Metropolitan Hospital is delayed. The programme office has not been established.	**Quality and Safety and workforce KPIs have been identified and will be tracked against trigger points to inform service reconfiguration.**	Q4	R
					3. To design and deliver a detailed clear workforce delivery programme towards 2019 by end Q4 2017	3. Workforce plan not finalized. Interim reconfiguration is a potential risk and therefore workforce plans will need revising.	**Governance proposals for managing interim reconfiguration as well as the move to Midland Metropolitan Hospital and delivery of the retained estate plans will be finalised in Q1.**	Q4	R

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
					4. Confirm MMH opening as some of the 7 day service plan is dependent on a single acute site end Q3 2017	4. Date not yet confirmed and likely to have a multi year delay		Q3	R

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
TL	**BAF11**	**MPA**	**Estates Plan**	There is a risk that confusion over the governance of key decisions in West Birmingham compromises the redesign of services on a 'Midland Met' footprint resulting in **operational dysfunction** of the opening of the New Hospital.	• A programme to put in place controls is a foreseeable outcome from the GE review **<u>Actions</u>** 1. Draft problem specification document and seek to agree it with the CCG and BCC [October 2017] 2. Quantify for the Board the boundary impact of cross area and out of area patients [October 2017]	1. We continue to work to shape a shared approach to western Birmingham. Good progress has been made with positioning WB in both STP geographies and with ensuring that a locality approach can be taken in the area. BCC recognize and accept the diversity needed if the city is to progress and this intent is captured in the CQC action plan as well. 2. This remains incomplete and awaits the action of the CCG. We will use the weekly ICS board to address this action during June.	**As per progress reported** **As per progress reported**	**Q4** **Q4**	**G** **R**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
DC	BAF12	Q&S	R&D Plan	There is a risk that we are unable to achieve our qualitative and quantitative goals for research because we **do not broaden the specialties that are research active**, principally because we are unable to recruit personnel with the time and inclination for research.	• No explicit recruitment strategy for clinicians with a research interest **<u>Actions</u>** 1. Identify at least two new research active specialties for each year of the R&D plan – CCS and T&O year 2. Manage the growth of R&D activity through group PMO R&D Plans 3. Have an active medical recruitment strategy that favors new consultants with a research interest and track record.	1. Critical Care – REST study opened in June 2017 and COMPRESS-RCT study opened in September 2017. Orthopaedics – DRAFFT2: Distal Radius Acute Fracture Fixation Trial open mid October 2017 2. R&D plan is managed through Group PMO and monthly progress report on complete plan is shown on Exec PMO wall. 3. As part of the AAC recruitment process a university representative is invited onto the interview panel for recruitment. Research and teaching subjects are both covered in the questions as part of this process. Proposals for increasing time at QIHD meetings to promote research activity amongst wider team being explored.	**As per progress reported.** **Recruitment to studies reached targets for 17/18 and monitored monthly.** **When University Rep not available, these topic areas are covered by the MD who has an educational and research background.**	- - -	G G G

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
TL	**BAF13**	**Public Health, Community Develop-ment & Equality Committee**	**Public Health Plan**	There is a risk that **we do not deliver improved mental health** and wellbeing across our workforce because our interventions do not work or are poorly targeted, or because the drivers of ill health grow through organisational and societal change and churn.	• Levels of sickness owing to MH are not reducing, strengthened actions required. • Current research registrar looking for enhanced best practice. **<u>Actions</u>** 1. Complete best practice review led by the Occupational Health Department 2. Develop annual mental well-being employee assessment proposal for pilot consideration	1. A plan has been agreed by the Board, which includes an assessment model now as a pilot. This will be complete by the end of July. 2. The OD team have developed an action plan, whose implementation will be closely tracked during Q1 and Q2.	**We have completed the actions listed but are not yet in a place where there is a feeling of concerted effort or a new approach. This will need to change in June and July as we look to reduce sickness towards 3%.**	**Q4**	**A**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
TL	**BAF14**		**2020 Vision**	There is a risk that the integrated care model preferred by SWBH is not consistent with wider regional NHS plans resulting in new organisational forms being developed in **competition** with the Trust.	• A programme to put in place controls is a foreseeable outcome from the GE review **<u>Actions</u>** 1. Present a paper to the November Trust Board outlining organizational form options for each district	1. Strong progress has been made with the BC STP ACS, which will be subject to a development workshop on February 9th and should be completed before the end of March. A similar timescale is the ambition for the SWB ACS and an initial event to co design a solution took place on January 20th. The CCG remains focused on an alliance model. The Trust continues to develop bilateral partnering agreements in support of a wider integration strategy.	**As per progress reported.**	**Q4**	**A**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
RB	BAF15		2020 Vision	There is a risk that difficulties in recruiting and retaining local GPs leads to unwarranted variation in patterns of care resulting in **excess secondary care demand**.	• Absence of a preferred Trust or agreed system approach to non-PBR controls **Actions** 1. Establish new leadership posts to increase external facing leadership capacity to work on primary care relations and workforce plan - including Primary Care leadership in PCCT (2018)and the Director of Innovation and Partnership [Q2 2017]	1. Failed to recruit to Director of Operations and Group Director posts. Appointed Director of Nursing and Director of Therapies. Head hunters engaged to support recruitment search.	**Partial success in recruitment but gaps are a risk in Q2. Head hunters supporting recruitment search.**	**Revised to Q4**	**R**
					2. Work with Primary Care leads in CCG to establish a joint workforce plan to support retainment and recruitment of GPs [Q4 2017]	2. There has been a delay in establishing CCG scaled workforce group. Locality based work likely to be more productive.	**Work with partner primary care organisations to establish workforce needs and plans in 2018.**	**Revised to Q1**	**R**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
					3. Establish new model of care and contracting on an integrated and risk shared basis with primary care providers [Q1 2018]	3. New partnerships established directly with primary care underpinend by memorandums of understanding.	**Referrals and follow up activity redistributed between secondary and primary care with partner organisations.**	**Q1**	**G**
					4. Ensure effective referral management processes in place [Q4 2017]	4. Electronic referral implementation completed.	**This will mature partnerships in 2018 and be evaluated quarterly.ICS development to be fully scoped and implemented.**	**Q4**	**G**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	2017/18 Year End Summary	Deadline	Status
TL	**BAF16**		**2020 Vision**	Collapse in local care home provision arising from commercial pressures and immigration policy increases SWBH admissions and reduces patterns of discharge creating **pressure on acute hospital beds.**	• Analysis of current care provision against learning from care home Vanguards **<u>Actions</u>** 1. Develop care home network proposal for a future Trust Board meeting. 2. Brief the Trust Board in October on Better Care Fund submission [October 2017]	Considerable work has gone into creating a proposal to support care home provision in Tipton, which may be scaleable beyond there. This could form part of a BCF proposition, or may be 'folded' into the cooperative working agreement. We will bring the proposal back to the Board in July.	**As per progress reported.**	**Q4**	**A**

Status				
G		Action completed		
A		Action on track to be delivered by the agreed date		
R		Action off track and revised date set		

May 2018 V5

Paper ref:	TB (06/18) 023

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Integrated Quality & Performance Report (IQPR) April 2018		
Sponsoring Executive	Dave Baker, Director of Partnerships and Innovation		
Report Author	Yasmina Gainer, Head of Performance & Costing		
Meeting	Public Board	**Date**	7th June 2018

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

1) Volume of successes across the breadth of the IQPR and further significant successes in Persistent Reds.

2) Specific under-performance in Diagnostics; HSMR/RAMI; 28 day breaches.

3) New indicators this month; measuring notice period for patients less than 3 weeks for outpatient and inpatient appointments.

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

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

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

OMC, PMC, CLE

4. Recommendation(s)

The Board is asked to:

a.	Note April performance and risks identified to Diagnostics
b.	Confirm that assurance on mortality indicators improvements has been provided
c.	Note progress on IQPR persistent reds

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	

Points of Note from IQPR and Persistent Reds

April 2018 - Summary

1) Overall Performance

The Trust continues to perform across many indicators some risk identified below in item 2; improvements and focus are evident in several other areas including the 'persistent reds' action plan; early notification of a maternal death in May.

2) Specific under-performance likely to continue in the short term:

a) Cancer performance signals pressure for May and June 62-day target, but no risk is perceived in respect of the Q1 2018-19 delivery;

b) Diagnostic performance (DM01) second month running below target, recovery in June;

c) HSMR and RAMI weekend mortality indicators are highlighting the trust as an outlier;

d) whilst elective cancellations show a significant improvement in-month there have been two 28 day breaches.

3) Performance Targets 2018-19 :

- A&E performance trajectory has been signed off with NHSI and NHSE.
- CDIff annual target has been revised down from 30 to 29 per annum.
- All other national performance standards remain consistent to last year.
- CCG may signal local level changes as part of signing off the final 2018-19 contract.
- Internal IQPR thresholds are due for their annual review, which is planned to take place at the PMC where standards will be confirmed or revised

4) IQPR Persistent Red Indicators

IQPR Persistent Red indicators are progressing with focus on '12x resolve items. One indicator resolved in April (A&E unplanned re-attendances reduced to 4.6% from 7.9% in February and over-achieved the standard of 5%). We will now try to hold this for 3 months before considering removing it from persistent red reporting.

Several others are showing significant improvement from even last month such as elective cancellations down from 1.7% to 0.9%, only 0.1% to go; and looking forward to May we know that the treatment functions underperforming for RTT will drop from 4 to 3 with Oral Surgery beginning to perform in May to the 92%. Neutropenic Sepsis continues to improve and the improvement may be greater as one of the breaches may be validated out meaning the performance is ~95%. Open referrals is the only persistent red that seems to be trending in the wrong direction.

Trajectories are being pulled together for all the persistent reds 'resolve' items and 'resolve by' dates have been provided as we can see in the table on page 8.

5) New Indicators

The IQPR incorporates a couple of new indicators this month; measuring 'appointment offers to patients with less than 3 weeks'; it should be noted that at this stage these are only top level KPIs; the next step is deep-dive into the more granular parts of this data set to tease out the real 'poor offers' from 'agreed offers' under 3 weeks; the latter mostly resulting from patient cancellations being filled by patients who agreed to be brought forward whereby the trust has been good at managing its capacity fill rates. A report highlighting deep-dive will be presented to OMC in June.

Key IQPR Indicators Summary for April 2018-19 (month 1):

Infection Control :

- □ A robust performance continuous throughout April all IQPR indicators delivering to or above required standards.
- □ The Trust has had 2xCDiff cases in April vs a 2.0 target; full year target is set at 29 cases (last year 30)
- □ There were no MRSA cases full year and MRSA screening, electively and non-electively, over-achieves targets in April, other than Medicine & EC.

Harm Free Care :

- □ Safety Thermometer at 93.1% in April against the standard of 95%; continues to marginally under-deliver to standard. Falls and Pressure Ulcers (PUs) are a major contributor to this indicator.
- □ In April there were 9x PUs in the acute setting; 7x at grade 2 and 2x grade 3; additionally there were 4x cases in community setting. PUs are monitored via the Safety Plan dashboards.
- □ In April we have seen a lower level of falls compared to March, however, still increased to long term average levels; x97 falls (x112 last month) which resulted in 2x serious injury. Falls are monitored via the Safety Plan dashboards.
- □ VTE assessments continue to hit targets and in April the trust delivered 95.5% of assessments, missing 323. Missed assessments being monitored via the Safety Plan.
- □ WHO Safer Surgery compliance is stubborn in certain areas delivering however a steady, small improvement month on month with 99.3% in April, performance under-delivery will continue to be actively monitored and addressed with a data quality review being progressed over the next week. Recovery to standard projected for June.

Access Targets :

1 RTT

- RTT incomplete achieves 92.5% standard in April and routinely delivers the incomplete standard for the last 13 months,
- The Trust has seen its waiting list increased to around 31, 387 patients in April with 2,354 patients on the backlog (>18 weeks wait time).
- 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 April .
- Acute Diagnostics (DM01) has failed to deliver the 99% in April and is expected to recover in June. April performance at 97.16% with 243 breaches; challenged mainly in Cardiac CT diagnostics. Improvement plan has been put in place; this establishes demand and capacity profiles for the moderate term, aligns cardiology and radiology rotas with strengthened scheduling. The DCOO for Planned Care will oversee delivery. The moderate to longer term growth / demand will be reviewed by the COO in July to ensure sustained recovery.

2 Cancer

- Recognised as a delivering Trust; meeting routinely most of the cancer standards. The Trust completes Q4 2017-18 and achieved performance across the full year having met each of the cancer standards.
- April 62 day standard confirmed as delivering 87.5% but risks to May & June 62- day target delivery have been identified and are being managed
- Neutropenic sepsis continuous to improve with only 3 patients breaching in April (3/36) therefore patients treated at 92%. Actions continue with RCAs for each breach. Significant improvement to previous years and especially year on year aiming to achieve the full 100% compliance by August 18.
- Inter-Provider Transfers - deliver only 55% of tertiary referrals within the 38 days requirement in March. The day 38 target has now become live nationally from 1st April 18 and is being monitored. Primary focus on meeting the 38 day target needs to be on diagnostic services in improving current wait times. Our local improvement focus is on Straight-to-Test pathways in colorectal service and other specialties, which have reduced waits for tests and 1st OPD. A trajectory will be reported and overseen through OMC.

3 A&E

- April performance at 83.92% achieving trajectory agreed with NHSi of 82.7%;
- Trajectory agreed with NHSi to get to 95% in March 2019. Sandwell performance is mainly challenged.
- 2,745 breaches of the 4 hour target were experienced in April
- Patient bed moves for non-clinical reasons reduced further in April to 45.

- □ May performance as at 29th May at ~80.14% vs NHSi trajectory of 84%. There are significant challenges with A&E at present across both sites which suggest that the May performance may be indicative of future months without some intervention. Key Issues are twofold:
    - Workforce challenges - A gap of ~ 4.3 Consultant staff (13.7 versus establishment of 18). There is a further gap of ~7 specialist doctors. These shortages create further pressures on the team and how they work;
    - Despite attendance activity being down, admission activity is up, which supports the view that the acuity of the attendees is increasing;

In response to this the Trust is planning to:

1. Work on admission reduction initiatives;
2. Focus on retention and recruitment issues.

We are working closely with NHSI on this.

- □ Fractured Neck of Femur Best Practice Tariff delivery for March is at 80.7% (85%) just below the 85% target in the month. The performance continuous to be inconsistent month on month.
- ☐ Emergency Care Patient Impact - Unplanned Re-attendance Rate improves to 4.6% vs 5% target and previous under-performance. One of persistent reds, which has now over-achieved the target.

Obstetrics:

- □ C Sections in April slightly above target at 26.9% vs target of 25%; in April we observe increase in the number of elective patients normally, but this is governed by clinical guidance.
- □ Breastfeeding in April 75.9% against the target of 74%.
- □ Early notification of a maternal death in the beginning of May.

Stroke & Cardiology:

- □ At this stage in the month the IQPR reports the post-validated WD20 position
- □ All IQPR indicators generally deliver to standard or above for these services.
- □ Thrombolysis within the hour is affected by clinical reasons and some operational processes, which are RCAed routinely and managed. April performance, however, is at 100% which means all patients eligible for thrombolysis have received timely treatment.
- □ Admissions to Stroke Ward within 4 hours remain inconsistent; in April the performance is 67.3% vs the standard of 80%. This can be the result of several different factors, one of such is multiple stroke patients at the same time. But when on the ward, patients do spend more than 90% of their stay there (91.5% of patients in April spend more than 90% of their stay on the stroke ward).
- □ TIA (High Risk) Treatment <24 Hours from receipt of referral is 100% at April vs target of 70%
- □ TIA (Low Risk) Treatment <7 days from receipt of referral is at 96.2% in April vs target of 75%.

- For April Primary Angioplasty Door to balloon time (<90 minutes) is meeting the target of 80% at 92%. Primary Angioplasty Call to balloon time (<150 minutes) at 85.7% vs 80% target.

Workforce :

- Mandatory Training - showing significant improvement
- Mandatory Training at the end of April is at 91.1% overall against target of 95%;
- Health & Safety related training is above the 95% target at 95.2% in April and achieving standard for the first time in 9 months, an excellent achievement.
- PDR completion approach has changed to quarterly delivery, this follows that this indicator will report in June (and subsequent quarters), the target remains at 100%.
- Sickness rate in-month is at a reduced level of 4.14% following mainly a reduction in short term sickness cases (at 688 in April), long term sickness cases remain fairly static at 226.
- RTW at 84.1% in April, an improvement to last month, with more work to be done to achieve the standard, which is currently at 100%, but being reviewed.
- The Trust annualised turnover rate is at 14.3% [14.2%] in April slightly increasing to previous months,
- The Trust Nursing turnover target has been confirmed at 10.7% and as at April reporting at 13.7% (13.5%); we will aim to narrow down the nursing turnover indicator to show only 'qualified nursing' and will report from May onwards.

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 last year, consistently below set targets. Impacted by winter pressures and resulting cancellations, bed capacity but also sickness.
- In April we see a large improvement and although early days we are hopeful that this will be sustained.
- Cancellations on the day amounted to 30 (rough target of 27) of which 3 were avoidable (10%).
- These 30 late cancellations in April represent 0.9% of our elective admissions vs the 0.8% target.
- There were two 28 Day breaches in month, both occurred in T&O.
- Theatre in-session utilisation is consistently below target of 85%; 73.2% in month of April
- Overall session utilisation (outside routine session timings) for April is at 78.3%
- Intensive planned care focus aims to improve booking rates, scheduling and throughput through enhanced job planning and hence 'minutes utilisation' will improve as a result, but will always be

impacted by levels of cancellations and bed-capacity in the organisation (where patient stay is required)

- Theatre dashboards indicate 'early finishing' as a potential area of focus and opportunity; 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, this results in lower than optimal throughput/productivity in certain specialities. 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 planned to be in place for June 2018-19 and are also used to drive 'production plan' (planned care) contractual commitments.

Data Completeness:

- Open referrals are, 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 required improvements are subject to a future 'data quality flag' report which will be driven with the groups.
- The Data Quality Committee, at which there has been a request for improved group data quality leads attendance, will further drive the improvement against identified issues.

CQUINs 2017-18 :

- The funding value full year 2017/18 was £8.8m for the trust, combining national, specialised and public health schemes.
- 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 completed at the end of April2018; SWBCCG has confirmed the outcomes and we have a final delivery agreement. We still await specialised and public health feedback.

- Across the schemes, a potential loss value has been calculated at £850k, a c10% of the total annual funding value :
  - Improvement of health & wellbeing of NHS staff - improvement of 5% against 2 out of 3 specific staff survey questions did not materialise (impact £452k)
  - Sepsis screening and documentation delivered partially (impact £170k)
  - Antibiotic usage did not deliver the 1% reduction year on year mainly driven by the need to use alternative antibiotics higher in dosage (impact £170k)
  - Secondary Care Dental : Audit of Day Case Activity (impact £55k)

  - Note: the eRS CQUIN will also need confirming with the CCG. All eRS slots are not fully open which is fine providing exclusions have been confirmed as 'acceptable'. This is only a risk at this stage. We should aim to complete this agreement before Oct2018 when payment will only be received for eRS processed referrals unless agreed.

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)

Persistent Reds :

Process & Insight :

- May OMC tabled all 12 'resolve' items. Papers with forecast trajectories will be forthcoming, to allow the Performance team to build graphs showing trends against improvement target, national standard.
- Future OMC discussions will be discussing exceptions and Group Reviews will refer to persistent reds going forward.

Performance: Summary of performance up to April 2018 :

Resolve items (restore to original standard)

- Resolve items have again moved largely into the right direction in April as we observe many improvements.
- 1x indicator has reached recovery to full standard; A&E unplanned re-attendances reduce to 4.6% from 7.9% in February and over-achieve the standard of 5%. We now need to focus on sustainability.
- Other items worthy of mention in April are:
  a) elective cancellations dropping to 30 in April
  b) medical appraisal up to 87.2% from previous 81% towards the 95% target
  c) Neutropenic Sepsis continually improving, but challenged by out-of-hours A&E attendances – a number of initiatives going on to close this out including meetings with ambulance services.
- Other items showing improvement with some remaining fairly static to previous trends.

Improve items (a reduced improvement target has been agreed to build up to required standard)

- 'Improve' items total across 11 indicators which have been prioritised to improve. Agreement for improvement will be finalised at the next OMC agenda
- A number of those items are already improving.

The table below shows the <u>12x resolve prioritised</u> indicators against the April performance:

May 29, 2018

[IQPR & Persistent Reds Cover Sheet Supplement : TRUST BOARD]

	Indicator	Measure	2018-19 Year	Responsible Lead	Treatment	Actual Performance Jan-18	Feb-18	Mar-18	Apr-18	Resolve By Date
Harm Free Care	WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	David Carruthers	Resolve	98.6%	99.1%	99.4%	99.3%	Jun-18
	Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	=> No	0	Michelle Harris	Resolve	93.0%	72.0%	91.3%	91.7%	Aug-18
Cancelled Operations	Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	0.8	Tina Robinson	Resolve	1.0%	1.0%	1.7%	0.9%	?
	No. of Sitrep Declared Late Cancellations - Total	<= No	320		Resolve	40	37	59	30	?
	Weekday Theatre Utilisation (as % of scheduled)	=> %	85	Liam Kennedy	Resolve	71.2%	74.2%	71.6%	73.2%	?
Access To Emergency Care & Patient Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5	Michelle Harris	Resolve	7.7%	7.9%	5.3%	4.6%	Sustain
Workforce	PDRs - 12 month rolling	=> %	95	Raffaela Goodby	Resolve	73.9%	72.8%	81.9%		New Process to Qtrly Reporting
	Medical Appraisal	=> %	95	David Carruthers	Resolve	78.1%	79.3%	81.4%	87.2%	?
	Return to Work Interviews following Sickness Absence	=> %	100	Raffaela Goodby	Resolve	80	81	79.7%	82.6%	Target in Review
Referral to Treatment (RTT)	Patients Waiting >52 weeks	<= No	0	Liam Kennedy	Resolve	1	3	2	3	Apr-19
	Treatment Functions Underperforming (Incomplete)	<= No	0	Liam Kennedy	Resolve	4	4	4	4	Jun, Aug & Oct18
Open Referrals	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No		Liam Kennedy	Resolve	144,564	149,221	152,201	155,865	Proposal Submitted

PDRs process is now managed on a quarterly basis; this indicator therefore will report quarterly, next due in June.

Resolve items: Are required to be restored to standard

Table Showing Total Resolve & Improve Indicators :

Resolve	Improve
1. WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	1. Sickness Absence Monthly & Cumulative
2. Neutropenia Sepsis (Door to Needle Time Greater Than 1 Hour)	2. Sickness LTS & STC (cases)
3. Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	3. Mandatory Training
4. No. of Sitrep Declared Late Cancellations -Total	4. Nursing Turnover / Employee Turnover
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. Falls
10. PDRs - 12 month rolling	10. Patient Safety Thermometer - Overall Harm Free Care
11. Medical Appraisal	11. FFT Response & Score rates
12. Return to Work Interviews following Sickness Absence	

Rules are being considered, which will govern when agreed, what constitutes an addition to persistent reds and hence an increased focus, and which items will be removed from current lists. In short, there will be rules which will state the number of months in which an indicator can fail/deliver before it is added/removed.

Sandwell and West Birmingham Hospitals NHS Trust

Integrated Quality & Performance Report

Month Reported: April 2018

Reported as at: 31/05/2018

TRUST BOARD

Contents

April 2018

Infection Control

CDiff - compliant
• x2 C. Diff cases reported during the month of April vs 2.0 in month target.

• The annual target set by NHS England for 18/19 is at 29 (lower compared to last year's target of 30).

MRSA - compliant
• Nil cases of MRSA Bacteraemia were reported in April.
• Annual target 18/19 set at zero.

MRSA Screening - compliant overall, but not in all groups/directorates
• Non-elective patients screening 90.2%
• Elective patients screening 86.6.0%
• Both indicators are compliant with 80% target although not in every group.

Elective screening, whilst compliant with standard at trust level, it is still not for Medicine & EC. The Group need to take forward with Infection Control lead to ensure improvement is visible.

MSSA - not compliant
MSSA Bacteraemia (expressed per 100,000 bed days)
In April the rate is at 10.8 compared to target of 9.42 slightly higher than in previous months.

Harm Free Care

Safety thermometer - not compliant
• 93.1% reported for April;

NHS Safety Thermometer target 95%, whilst recent months saw steady improvement, we continue fail standard.

• x97 [x112] falls reported in April with x2 [x1] falls resulting in serious injury; whilst lower than last month, it still is a large step up in numbers of falls based on long term average of 77 per month.
• Annual target remains at 804 until the Chief Nurse confirms new targets;
• In month, there were 45 falls within community, 52 in acute settings.
• A new indicator will be added from May to report falls per 1,000 OBD
• 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.

• x9 [x6] avoidable, hospital acquired pressure sores reported in April of which : x7 grade 2, x2 grade 3
• x4 separate cases reported within the DN caseload.
• CNO keep in view as part of Safety Plan

• x5 [x4] serious incidents reported in April ;
• Routine collective review in place and reported to the Q&S Cttee.

• WHO Safer Surgery (Audit - brief and debrief - % lists where complete) as at April at 99.3% (99.4%) vs the 100% target. Improving last couple of months, but persistently some lists are missed. Checks of paper records indicate that all sessions have been briefed and debriefed, hence data quality in system is being checked to ensure it maps the correct records. Recovery to standard planned for June.

• No never event was reported in April
• No medication error causing serious harm in April

• x34 DOLS have been raised in April of which 34 were 7-day urgents;

VTE Assessments - compliant
• Compliance in April recovers from last month to 95.5%; performing generally to target during the last 18 months, however, in March we saw a dip in performance to 93.9%;
• 323 assessments were missed in April; being addressed through Safety Plan roll out to secure 100% compliance.

Obstetrics

C-section rate - not compliant, but no concern
• The overall Caesarean Section rate for April is 26.9% (25.6%) above the 25% target; usually the increase is mainly driven by non-elective cases, but this month we see an increase in elective patients. This indicator observers clinically driven demand, which periodically will exceed the target set.
• Elective rates are at 10% (historical long term avg trend of 8%) and non-elective rates are 16.9% in the month (slightly lower than long term avg historical performance)
• Performance considered at Q&S & Board and to be kept in view.

• Adjusted perinatal mortality rate (per 1000 births) for April 7.97 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 level of births in April is at 501, increasing to the last two months, in line with levels in the same period of last year

• Post Partum Haemorrhage (>2000ml) nil reporting in April against a target of 4

• Puerperal Sepsis for April is in line within previous levels; Audit is in progress as per CQC action plan.

• No maternal deaths were reported in April; but there was a maternal death at the beginning of May, which will be reported in next period.

Breastfeeding - compliant
• Breastfeeding initiation performance reports quarterly; April month count is at 75.9% compliant with the 74% target.

Mortality & Readmissions

Mortality - alerts against Trust HSMR & Weekend rates at Sandwell
• The Trust overall RAMI for most recent 12-mth cumulative period is 108 (available data is as at January) reporting now following the 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 126 respectively. MDO review and report to the Trust Board in April recommended an improvement plan for Sandwell site weekend mortality as this is higher than expected.
• SHMI measure which includes deaths 30-days after hospital discharge is at 110 for the month of November (latest available data).
• HSMR identifying Sandwell as an outlier, which is being progressed via the Mortality and Quality Alerts Committee.
• **RAMI New Memo:** 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.

• Deaths in Low Risk Diagnosis Groups (RAMI) - month of January is 133, higher than previous periods. This indicator measures in-month expected versus actual deaths so subject to larger month on month variations. Assurance required.
• Crude in-month mortality rate for March month is 1.4% [1.6%] slightly lower than last month and closer to 12mths avg trend (1.3); the rolling crude year to date mortality rate has increased to 1.4
• There were x143 [x142] deaths in our hospitals in the month of March; higher than last year same period which was at 100

Mortality Reviews within 42 Days - not compliant
• Mortality review rate in February at 41% 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 March
• 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 •
April indicates that 91.5% of patients are spending >90% of their time on a stroke ward, compliant with the 90% operational threshold in the month;

Admission to Acute Stroke Ward - not compliant
• April admittance to an acute stroke unit within 4 hours is at 67.3% vs national standard of 80%; impacted by a larger number of admissions at the same time.

Scans - compliant

• Pts receiving CT Scan within 24 hrs of presentation delivery in month at 98.1% [100%] meeting the 95% standard in month consistently
• Pts receiving CT Scan within 1 hr of presentation is at 73.6% in April; both indicator consistently meet performance.

Thrombolysis - compliant
Compliance at 100% in the month of April

Angioplasty - compliant • For April
Primary Angioplasty Door to balloon time (<90 minutes) is below target of 92.0% vs target of 80% .
• Primary Angioplasty Call to balloon time (<150 minutes) at 85.7% against a target of 80%. Both indicators consistently meet performance targets.

RACP - compliant
RACP performance for April at 100% [100%] exceeding the 98% target consistently

TIA Treatments - compliant
• TIA (High Risk) Treatment <24 Hours from receipt of referral delivery as at April at 100% against the target of 70%.
• TIA (Low Risk) Treatment <7 days from receipt of referral delivery at April is 96.2% against a target of 75%.
•Both indicators are consistently delivering over the required standard; SWB is not significantly being impacted by additional volumes, as yet, caused by the Walsall to Wolverhampton Stroke service transfer.

Cancer Care

Cancer standards - compliant
• Reporting always one month in arrears hence IQPR period reported is March. The Trust has delivered all targets for the full year as previously reported.
• April delivery predicted across all headline cancer targets, but May and June under some capacity pressure, which is being managed and there is no risk to Q1 delivery.
• April 62 Days target specifically is predicted at 87.5%, but as mentioned above under management for May and June

Patient Waiting times
• x5.5 patients waited longer than the 62 days at the end of March.
• 3 [x2] patients waited more than 104 days at the end of March (1 x Lung, 1 x CUP, 1 x Gynae)
• The longest individual patient waiting time for treatment as at the end of March was 280 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.
• (3/36 patients) - a 92% of patients have been treated within the hour, 8% of patients failed to receive treatment within prescribed period (less than 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
• 55% of tertiary referrals were met within 38 days requirement in March. The day 38 target has now become live from 1st April 18 with no tolerance. Straight-to-Test has commenced in colorectal service and other specialties which have moved to 10 days for 1st OPD, although this is not been consistently met. Primary focus on meeting the 38 day target needs to be on diagnostic services in improving current wait times.

Patient Experience - MSA & Complaints

MSA - compliant
• For April there were no MSA breaches reported.
• The trust continues to monitor all breaches.

Friends & Family - not compliant on responses and scores
• 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 last 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 April is 83 [97] with 2.5 [5.9] formal complaints per 1000 bed days, showing a reduction to last month to last year same period (2.9).
• 100% have been acknowledged within target timeframes (3 days)
• 12% [25%] in-month responses have been reported beyond agreed target time; escalated to DG for remedy.

Patient Experience - Cancelled Operations

Cancelled Ops - not compliant but significant improvement to last month
• 30 sitrep declared late (on day) cancelations were reported in April. A large reduction from last month of 59. Of these 3 (10%) were avoidable; all cancellations are subject to an escalation process to minimise numbers
• As a proportion of elective admissions, this represents 0.9% in April (1.7% in March), we can therefore see a massive improvement in April; 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, but dependency will be reduced on beds with the opening of the '23hr day unit'.

28 Day Breaches - not compliant
• There were 2x breach of the 28 days guarantee in April both in T&O
• No urgent cancellations took place during the month of April

Theatre Utilisation - not compliant
• Theatre in-session utilisation is consistently below target of 85%; 73.2% in month of April
• Overall session utilisation (outside session timings) for April is at 78.3%
• Intensive planned care focus aims to improve booking rates, scheduling and throughput through enhanced job planning and hence 'minutes utilisation' will improve as a result, but will always be impacted by levels of cancellations and bed-capacity in the organisation (where patient stay is required)
• Theatre dashboards indicate 'early finishing' as a potential area of focus and opportunity; 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/productivity in certain specialities.

Emergency Care

ED 4hr standard - compliant to agreed NHSI trajectory
• The Trust's performance against the 4-hour ED wait target in April at 83.92% [79.9%] hence delivering against the NHSI agreed trajectory of 82.7% but below 95% national target;
• 2,745 (3,582) breaches were incurred in April
• The Trust agreed with NHSI an improvement trajectory which aims to deliver 95% performance in March 2019

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 173 (196) in April.
• x6 [x21] cases were > 60 minutes delayed handovers in April; the Trust performs generally very well in this category with only 71 breaches last year where delay was > 60 mins

• Handovers >60mins (against all conveyances) are therefore 0.14% (6 cases)in April against total WMAS conveyances which were 4,308 in the month. The target is only 0.02% .

Fractured NOF - not compliant
• Fractured Neck of Femur Best Practice Tariff delivery for March is at 80.7% (85%) just below the 85% target in the month.
• The performance continuous to be inconsistent month on month

Bed moves after 10pm not compliant:
• There were 43 (75) reported bed moves in April 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

Referral To Treatment

RTT - incomplete pathway - compliant, but validation continuous
• RTT incomplete pathway for April at 92.5% against the national target of 92.0%;
• 4 specialities are below the 92% standard in April on the incomplete pathway, but Oral Surgery on track to achieve standard in May. Remaining improvement planned for : Cardiology, T&O and Plastics with full recovery of all specialities expected by Oct2018

52 Week Breaches - not compliant •
There is 2x 52 week breaches in April on the incomplete pathway;

Acute diagnostic waits - not compliant • Diagnostic
(DM01) performance for April is below standard of 99% at 97.15%; • 243
breaches were incurred mainly in Cardiac CT improvement plans will be in place to address this particular issue of co-aligning rotas
• Performance not expected to improve until June

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 with the Group DQ Leads •
Additionally, data quality issues are to be embedded in Group Reviews to allow for more awareness

Open Referrals - not compliant
• Open Referrals, referring to patients in the system without a future waiting list activity, stand at 155,000 as at April 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 155,000 total), are subject to auto-closures since Jan2016 and follow a set protocol.
• <u>The recommendations to COO include</u>: 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 - new organisational process is to measure PDR delivery quarterly. The next reporting will be due in June.

Sickness & Return to Work - not compliant
• In-month sickness for April is at 4.14% ; the cumulative sickness rate is 4.47% [4.48%].
• The number of short term sickness in the month reported at 688 [818] cases; long term 226 [226] cases;
• Return to Work in month is up to 84.1% [82.1%] below the 100% current target (target being reviewed for acceptable tolerance)

Turnover rate - not compliant • The
Trust annualised turnover rate is at 14.3% [14.2%] in April slightly increasing to previous months,
• The Trust Nursing turnover target has been confirmed at 10.7% and as at April reporting at 13.7% (13.5%) - the Chief Nurse has requested for this indicator to reflect only 'qualified nursing' and this will be reporting from May

Mandatory Training - showing significant improvement
• Mandatory Training at the end of April is at 91.1% overall against target of 95%;
• Health & Safety related training is above the 95% target at 95.2% in April and achieving standard for the first time in 9 months, an excellent achievement.

CQUINs & Local Quality Requirements 2017/18

CQUINs : Full Year Agreed Position
• The funding value full year 2017/18 was £8.8m.
• The trust has submitted the final delivery results for Q4 at the end of April and the CCG has now fed back on the national schemes.
• The risks identified have materialised to £850k
• Under-Achievement 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 not achieved the 1% reduction year on year (170),
4) Secondary Care Dental : Audit of Day Case Activity (£55k)
Note: 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 at this stage, however we should aim to complete this agreement before Oct2018 when payment will only be received for eRS processed referrals unless agreed

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 for community dementia and falls assessments) in place at this stage demonstrating a good management of performance issues and responsiveness during the year. We have pre-agreed the LQRs for 2018-19 but awaiting formal contract sign off where this is incorporated in the appropriate schedules.

Operational Efficiency

• A new addition to the IQPR, this is the first month of reporting with two new indicators measuring 'patients notification time 'Routine Outpatient Appointments with Short Notice(<3Wks) and Inpatient Offer to Appointment (<3wks)
• worth noting that at this stage these are top level KPIs; the next steps are a deep-dive into the more granular parts of this data set to tease out the real 'poor offers' from 'agreed offers' under 3 weeks which would have resulted from patient cancellations being filled by patients who agreed to be brought forward whereby the trust has been good at managing its capacity fill rates. A report highlighting deep-dive will be presented to OMC in June.

Summary Scorecard - April (In-Month)

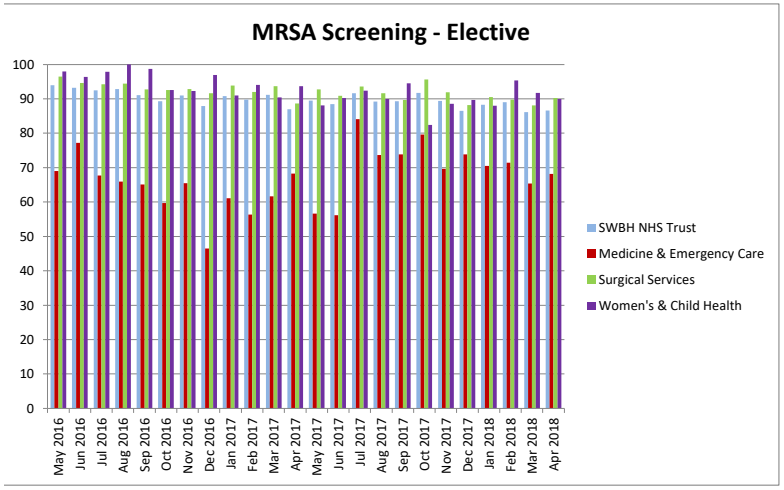
Summary Scorecard

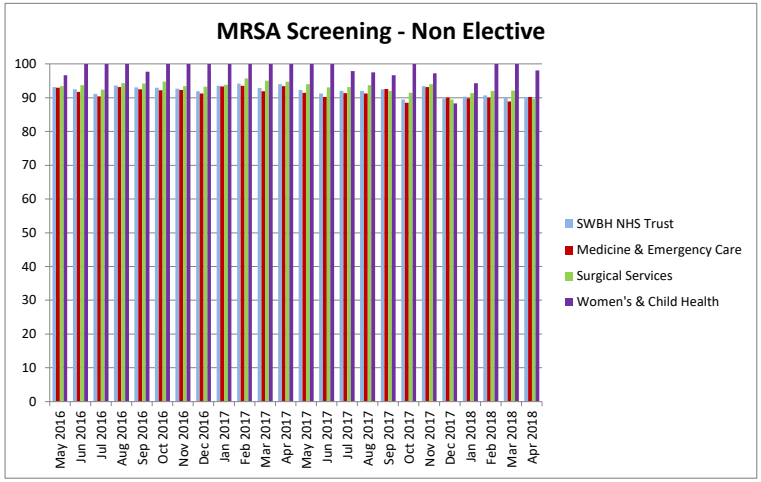
Section	Red Rated	Green Rated	None	Total
Infection Control	1	5	0	**6**
Harm Free Care	10	4	11	**25**
Obstetrics	3	6	5	**14**
Mortality and Readmissions	1	1	11	**13**
Stroke and Cardiology	3	8	0	**11**
Cancer	0	10	5	**15**
FFT, MSA, Complaints	13	2	9	**24**
Cancellations	5	4	0	**9**
Emergency Care & Patient Flow	8	7	5	**20**
RTT	7	1	6	**14**
Data Completeness	1	9	9	**19**
Workforce	8	2	10	**20**
Temporary Workforce	0	0	28	**28**
SQPR	10	0	8	**18**
Operational Efficency	0	0	2	**2**
Total	**70**	**59**	**109**	**238**

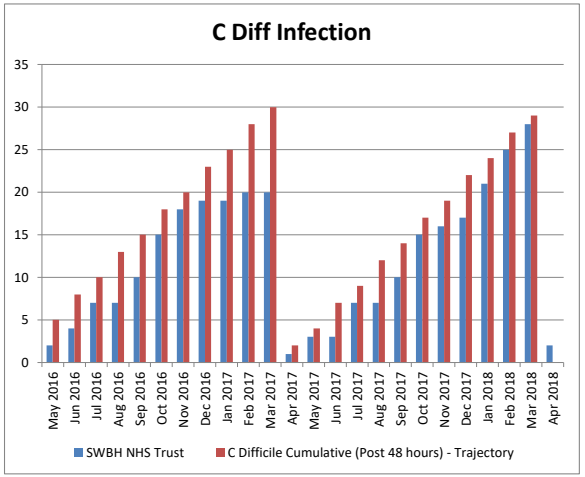
• Persistently red-rated performance (>12months) indicators (39 out of the above 70) are subject to performance improvement and monitoring; priorities for improvements have been re-confirmed at OMC as not all indicators carry the same level of significance. Indicators agreed to be 'resolved' (restore to original standard) are overseen by OMC.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Nov 2016) N D J F M A M J J A S O N D J F M A	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
4			C. Difficile	<= No	29	2.5		Apr 2018	0	1	0			1		2	2	
4			MRSA Bacteraemia	<= No	0	0		Apr 2018	0	0	0			0		0	0	
4			MSSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9.42		Apr 2018								10.8	10.8	
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	94.9	94.9		Apr 2018								10.8	10.8	
3			MRSA Screening - Elective	=> %	80	80		Apr 2018	68.2	90.3	89.9			10		86.6	86.6	
3			MRSA Screening - Non Elective	=> %	80	80		Apr 2018	90.2	89.7	98.1			100		90.2	90.2	

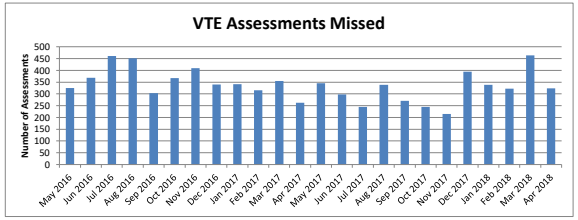


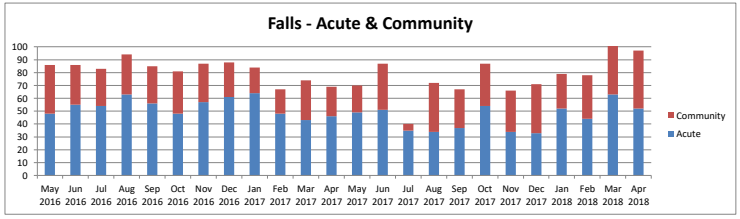


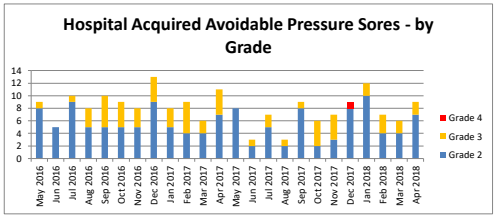


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2016) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	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																			Apr 2018								93.1	93.1	
8		d	Patient Safety Thermometer - Catheters & UTIs	%			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	5.00	Apr 2018								0.42	0.42	
			Number of DOLS raised	No			25	22	15	14	23	15	14	6	27	22	20	48	31	19	36	30	27	34	Apr 2018	16	11	0	-	-	7		34	34	
			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	34	Apr 2018	16	11	0	-	-	7		34	34	
			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	2	Apr 2018	1	1	0	-	-	0		2	2	
			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	4	Apr 2018	2	0	0	-	-	2		4	4	
			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	4	Apr 2018	3	1	0	-	-	0		4	4	
			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	0	Apr 2018	0	0	0	-	-	0		0	0	
			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	0	Apr 2018	0	0	0	-	-	0		0	0	
8			Falls	<= No	804	67	87	88	84	67	74	69	70	87	85	72	67	87	66	71	79	78	112	97	Apr 2018	35	16	0	1	0	45	0	97	97	
9			Falls with a serious injury	<= No	0	0	2	3	3	1	2	1	1	1	1	3	2	3	1	0	0	0	1	2	Apr 2018	0	0	0		0	2	0	2	2	
8			Grade 2,3 or 4 Pressure Ulcers (Hospital Aquired Avoidable)	<= No	0	0	8	13	8	9	6	11	8	3	7	3	9	6	7	9	12	7	6	9	Apr 2018	4	3	0			2		9	9	
			Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload Acquired)	<= No	0	0	2	5	6	8	6	5	8	4	7	4	3	6	4	4	2	4	4	4	Apr 2018						4		4	4	
3		d	Venous Thromboembolism (VTE) Assessments	=> %	95	95																			Apr 2018	94.2	97.1	93.1					95.5	95.5	
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	100	100																			Apr 2018	100.0	98.8	100.0		100.0			99.3	99.3	
3			WHO Safer Surgery - brief (% lists where complete)	=> %	100	100																			Apr 2018	100	98	96		100			98.8	98.8	
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	100																			Apr 2018	99	98	96		100			98.6	98.6	
9		d	Never Events	<= No	0	0	1	0	0	1	0	0	1	1	0	1	0	0	0	0	0	0	0	0	Apr 2018	0	0	0	0	0	0		0	0	
9		d	Medication Errors causing serious harm	<= No	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	Apr 2018	0	0	0	-	0	0		0	0	
9		d	Serious Incidents	<= No	0	0	5	10	5	6	5	4	4	3	1	8	5	4	6	4	3	5	4	5	Apr 2018	2	0	1	0	0	2	0	5	5	
9			Open Central Alert System (CAS) Alerts	<= No			10	8	6	5	4	8	9	27	3	3	8	10	6	5	7	6	5	8	Apr 2018								8	8	
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	No	0	0	1	2	0	1	0	0	0	1	1	1	0	0	1	1	2	2	2	2	Apr 2018								2	2	
			Safety Plan - Input Non-Compliant Days	<= No		<=3 Per Ward	-	-	-	-	-	-	-	-	-	-	-	221	-	-	-	64	-	-	Feb 2018								64	2021	
			Safety Plan - Checks Compliant	%	98	98	-	-	-	-	-	-	-	-	-	-	-	99.0	-	-	-	99.4	-	-	Feb 2018								99.43	98.70	
			Safety Plan - Missed Checks	=> No		<=3 Per Ward	-	-	-	-	-	-	-	-	-	-	-	288	-	-	-	38	-	-	Feb 2018								38	6808	

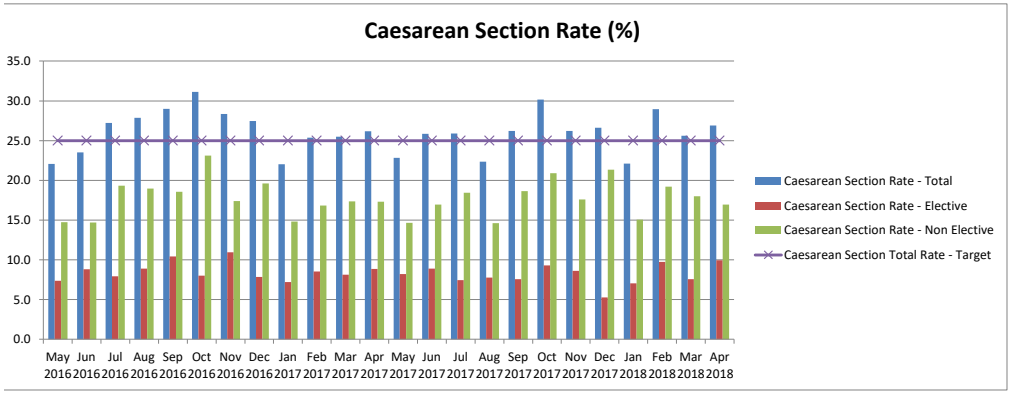


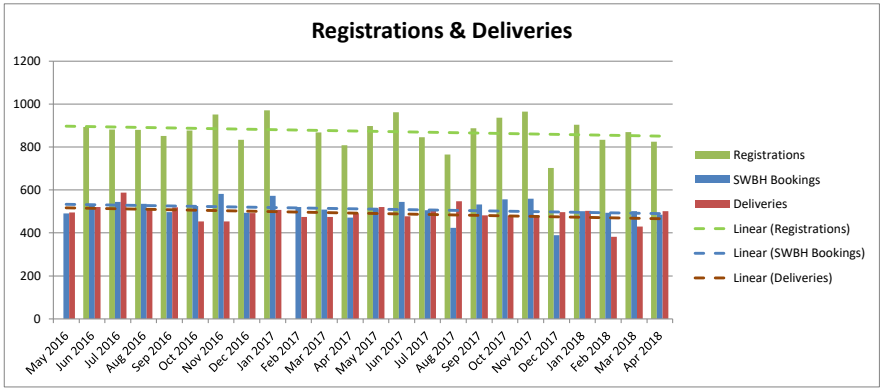




Patient Safety - Obstetrics

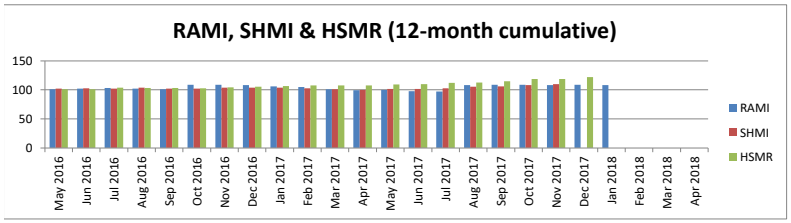
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory 2016-2017 Year	Trajectory 2016-2017 Month	Previous Months Trend (since Nov 2016) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Month	Year To Date	Trend
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			Apr 2018	26.9	26.9	
3		•	Caesarean Section Rate - Elective	<= %			11	8	7	9	8	9	8	9	7	8	8	9	9	5	7	10	8	10	Apr 2018	10.0	10.0	
3		•	Caesarean Section Rate - Non Elective	<= %			17	20	15	17	17	17	15	17	18	15	19	21	18	21	15	19	18	17	Apr 2018	16.9	16.9	
2		•d	Maternal Deaths	<= No	0	0																			Apr 2018	0	0	
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Apr 2018	0	0	
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																			Apr 2018	1.20	1.20	
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Apr 2018	7.97	7.97	
12			Stillbirth Rate (Corrected) (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	2.11	2.10	4.02	1.99	2.58	4.66	5.98	Apr 2018	5.98	5.98	
12			Neonatal Death Rate (Corrected) (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	4.22	2.10	0.00	0.00	2.58	0.00	1.99	Apr 2018	1.99	1.99	
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	85.0	85.0																			Apr 2018	90.2	90.2	
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																			Apr 2018	125.2	125.2	
2			Breast Feeding Initiation (Quarterly)	=> %	74.0	74.0	-->		-->	-->		-->	-->		-->	-->									Apr 2018	75.91	75.91	
2		•	Puerperal Sepsis and other puerperal infections (variation 1 - ICD10 O85 or O86) (%) -	<= %			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	0.8	Apr 2018	0.84	0.84	
2		•	Puerperal Sepsis and other puerperal infections (variation 2 - ICD10 O85 or O86 Not O864) (%)	<= %			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	0.8	Apr 2018	0.84	0.84	
2		•	Puerperal Sepsis and other puerperal infections (variation 3 - ICD10 O85) (%)	<= %			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	0.3	Apr 2018	0.28	0.28	

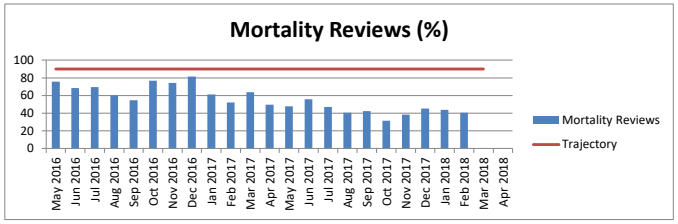


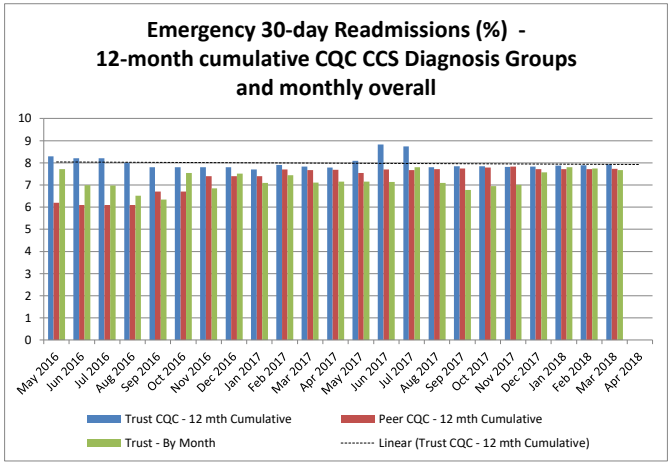


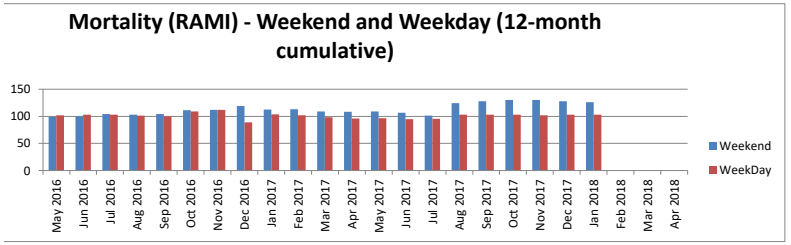
Clinical Effectiveness - Mortality & Readmissions

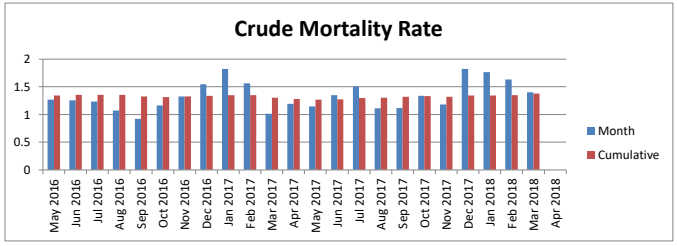
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2016) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	109	108	106	105	101	99	100	98	97	108	109	109	108	109	108	-	-	-	Jan 2018									1046	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	112	89	104	102	98	96	97	95	95	103	103	103	102	103	103	-	-	-	Jan 2018									1000	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	112	119	112	113	109	109	109	106	101	124	128	130	130	128	126	-	-	-	Jan 2018									1191	
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	104	104	104	103	101	100	102	102	103	106	106	108	110	-	-	-	-	-	Nov 2017									836	
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			105	106	107	108	108	107	109	110	112	113	115	118	119	122	-	-	-	-	Dec 2017									1025.2	
5		C	Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	139	84	105	72	88	62	61	78	78	71	144	62	120	90	133	-	-	-	Jan 2018								133		
3			Mortality Reviews within 42 working days	=> %	90	90																-	-		Feb 2018	39	58	0			0		41	44	
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			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	1.4	-	Mar 2018								1.40		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			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	1.4	-	Mar 2018									1.32	
			Deaths in the Trust	No			129	143	172	139	100	105	113	129	142	109	109	133	119	169	178	142	143	-	Mar 2018								143	1591	
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			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	7.7	-	Mar 2018								7.67		
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			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	7.3	-	Mar 2018									7.32	
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			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	7.9	-	Mar 2018	-	-	-			-			7.93	





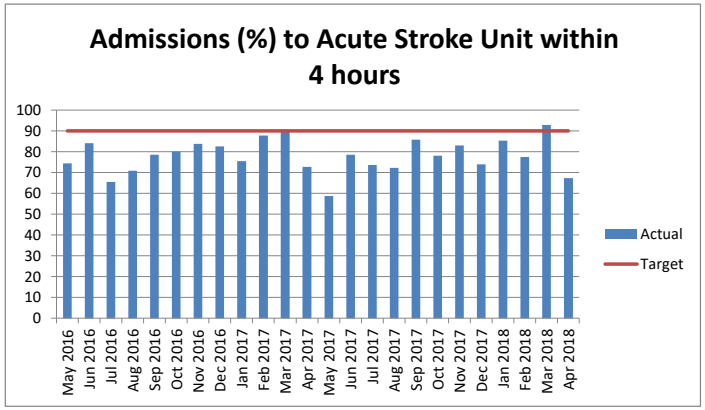


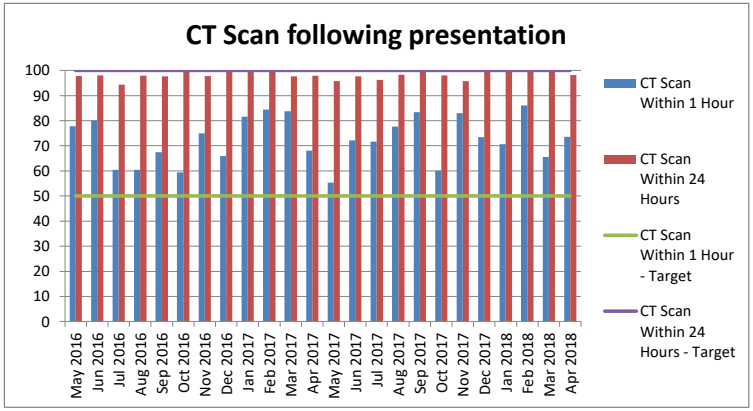


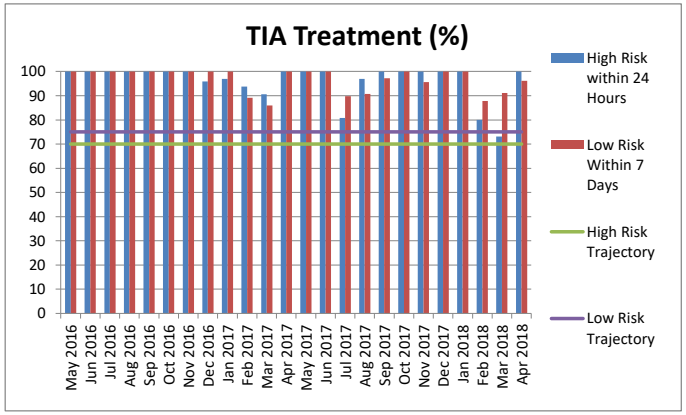


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Nov 2016) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Month	Year To Date	Trend
3			20WD: Pts spending >90% stay on Acute Stroke Unit	=> %	90.0	90.0																			Apr 2018	91.5	91.5	
3			20WD: Pts admitted to Acute Stroke Unit within 4 hrs	=> %	80.0	80.0																			Apr 2018	67.3	67.3	
3			20WD: Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0																			Apr 2018	73.6	73.6	
3			20WD: Pts receiving CT Scan within 24 hrs of presentation	=> %	95.0	95.0																			Apr 2018	98.1	98.1	
3			20WD: Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			Apr 2018	100.0	100.0	
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0																			Apr 2018	100.0	100.0	
3			20WD: TIA (High Risk) Treatment <24 Hours from receipt of referral	=> %	70.0	70.0																			Apr 2018	100.0	100.0	
3			20WD: TIA (Low Risk) Treatment <7 days from receipt of referral	=> %	75.0	75.0																			Apr 2018	96.2	96.2	
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0																			Apr 2018	92.0	92.0	
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0																			Apr 2018	85.7	85.7	
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0																			Apr 2018	100.0	100.0	



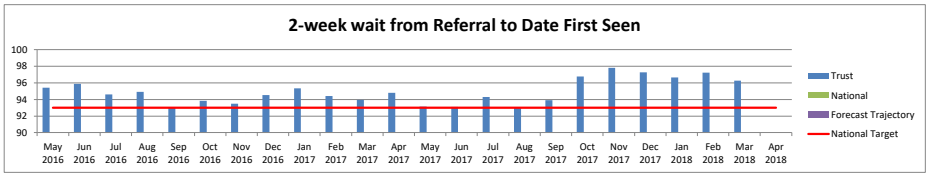


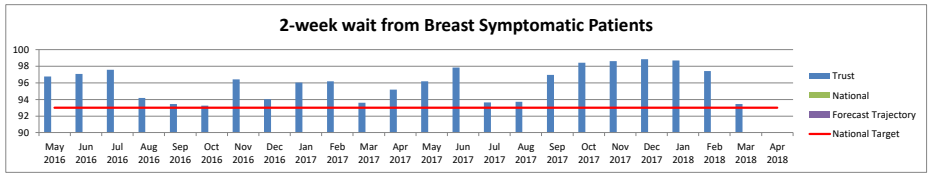


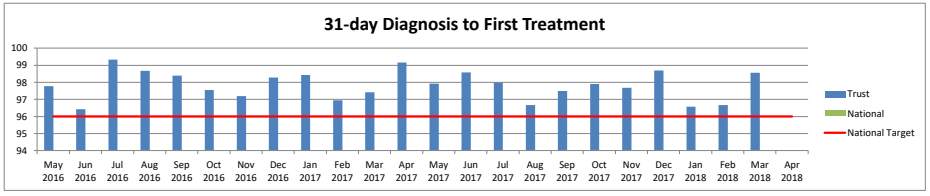
The stroke indicators in the IPR are based on 'patient arrivals' not 'patient discharged' as this monitors pathway performance rather than actual outcomes which may / may not change on discharge.
National SSNAP is based on 'patient discharge' which is more appropriate for outcomes based reporting.
Both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

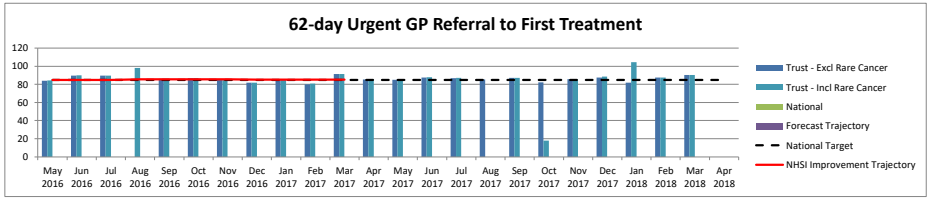
Clinical Effectiveness - Cancer Care

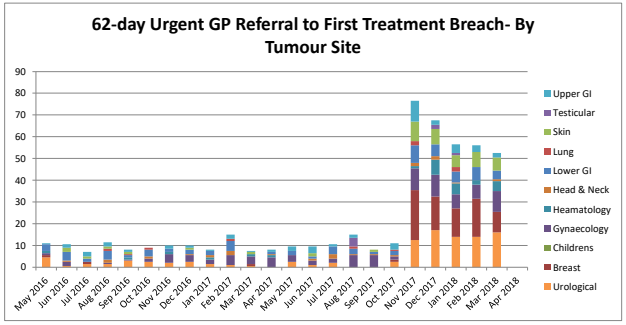
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2016) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
1			2 weeks	=> %	93.0	93.0																			Mar 2018	96.6	95.5	98.7			0.0		96.2	95.3	
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																			Mar 2018		-						93.5	96.5	
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																			Mar 2018	100.0	97.5	100.0			0.0		98.6	97.8	
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0																			Mar 2018								95.5	97.0	
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																			Mar 2018								100.0	100.0	
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																			Mar 2018								-	0.0	
1			62 Day (urgent GP referral to treatment) Excluding Rare Cancer	=> %	85.0	85.0																			Mar 2018	92.6	89.7	95.0			0.0		90.5	86.2	
1			62 Day (urgent GP referral to treatment) Including Rare Cancer	=> %	85.0	85.0																			Mar 2018	92.6	89.7	95.0			0.0		90.5	81.4	
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																			Mar 2018	0.0	100.0	0.0			0.0		100.0	97.1	
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																			Mar 2018	88.9	100.0	100.0			0.0		93.8	91.1	
1			Cancer - Patients Waiting over 62 days	No			11	10	8	15	8	8	10	10	11	11	9	11	12	9	13	9	6	-	Mar 2018	1.0	3.5	1.0			0.0		5.5	116.0	
1			Cancer - Patients Waiting over 104 days	No			2	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	3.0	-	Mar 2018	1.0	0.0	2.0			0.0		3.0	32.5	
1			Cancer - Longest Waiter in days	No			77	107	120	150	162	140	139	106	102	184	141	125	173	104	102	113	280	-	Mar 2018	280	90	133			0		280		
1			Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	=> No	0.0	0.0	12	19	17	8	6	11	6	4	10	3	7	8	7	7	3	9	4	3	Apr 2018	3	0	0			0		3	3	
			IPT Referrals - Within 38 Days Of GP Referral for 62 day cancer pathway	%			0	0	33	0	50	0	0	0	25	25	67	0	20	0	54	0	55	-	Mar 2018	-	-	-			-		55	25	

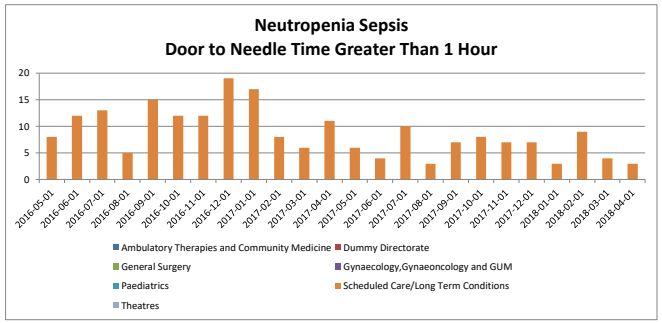


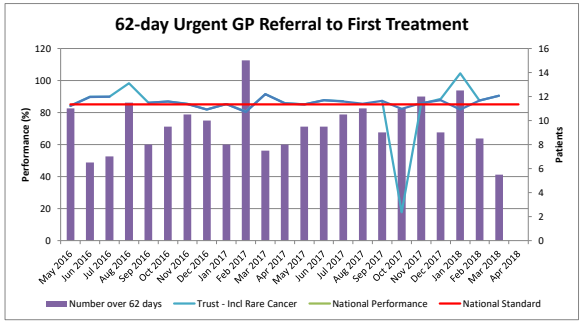






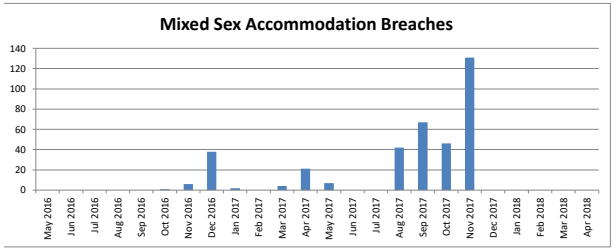


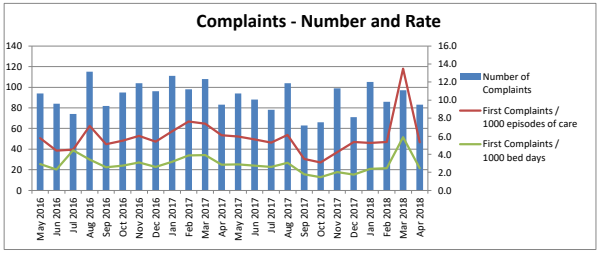


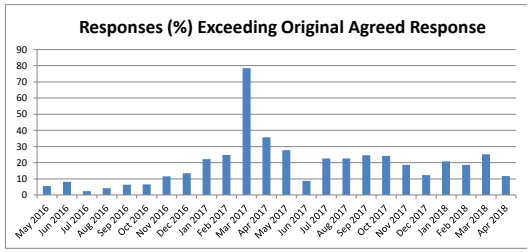


Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2016) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	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	17	10	15	9.7	7.9	9.3	11	11	12	13	10	19	9.748	8.3	-	9.8	10	8.3	Apr 2018								8	8	
8		a	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95.0	95.0	94	97	97	95	96	95	92	92	83	83	83	82	85.47	89	-	88	88	89	Apr 2018								89		
8		b	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50.0	50.0	4.8	5.9	5.4	4.3	4.2	5.5	3.8	2.4	3.8	2.8	3.4	3.3	3.426	3.6	-	3.8	7	7.9	Apr 2018	7.86							7.9	7.9	
8		a	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95.0	95.0	75	73	77	76	73	75	71	73	72	75	73	73	57.95	-	-	75	74	77	Apr 2018	76.7							77		
8			FFT Response Rate: Type 3 WiU Emergency Department	=> %	50.0	50.0	0.3	1.2	0.6	0	0	0.1	0	-	0	-	-	-	-	8.8	-	5	###	###	Apr 2018	-							-	0.0	
8			FFT Score - Adult and Children Emergency Department (type 3 WiU)	=> No	95.0	95.0	100	100	65	0	0	0	0	0	0	0	-	-	-	16	-	0	0	0	Apr 2018	-							0		
8			FFT Score - Outpatients	=> No	95.0	95.0	89	90	88	88	90	90	89	88	91	89	89	91	92	90	-	92	90	91	Apr 2018								91		
8	NEW		FFT Score - Maternity Antenatal	=> No	95.0	95.0	90	86	97	11	95	88	90	75	90	50	90	93	76.19	75	-	0	100	0	Apr 2018								0		
8	NEW		FFT Score - Maternity Postnatal Ward	=> No	95.0	95.0	93	90	91	29	83	91	86	73	73	81	84	89	81.25	74	-	0	100	0	Apr 2018								0		
8	NEW		FFT Score - Maternity Community	=> No	95.0	95.0	100	50	0	0	80	100	100	0	0	50	0	0	0	0	-	0	0	0	Apr 2018								0		
8			FFT Score - Maternity Birth	=> No	95.0	95.0	88	90	88	23	92	82	83	69	76	58	48	83	74.2	100	-	94	100	-	Mar 2018								100		
8			FFT Response Rate - Maternity Birth	=> %	50.0	50.0	17	13	8.2	5.4	21	8.9	11	7	7.1	5.2	5.2	13	6.874	0.2	-	23	1.2	-	Mar 2018								1	8	
13		a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	6	38	2	0	4	21	7	0	0	42	67	46	131	0	0	0	0	0	Apr 2018	0	0	0		0	0		0	0	
9			No. of Complaints Received (formal and link)	No			104	96	111	98	108	83	94	88	78	104	63	66	99	71	105	86	97	83	Apr 2018	36	24	12	0	3	3	5	83	83	
9			No. of Active Complaints in the System (formal and link)	No			148	157	176	177	194	205	184	185	184	167	154	136	148	161	187	181	183	176	Apr 2018	81	45	26	0	3	10	11	176		
9		a	No. of First Formal Complaints received / 1000 bed days	Rate1			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	2.5	Apr 2018	2.08	3.39	2.75			0		2.47	2.47	
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			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	###	5.3	Apr 2018	5.68	7.04	3.41			0		5.32	5.32	
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	=> %	100	100	100	100	99	98	94	100	100	100	100	100	98	100	89.87	92	99	100	99	100	Apr 2018	100	100	100	0	100	100	100	100	100	
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	<= %	0	0	11	13	22	25	79	36	28	8.6	23	23	25	24	18.71	12	21	19	25	12	Apr 2018	15.4	3.57	18.2	100	0	100	0	12	12	
9			No. of responses sent out	No			79	79	76	95	84	67	106	87	83	67	85	73	65	38	75	65	81	77	Apr 2018	26	28	11	2	1	1	8	77	77	
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jul 2016	N	N	N	N	N	N	N	No		
			Patient Harm - New Claims	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11	6	15	Apr 2018	-	-	-	-	-	-	-	15	15	
			Patient Harm - Ongoing Claims	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	491	474	473	Apr 2018	-	-	-	-	-	-	-	473	473	
			Patient Harm - Closed Claims	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	26	0	16	Apr 2018	-	-	-	-	-	-	-	16	16	

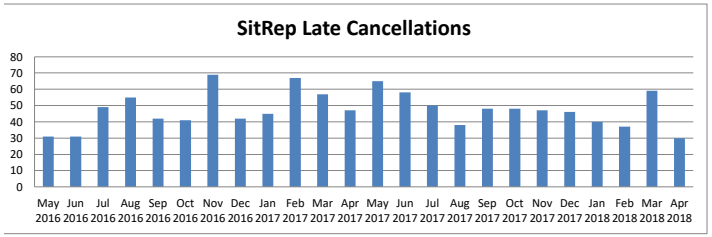


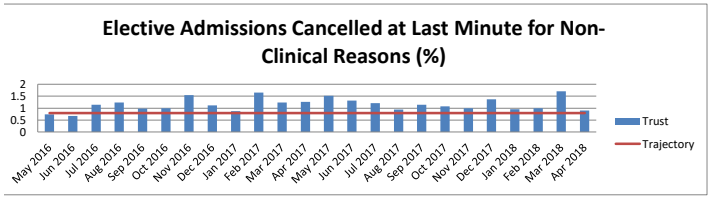


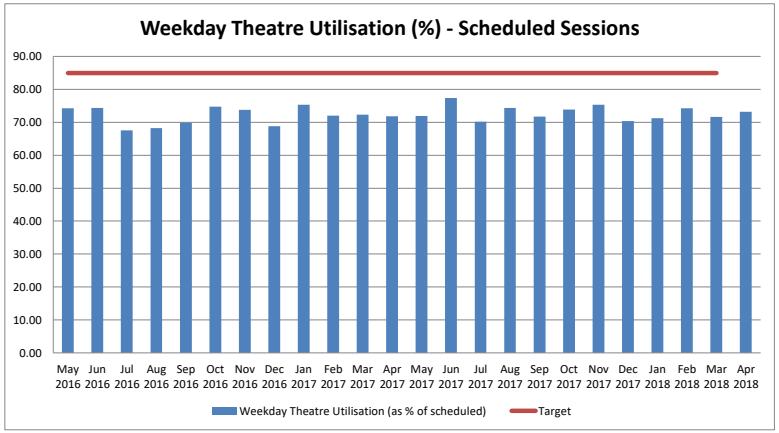


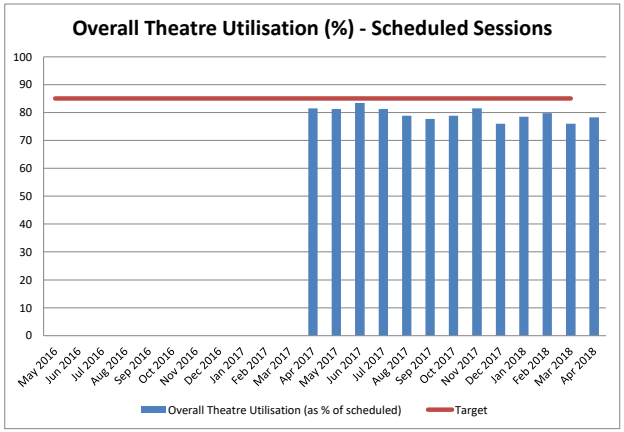
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2016) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	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	69	43	45	67	57	47	65	58	50	38	48	48	47	46	40	37	59	30	Apr 2018	0	24	6			0		30	30	
2			No. of Sitrep Declared Late Cancellations - Avoidable	No			28	19	13	19	17	24	27	20	21	12	31	11	14	13	17	10	14	3	Apr 2018	0	2	1			0		3	3	
2			No. of Sitrep Declared Late Cancellations - Unavoidable	No			41	18	29	48	37	23	37	37	29	26	17	31	33	33	23	28	45	26	Apr 2018	0	21	5			0		26	26	
2		•	Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	0.8	0.8	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	0.9	Apr 2018	-	1.24	2.33			0.00		0.9	0.9	
2		•e•	Number of 28 day breaches	<= No	0	0	0	3	6	0	0	1	0	0	0	2	0	0	0	0	2	0	1	2	Apr 2018	0	2	0			0		2	2	
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	Apr 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	Apr 2018	0.0	0.0	0.0			0.0		0	0	
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	<= No	0	0	3	4	0	3	0	3	1	3	1	1	0	1	1	1	4	3	2	0	Apr 2018	0	0	0			0		0	0	
			Multiple Hospital Cancellations experienced by same patient (all cancellations)	<= No	0	0	50	63	61	62	67	51	45	72	55	53	71	70	62	59	72	59	89	62	Apr 2018	10	42	10			-		62	62	
3			All Hospital Cancellations, with 7 or less days notice	<= No	0	0	273	272	269	284	257	219	230	250	245	213	243	294	244	272	302	212	276	224	Apr 2018	23	158	43			-		224	224	
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0																			Apr 2018	0.0	74.6	74.2			56.5		73.2	73.2	
			Overall Theatre Utilisation (as % of scheduled)	<= %	85.0	85.0	-	-	-	-	-														Apr 2018	0.0	79.5	82.1			60.0		78.3	78.3	



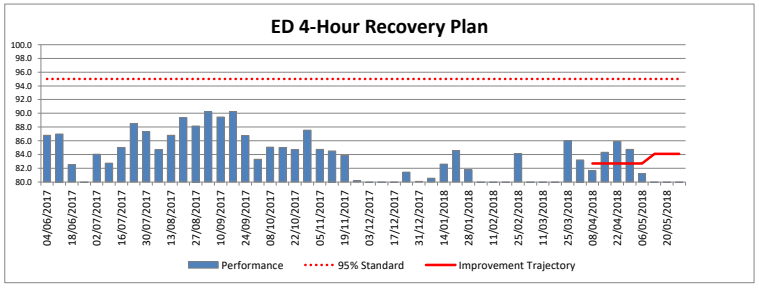


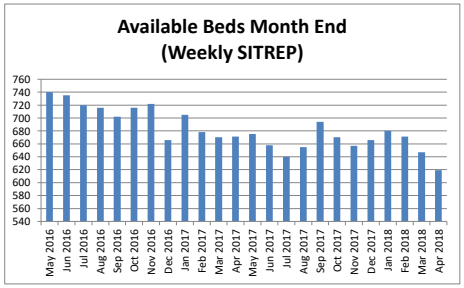


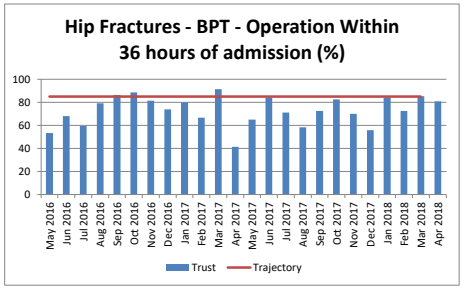


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend
2		e	Emergency Care 4-hour waits	=> %	95.00	95.00																			Apr 2018	77.6	87.4	98.6	83.92	83.92	
2			Emergency Care 4-hour breach (numbers)	No			3237	3324	2821	3046	2875	2814	3549	3014	2686	2177	2150	2800	3168	3814	3249	3377	3582	2745	Apr 2018	1666	1062	17	2745	2745	
2		e	Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			Apr 2018	0	0		0	0	
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			Apr 2018	13	15	35	14	14	
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Apr 2018	71	56	96	65	56	
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0													-						Apr 2018	3.84	5.22	4.89	4.59	4.59	
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Apr 2018	5.95	7.37	4.97	6.55	6.55	
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	162	193	162	129	107	110	159	242	111	127	90	143	207	208	163	160	196	173	Apr 2018	131	42		173	173	
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	21	19	11	13	5	0	12	6	1	0	1	4	6	11	5	4	21	6	Apr 2018	4	2		6	6	
11			WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Apr 2018	0.18	0.10		0.14	0.14	
11			WMAS - Emergency Conveyances (total)	No			4261	4622	4410	4034	4206	4137	4376	4254	4429	4278	4174	4557	4424	4725	4561	4081	4487	4308	Apr 2018	2221	2087		4308	4308	
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																		-	Mar 2018	0.4	0.6		0.5	2	
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	503	674	629	512	583	546	501	483	635	539	512	598	545	591	613	541	433	479	Apr 2018				479	479	
			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities) as % of Available Beds	%	3.5	3.5	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	2.7	Apr 2018				2.66	2.66	
2			Delayed Transfers of Care (Acute) - Finable Bed Days (Birmingham LA only)	<= No	0	0	272	449	435	309	375	324	258	312	370	256	288	272	149	226	268	193	152	176	Apr 2018				176	176	
2			Patient Bed Moves (10pm - 6am) (No.) -ALL	No			679	666	682	633	586	584	651	536	580	574	633	674	657	719	769	654	796	570	Apr 2018				570	570	
2			Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units	No			273	251	249	228	221	229	234	205	245	216	233	231	268	291	282	215	278	244	Apr 2018				244	244	
	New		Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units and Transfers for Clinical Reasons	No			59	45	32	43	46	44	33	37	29	23	43	39	54	72	65	48	75	43	Apr 2018				43	43	
			Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85.0	85.0																			Apr 2018				81	80.7	

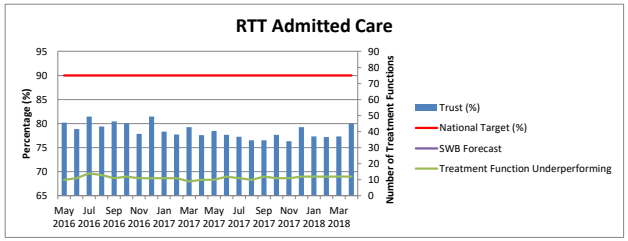


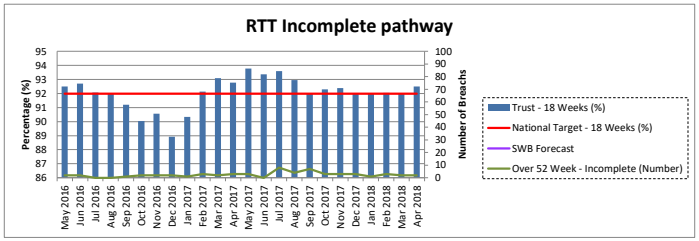


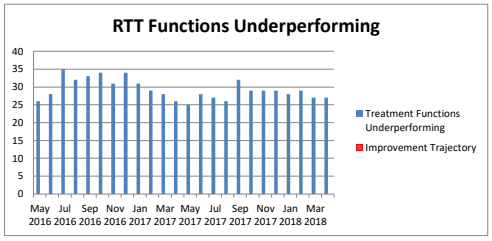


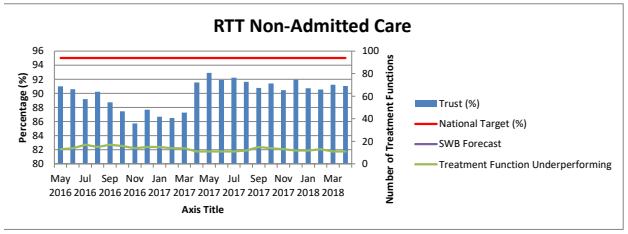
Referral To Treatment

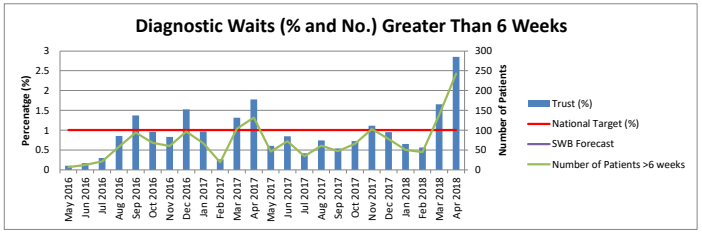
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2016) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
2			RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Apr 2018	91.2	74.2	84.8			81.4		80.02		
2			RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Apr 2018	78.4	90.9	94.2			83.5		91.05		
2			RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Apr 2018	90.3	91.3	93.3			95.6		92.50		
			RTT - Backlog	No			3417	3908	3204	2578	2214	2327	2024	2188	2115	2304	2571	2451	2322	2410	2337	2356	2404	2354	Apr 2018	524	1333	94			107		2354		
2			Patients Waiting >52 weeks	<= No	0	0	3	2	0	3	6	5	3	2	10	10	14	7	7	6	4	6	5	4	Apr 2018	0	3	1			0		4	4	
2			Patients Waiting >52 weeks (Incomplete)	<= No	0	0	2	2	1	3	2	3	3	0	8	4	7	3	3	3	1	3	2	2	Apr 2018	0	2	0			0		2	2	
2			Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	<= No	0	0	31	34	31	29	28	26	25	28	27	26	32	29	29	29	28	29	27	27	Apr 2018	6	16	2.0			2.0		27		
			Treatment Functions Underperforming (Incomplete)	<= No	0	0	6	8	5	4	5	5	4	5	5	4	5	4	5	5	4	4	4	4	Apr 2018	1	3	0			0		4		
2			Acute Diagnostic Waits in Excess of 6-weeks (End of Month Census)	<= %	1.0	1.0																			Apr 2018	0.6	4.3	0.0		3.2	0.0		2.85		
			Acute Diagnostic Waits in Excess of 6-weeks (In Month Waiters)	No			817	498	902	387	577	942	931	650	833	652	1336	914	1064	847	1672	531	373	1002	Apr 2018	40	87	-		866	-		1002		

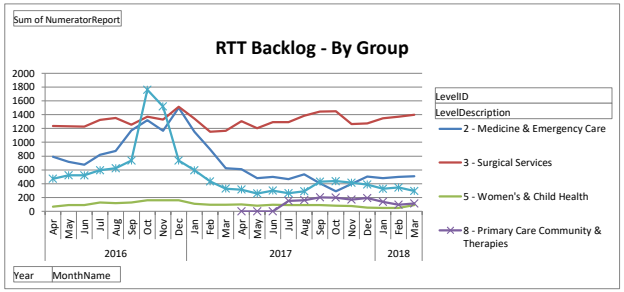


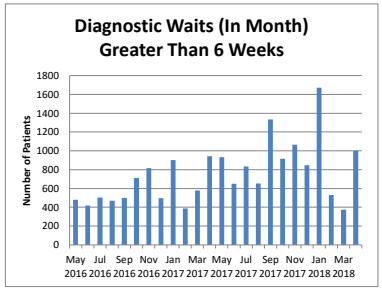


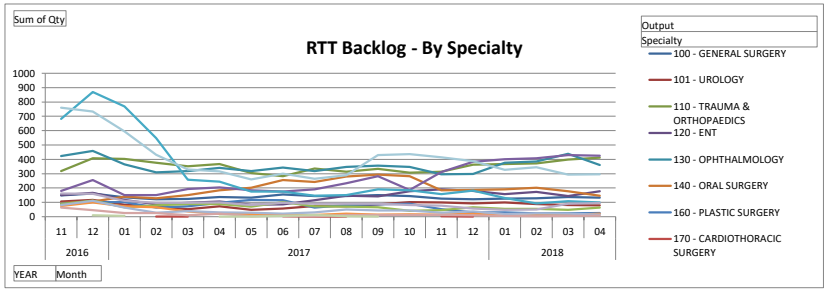






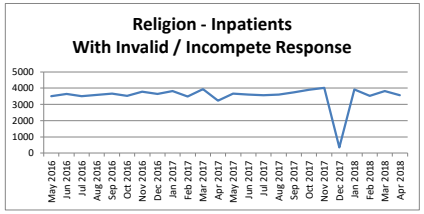


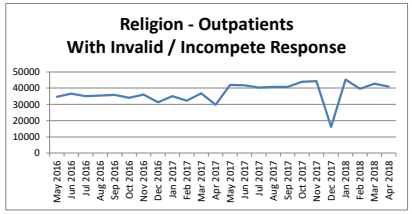


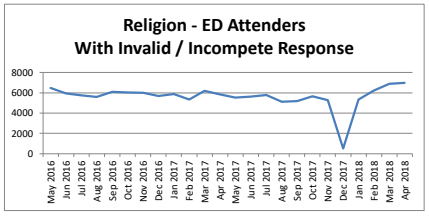


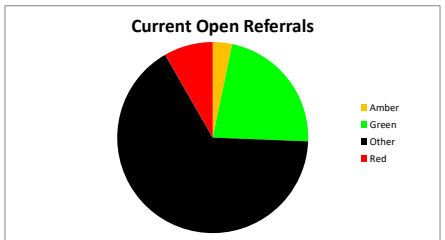
Data Completeness

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2016) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
14			Data Completeness Community Services	=> %	50.0	50.0																			Apr 2018							61.2	61.2		
2		•	Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0						-												-	Mar 2018								99.4		
2		•	Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0						-												-	Mar 2018								99.1		
2		•	Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0						-												-	Mar 2018								99.5		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=> %	99.0	99.0	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	99.0	-	Mar 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	99.6	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	99.6	-	Mar 2018								99.6	99.5	
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=> %	95.0	95.0	97.6	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	97.3	-	Mar 2018								97.3	97.3	
2			Ethnicity Coding - percentage of inpatients with recorded response	=> %	90.0	90.0																		-	Mar 2018								90.7	91.0	
			Ethnicity Coding - percentage of outpatients with recorded response	=> %	90.0	90.0																		-	Mar 2018								89.9	90.5	
			Protected Characteristic - Religion - INPATIENTS with recorded response	%			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	68.8	69.5	Apr 2018								69.5	69.5	
			Protected Characteristic - Religion - OUTPATIENTS with recorded response	%			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	52.4	52.1	Apr 2018								52.1	52.1	
			Protected Characteristic - Religion - ED patients with recorded response	%			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	66.3	65.1	Apr 2018								65.1	65.1	
			Protected Characteristic - Marital Status - INPATIENTS with recorded response	%			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	100.0	100.0	Apr 2018								100.0	100.0	
			Protected Characteristic - Marital Status - OUTPATIENTS with recorded response	%			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	38.6	38.8	Apr 2018								38.8	38.8	
			Protected Characteristic - Marital Status - ED patients with recorded response	%			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	39.0	38.3	Apr 2018								38.3	38.3	
2			Maternity - Percentage of invalid fields completed in SUS submission	<= %	15.0	15.0																		-	Mar 2018								6.7	6.8	
2			Open Referrals	No			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	294,489	Apr 2018	68,013	149,307	38,615	7,907	790	29,857		294,489		
			Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			92,360	95,712	99,043	102,895	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	155,865	Apr 2018	40,464	75,110	23,118	4,003	706	11,751		155865		
			Closed Referrals	No			22,808	19,249	22,884	19,938	22,144	18,244	21,289	21,329	21,386	20,869	21,629	22,908	22,618	19,379	23,689	19,540	19,344	18,194	Apr 2018	4,303	9,443	2,358	266	13	1,811		18,194		

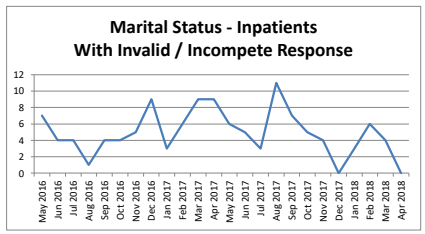


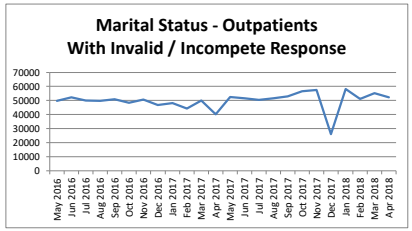


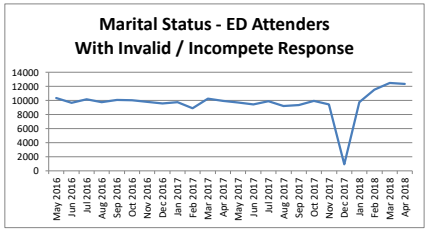




RED : To be validated and closed by clinical groups.
AMBER : To be validated and closed by clinical groups.
GREEN : Automatic Closures.

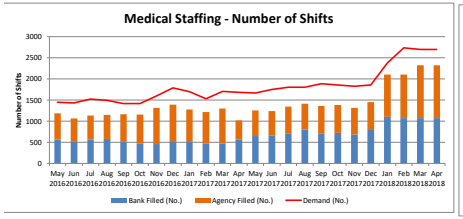


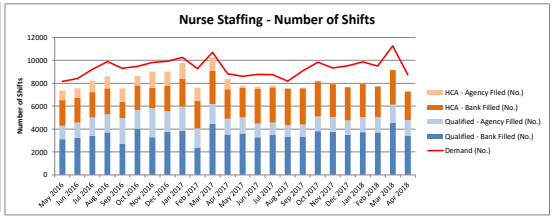




Temporary Workforce

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2016) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
			Medical Staffing - Number of instances when junior rotas not fully filled	<= %	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	
			Medical Staffing - Demand	No			1596	1786	1699	1534	1703	1682	1669	1753	1805	1804	1887	1858	1823	1854	2381	2740	2696	2696	Apr 2018	1910	563	181	0	30	12	0	2696	2696.0	
			Medical Staffing - Total Filled	%			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	86.09	Apr 2018	83.3	93.8	89	0	100	100	0	86	86.1	
			Medical Staffing - Bank Filled	%			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	46.19	Apr 2018	42.3	55.7	54	0	26.7	83.33	0	46	46.2	
			Medical Staffing - Agency Filled	%			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	53.81	Apr 2018	57.7	44.3	46	0	73.3	16.67	0	54	53.8	
			Medical Staffing - Filled Shifts - Snr Consultant	No			237	187	152	217	270	120	214	219	258	320	312	329	324	334	311	181	352	352	Apr 2018	227	88	5	0	30	2	0	352	352.0	
			Medical Staffing - Filled Shifts - Jnr Doctor	No			1108	1196	1144	1001	1026	896	394	1019	1087	1092	1074	1052	987	1113	1793	855	1969	1969	Apr 2018	1363	440	156	0	0	10	0	1969	1969.0	
			Nursing - Demand	No			9802	9935	####	9268	####	8825	8616	8784	8760	8197	9080	9849	9335	9535	9866	9500	####	8759	Apr 2018	4383	1747	1275	21	166	1100	67	8759	8759	
			Nursing - Total Filled	%			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	81.16	83.2	Apr 2018	82.4	90.4	74.6	100	60.2	87	97	83	83.2	
			Nursing - Qualified - Bank Filled	%			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	49.65	46.5	Apr 2018	40.9	43.3	62.7	95.2	22	58.62	35.4	46	46.5	
			Nursing - Qualified - Agency Filled	%			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	17.46	19.5	Apr 2018	25.6	20.1	3.36	0	77	7.42	0	19	19.5	
			Nursing - HCA - Bank Filled	%			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	32.89	34.1	Apr 2018	33.5	36.6	34	4.76	1	33.96	64.6	34	34.1	
			Nursing - HCA - Agency Filled	%			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	0.0	Apr 2018	0	0	0	0	0	0	0	0	0.0	
			AHPs - Radiography - Demand (Shifts)	No			321	290	526	332	525	332	372	315	334	335	231	235	198	176	309	349	305	111	Apr 2018	0	0	0	0	111	0	0	111	111	
			AHPs - Radiography - Filled (Shifts)	No			299	256	496	302	502	329	359	315	290	323	230	232	190	170	253	232	157	92	Apr 2018	0	0	0	0	92	0	0	92	92	
			AHPs - Physiotherapy - Demand (Shifts)	No			190	186	276	478	356	180	242	257	104	99	100	108	88	75	33	113	35	146	Apr 2018	0	0	0	0	0	146	0	146	146	
			AHPs - Physiotherapy - Filled (Shifts)	No			190	186	274	478	346	180	242	257	104	99	98	107	87	74	33	113	35	146	Apr 2018	0	0	0	0	0	146	0	146	146	
			AHPs - Other - Demand (Shifts)	No			96	567	413	530	1009	459	527	471	511	536	482	532	460	451	519	385	500	376	Apr 2018	181	40	8	0	68	36	43	376	376	
			AHPs - Other - Filled (Shifts)	No			200	567	412	527	885	457	527	471	508	534	476	520	445	440	502	371	497	349	Apr 2018	172	22	8	0	68	36	43	349	349	
			Admin - Demand (Shifts)	No			2479	2442	2381	4128	5135	4198	4228	4423	4054	4429	4091	4015	3928	3535	3778	3493	3607	2950	Apr 2018	537	306	65	244	47	284	1467	2950	2950	
			Admin - Filled (Shifts)	No			2452	2405	2348	4026	5079	4162	4184	4423	4031	4412	4025	3951	3838	3412	3707	3412	3496	2895	Apr 2018	531	305	64	242	47	282	1424	2895	2895	
			Facilities - Demand (Shifts)	No			1997	2172	2066	1971	2485	1795	2031	2101	1996	2182	2025	2059	2122	2008	2111	2226	2410	2192	Apr 2018	8	39	1	0	10	1	2133	2192	2192	
			Facilities - Filled (Shifts)	No			1969	2107	1992	1926	2425	1737	1999	2101	1966	2165	2006	2019	2098	1951	2054	2170	2384	2178	Apr 2018	7	39	1	0	10	1	2120	2178	2178	
			Interpreters - Demand (Shifts)	No			5508	4803	5159	4983	5634	4511	5139	5291	5101	4905	5116	5343	5699	4595	5354	4862	5079	4639	Apr 2018	-	-	-	-	-	-	-	4639	4639.0	
			Interpreters - Total Filled	%			99.5	99.5	99.5	99.6	99.6	99.9	99.7	99.7	99.8	99.9	99.8	99.6	99.7	99.7	99.9	99.5	99.9	99.5	Apr 2018	-	-	-	-	-	-	-	99	99.5	
			Interpreters - Bank Filled	%			77.6	76.9	78.4	79.5	78	77.3	78.5	77.7	77	77	78.3	77.9	78.7	77.8	78.9	77.8	79.6	79.8	Apr 2018	-	-	-	-	-	-	-	80	79.8	
			Interpreters - Agency Filled	%			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	20.2	Apr 2018	-	-	-	-	-	-	-	20	20.2	
			Interpreters - Unfilled	%			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	0.5	Apr 2018	-	-	-	-	-	-	-	1	0.5	

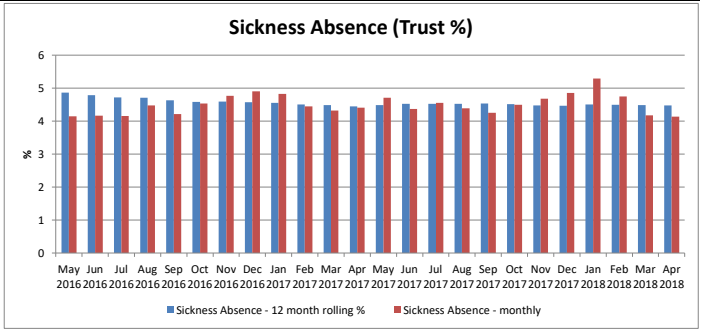


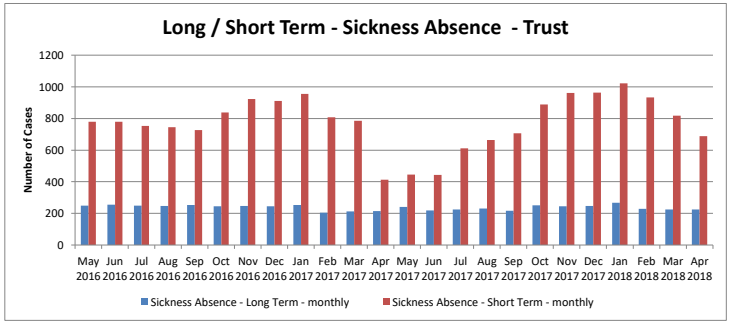


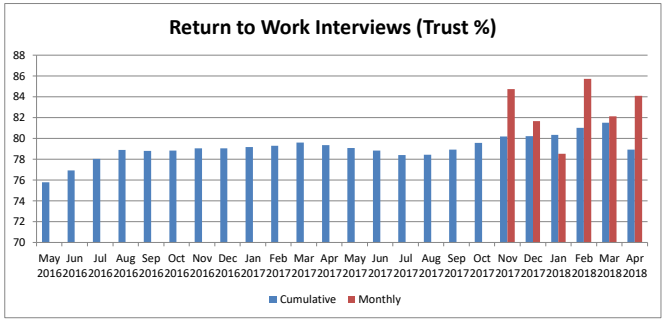
Workforce

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2016) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
3			PDRs - 12 month rolling	=> %	95.0	95.0																			Apr 2018	56.1	66.8	72.9	87.4	53.6	77.3	68.5			
7			Medical Appraisal	=> %	95.0	95.0																			Apr 2018	82.0	85.8	87.0	95.0	90.6	117.4	50.0	87.2	87.2	
3			Sickness Absence (Rolling 12 Months)	<= %	2.50	2.50																			Apr 2018	4.8	4.7	4.3	3.7	3.7	4.1	4.6	4.47	4.5	
3			Sickness Absence (Monthly)	<= %	2.50	2.50																			Apr 2018	5.1	4.4	3.9	2.7	3.3	3.7	3.9	4.14	4.1	
3			Sickness Absence - Long Term (Monthly)	No			247	246	253	205	213	214	241	218	225	232	216	251	246	247	267	230	226	226	Apr 2018	54	43	25	4	5	29	2	226	226	
3			Sickness Absence - Short Term (Monthly)	No			922	911	956	808	785	414	445	444	612	664	706	889	962	963	1021	932	818	688	Apr 2018	163	123	95	37	38	91	4	688	688	
3			Return to Work Interviews following Sickness Absence (Cumulative)	=> %	100.0	100.0																			Apr 2018	64.8	87.8	79.1	86.9	82.1	85.2	80.3	78.9	78.9	
			Return to Work Interviews following Sickness Absence (In Month)	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-							Apr 2018	77.7	90.5	78.5	88.6	82.2	92.9	83.5	84.1	84.1	
3			Mandatory Training	=> %	95.0	95.0																			Apr 2018	86.0	90.1	90.9	95.1	91.3	94.4	93.9	91.1		
3			Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	2.5	-	-	-	8.2	-	-		Feb 2018	6.2	6.1	6.3	14.1	6.0	3.7	15.5	8.2		
3			Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0																			Apr 2018	91.9	0.0	93.7	97.6	94.5	0.0	98.6	95.2		
7			Employee Turnover (rolling 12 months)	<= %	10.0	10.0																			Apr 2018								14.3	14.3	
			Nursing Turnover (Qualified Only)	<= %	10.7	10.7	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	13.7	Apr 2018								13.7	13.7	
7			New Investigations in Month	No			0	3	4	3	9	14	1	3	4	4	2	7	4	5	4	3	4	3	Apr 2018	0	3	0	0	0	0	0	3		
7			Vacancy Time to Fill	Weeks			21	21	21	22	21	20	21	23	25	20	21	21	21	23	25	23	23	25	Apr 2018								25		
7			Professional Registration Lapses	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2018	0	0	0	0	0	0	0	0	0	
7			Qualified Nursing Variance (FIMS) (FTE)	No			293	305	268	246	257	256	276	281	289	287	269	252	244	265	248	243	261	249	Apr 2018								249		
15			Your Voice - Response Rate	No			-->	-->	16.0	-->	-->	-->	-->	-->	18.8	-->	-->	-->	-->	-->	19.7	-->	-->	-->	Jan 2018	9	16.2	16.8	16.2	19.7	24.4	29.7	19.7		
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		

New organisational process to measure performance quarterly - next due in June







Operational Efficiency

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory		Previous Months Trend (since Nov 2016)																Data Period	Group								Month	Year To Date	Trend
					Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		M	SS	B	W	P	I	PCCT	CO			
			Routine Outpatient Appointments with Short Notice(<3Wks)	%			-	-	-	-	-	36	36	34	38	40	38	41	38	40	35	37	37	-	Mar 2018	32	34	-	56	26	100	30	-	**36.7**	**37.5**	
			Short Notice Inpatient Admission Offers (<3wks)	%			-	-	-	-	-	50	49	47	48	54	47	52	54	52	41	49	51	-	Mar 2018	56	47	-	66	39	100	54	-	**51**	**49.4**	
			Routine Outpatient Appointments with Short Notice(<3Wks)	Number			**In Production**																												
			Short Notice Inpatient Admission Offers (<3wks)	Number			**In Production**																												

Local Quality Indicators - 2017/2018

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory		Previous Months Trend (From Nov 2016)																	Data Period	Group							Month	Year To Date	Trend
					Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		M	SS	W	P	I	PCCT	CO			
			Safeguarding Adults Advanced Training	=> %	85	85	81	81	80	79	81	81	81	79	83	86	85	85	86	88	89	89	90	90	Apr 2018								90.328	90.33	
			Safeguarding Adults Basic Training	=> %	85	85	98	98	96	98	98	98	96	97	96	98	97	97	97	97	97	98	99	99	Apr 2018								98.594	99	
			Safeguarding Children Level 1 Training	=> %	85	85	98	98	97	98	98	98	97	98	96	98	98	98	98	98	98	98	99	99	Apr 2018								99.0	99.0	
			Safeguarding Children Level 2 Training	=> %	85	85	73	75	76	77	77	78	79	78	78	83	86	86	87	88	88	88	89	89	Apr 2018								89.4	89.4	
			Safeguarding Children Level 3 Training	=> %	85	85	75	78	78	81	84	85	88	89	88	87	85	85	90	90	90	90	91	91	Apr 2018								91.3	91.3	
			WHO Safer Surgery - Audit - brief and debrief (% lists where complete) - SQPR	=> %	100	100	97	95	97	99	99	98	98	98	99	99	99	99	98	100	99	99	99	99	Apr 2018	99.2	98.1	96.3			0		98.5	98.5	
			Morning Discharges (00:00 to 12:00) - SQPR	=> %	35	35	17	17	20	17	16	16	15	17	17	15	16	15	15	18	17	17	16	15	Apr 2018	15.5	9.09	20.9			28		15.5	15.5	
			ED Diagnosis Coding (Mental Health CQUIN) - SQPR	=> %	85	85	86	86	86	86	87	86	86	85	84	84	84	84	85	85	83	0	0	68	Apr 2018								68.5	68.5	
			CO Level >4ppm Referred For Smoking Cessation - SQPR	=> %	90	90	92	80	78	93	87	80	86	76	82	82	85	79	80	100	100	100	100	100	Apr 2018								100.0	100.0	
			BMI recorded by 12+6 weeks of pregnancy - SQPR	=> %	90	90	82	81	84	81	77	78	80	79	88	92	94	93	96	97	97	98	94	98	Apr 2018								97.5	97.5	
			CO Monitoring by 12+6 weeks of pregnancy - SQPR	=> %	90	90	76	75	73	78	79	76	75	75	74	71	74	80	76	79	76	77	76	80	Apr 2018								79.6	79.6	
			Community Gynae - Referral to first outpatient appointment Within 4 weeks of referral	=> %	90	90	8	11	33	66	83	93	95	92	67	38	13	20	65	-	-	57	-	-	Feb 2018								57.1	59.1	
			Community Nursing - Falls Assessment For Appropriate Patients on home visiting caseload	=> %	100	100	77	69	60	62	58	69	-	57	58	57	54	55	52	60	67	78	91	91	Apr 2018								90.8	90.8	
			Community Nursing - Pressure Ulcer Risk Assessment For New community patients at intial assessment	=> %	95	95	80	71	63	65	63	77	-	63	65	66	62	63	63	70	78	81	92	93	Apr 2018								92.8	92.8	

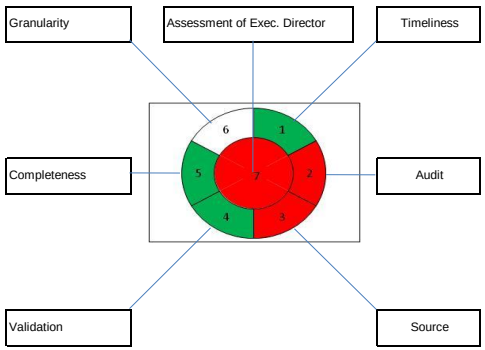
Legend

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	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC			
Patient Safety - Inf Control	C. Difficile	<= No	30	3																			Apr 2018	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Apr 2018	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective (%)	=> %	80	80																			Apr 2018	84	72	14	68.2		
Patient Safety - Inf Control	MRSA Screening - Non Elective (%)	=> %	80	80																			Apr 2018	90	91	100	90.2		
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	16	Apr 2018	5	11	0	16	16	
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	16	Apr 2018	5	11	0	16	16	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			4	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	Apr 2018	1	0	0	1	1	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			3	14	12	8	8	11	6	6	4	8	3	2	1	3	2	1	6	2	Apr 2018	1	1	0	2	2	
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	3	Apr 2018	2	1	0	3	3	
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	0	Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			5	2	1	0	0	1	1	1	5	0	0	0	0	0	0	0	0	0	Apr 2018	0	0	0	0	-	
Patient Safety - Harm Free Care	Falls	<= No	0	0	41	47	50	38	34	36	39	34	34	28	31	48	22	23	35	35	45	35	Apr 2018	9	26	0	35	35	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	2	3	3	1	2	1	1	0	0	1	1	3	0	0	0	0	0	0	Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	7	9	5	5	4	5	4	2	4	2	6	3	4	8	8	4	3	4	Apr 2018	0	4	0	4	4	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Apr 2018	94.3	90.0	96.5	94.2		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			Apr 2018	100.0	100.0	100.0	100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Apr 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																			Apr 2018	99	100	0	99.2		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Apr 2018	1	1	0	2	2	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98																	-	-	Feb 2018	50	37	26	39		

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Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			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	12.5	-	Mar 2018				**12.5**		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			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	10.7	-	Mar 2018					**9.8**	

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Section	Indicator		Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	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																			Apr 2018		91.5		91.5	91.5	
Clinical Effect - Stroke & Card	Pts admitted to Acute Stroke Unit within 4 hrs (%)	=> %	90.0	90.0																			Apr 2018		68.6		68.6	68.6	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			Apr 2018		75.5		75.5	75.5	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.0																			Apr 2018		98.1		98.1	98.1	
Clinical Effect - Stroke & Card	Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			Apr 2018		66.7		66.7	66.7	
Clinical Effect - Stroke & Card	Stroke Admissions - Swallowing assessments (<24h) (%)	=> %	98.0	98.0																			Apr 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																			Apr 2018		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=> %	75.0	75.0																			Apr 2018		96.2		96.2	96.2	
Clinical Effect - Stroke & Card	Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=> %	80.0	80.0																			Apr 2018		73.3		73.3	73.3	
Clinical Effect - Stroke & Card	Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			Apr 2018		85.7		85.7	85.7	
Clinical Effect - Stroke & Card	Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			Apr 2018		100.0		100.0	100.0	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Mar 2018			96.6	96.6		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Mar 2018			100.0	100.0		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Mar 2018			92.6	92.6		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			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	1	-	Mar 2018	-	-	1.00	1.00	24	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	1	1	1	1	1	0	1	0	0	0	2	2	0	0	1	1	-	Mar 2018	-	-	1.00	1.00	8	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			71	107	111	135	105	140	91	106	97	99	81	125	173	104	102	113	280	-	Mar 2018	-	-	280	280		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0.0	0.0	12	19	17	8	6	11	6	4	10	3	7	8	7	7	3	9	4	3	Apr 2018	-	-	3	3	3	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	6	30	2	0	4	21	7	0	0	3	61	46	129	0	0	0	0	0	Apr 2018	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			40	35	40	45	42	34	42	40	27	49	24	26	47	29	30	38	34	36	Apr 2018	29	7	0	36	36	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			63	62	66	61	75	79	79	91	83	82	74	59	75	67	73	78	76	81	Apr 2018	48	32	1	81		

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Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate EC	AC	SC	Month	Year To Date
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Apr 2018	-	-	-	-	
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	1	0	0	0	2	0	0	0	0	0	0	0	0	Apr 2018	0.0	0.0	0.0	0	0
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	6	2	4	6	2	3	11	3	5	2	8	2	3	4	6	0	7	0	Apr 2018	0.0	0.0	0.0	0	0
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	44	29	51	37	41	28	35	63	31	62	41	#####	#####	#####	#####	#####	#####	#####	Apr 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	Apr 2018	0.00	0.00	0.00	0.00	0
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95.0	95.0																			Apr 2018	77.6	87.4	Site S/C	82.8	82.8
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			1750	1866	1776	1769	1721	1662	1742	1580	1483	1280	1257	1636	1714	2188	2257	0	2635	1935	Apr 2018	1805	2	128	1935	1935
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0																			Apr 2018	0.0	0.0	Site S/C	0	0
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.0	15.0								-											Apr 2018	13.0	15.0	Site S/C	14	14
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60.0	60.0																			Apr 2018	71.0	56.0	Site S/C	63	63
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0													-						Apr 2018	3.8	5.2	Site S/C	4.6	4.6
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Apr 2018	6.0	7.4	Site S/C	6.7	6.7
Emergency Care & Pt. Flow	WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	162	193	162	129	107	110	159	242	111	127	90	143	207	208	163	160	196	173	Apr 2018	131	42		173	173
Emergency Care & Pt. Flow	WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	21	19	11	13	5	0	12	6	1	0	1	4	6	11	5	4	21	6	Apr 2018	4	2		6	6
Emergency Care & Pt. Flow	WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Apr 2018	0.18	0.10		0.14	0.14
Emergency Care & Pt. Flow	WMAS - Emergency Conveyances (total)	No			4261	4622	4410	4034	4206	4137	4376	4254	4429	4278	4174	4557	4424	4725	4561	4081	4487	4308	Apr 2018	2221	2087		4308	4308
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			Apr 2018	0.0	89.3	94.1	91.2	
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			Apr 2018	0.0	65.5	95.5	78.4	
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			Apr 2018	0.0	87.2	95.7	90.3	
RTT	RTT - Backlog	<= No	0	0	1168	1500	1154	897	622	610	479	497	467	538	407	288	398	504	480	497	509	524	Apr 2018	0	441	83	524	
RTT	Patients Waiting >52 weeks	<= No	0	0	2	1	0	0	1	1	2	1	7	4	1	0	0	0	0	1	0	0	Apr 2018	0	0	0	0	
RTT	Treatment Functions Underperforming	<= No	0	0	10	12	10	10	10	9	7	8	9	7	8	5	5	6	6	6	6	6	Apr 2018	0	5	1	6	

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RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0	🔴	🔴	🔴	🟢	🔴	🔴	🔴	🔴	🟢	🔴	🔴	🔴	🔴	🔴	🔴	🟢	🟢	🟢	Apr 2018	0	0.75	0	**0.60**	

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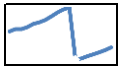
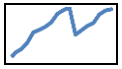
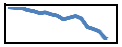
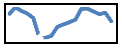
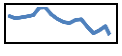
Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate EC	AC	SC	Month	Year To Date	
Data Completeness	Open Referrals	No			75,046	75,926	75,925	76,880	78,278	78,984	79,971	81,548	83,160	84,417	85,453	62,769	63,236	64,194	65,058	65,868	66,860	68,013	Apr 2018	15,038	28,172	24,803	68013		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Req	No			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	40,464	Apr 2018	12,794	16,307	11,363	40464		
Workforce	PDRs - 12 month rolling (%)	=> %	95.0	95.0																			Apr 2018	52.15	58.57	0		56.1	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Apr 2018	72.22	89.71	0		82.0	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15																			Apr 2018	4.94	4.76	0.00	4.83	4.83	
Workforce	Sickness Absence - In month	<= No	3.15	3.15																			Apr 2018	5.16	5.09	0.00	5.14	5.14	
Workforce	Sickness Absence - Long Term - In month	No			40	39	39	33	40	53	59	48	45	54	49	51	49	63	64	46	40	54	Apr 2018	23	31	0	54	54	
Workforce	Sickness Absence - Short Term - In month	No			206	243	223	207	182	66	68	80	131	145	157	173	233	236	219	203	212	163	Apr 2018	61	102	0	163	163	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100																			Apr 2018	56.6	70.6	0.0		64.76	
Workforce	Mandatory Training (%)	=> %	95.0	95.0																			Apr 2018	85.31	86.45	0		86.0	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	2.2	-	-	-	6.2	-	-	Feb 2018	6.49	5.93	0		2.5	
Workforce	New Investigations in Month	No			0	0	0	1	2	3	0	0	1	1	0	0	1	2	2	0	0	0	Apr 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	-->	-->	-->	-->	-->	9	-->	-->	-->	Jan 2018	9.6	8.5	0.0	9.0		
Workforce	Your Voice - Overall Score	No			-->	-->	3.68	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.51	3.90	3.58	3.68		

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Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate					Month	Year To Date	Trend
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		GS	SS	TH	An	O			
Patient Safety - Inf Control	C. Difficile	<= No	7	1																			Apr 2018	1	0	0	0	0	1	1	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Apr 2018	0	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80	80																			Apr 2018	93.43	94.85	0	0	53.66	90.3		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80	80																			Apr 2018	88.31	92.35	0	100	94.44	89.7		
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	11	Apr 2018	4	0	0	7	0	11	11	
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	11	Apr 2018	4	0	0	7	0	11	11	
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	1	Apr 2018	0	0	0	1	0	1	1	
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	0	Apr 2018	0	0	0	0	0	0	0	
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	1	Apr 2018	1	0	0	0	0	1	1	
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	0	Apr 2018	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Falls	<= No	0	0	12	13	8	6	6	10	7	11	11	4	5	5	10	10	17	7	15	16	Apr 2018	6	6	0	0	4	16	16	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	Apr 2018	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	1	1	2	1	1	3	0	2	0	0	2	2	1	2	2	3	3	Apr 2018	2	1	0	0	0	3	3	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Apr 2018	97.04	96.82	0	99.26	96.69	97.1		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			Apr 2018	100	99.72	83.66	100	100	98.8		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Apr 2018	100	100	95.8	0	100	98.1		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Apr 2018	100	100	95.8	0	100	98.1		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	Apr 2018	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2018	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Apr 2018	0	0	0	0	0	0	0	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98.0																	-	-	Feb 2018	78	0	0	0	0	58.3		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			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	5.5	-	Mar 2018						5.5		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			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	6.28	-	Mar 2018							6.1	

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Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate					Month	Year To Date	
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		GS	SS	TH	An	O			
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		Mar 2018	95.5	-	0.0	-	-	95.5		
Clinical Effect - Cancer	2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		Mar 2018	93.5	-	-	-	-	93.46		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		Mar 2018	97.5	-	0.0	-	-	97.47		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		Mar 2018	89.7	-	0.0	-	-	89.71		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			4	5	5	8	2	2	5	3	8	3	2	6	4	8	10	4	4	-	Mar 2018	-	-	-	-	-	3.5	55	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			2	2	0	2	1	1	1	0	2	2	0	2	0	3	3	1	0	-	Mar 2018	0	-	0	-	-	0	15	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			191	158	103	193	105	119	114	98	134	108	84	110	0	119	126	112	90	-	Mar 2018	90	-	0	-	-	90		
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	Apr 2018	0	-	0	-	-	0	0	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	8	0	0	0	0	0	0	0	39	6	0	2	0	0	0	0	0	Apr 2018	0	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			29	26	32	25	36	24	29	20	28	29	18	16	28	22	24	25	32	24	Apr 2018	13	2	2	0	7	24	24	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			39	45	62	63	66	78	61	51	57	50	38	40	36	47	47	52	50	45	Apr 2018	23	4	4	3	11	45		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Apr 2018	1.24	3.32	0	0.38	0.95	1.24		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	3	4	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2	Apr 2018	0	2	0	0	0	2	2	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	57	31	35	49	45	32	49	38	41	28	37	35	35	24	20	29	41	24	Apr 2018	9	7	0	1	7	24	24	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	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	74.6	Apr 2018	71.9	75.2	0.0	94.3	74.8	74.63		
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	Apr 2018	0	0	0	0	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (%)	%	95.0	95.0	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	98.6	Apr 2018	-	-	-	-	98.59	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	<= No	0	0	76	109	70	68	112	137	109	93	106	69	73	84	80	89	66	0	179	160	Apr 2018	99	42	0	1	18	160	160	
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	Apr 2018	-	-	-	-	0	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0	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	4.9	Apr 2018	-	-	-	-	4.89	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0	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	5.0	Apr 2018	-	-	-	-	4.97	-	-	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15	14	14	0	0	0	0	0	-	0	0	0	0	0	0	0	0	0	0	Apr 2018	-	-	-	-	35	0	0	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60	100	99	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2018	-	-	-	-	96	-	-	
Emergency Care & Pt. Flow	Hip Fractures BPT (Operation < 36 hours of admissions	=> %	85.0	85.0																			Apr 2018						80.7	80.7	

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Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate					Month	Year To Date	
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		GS	SS	TH	An	O			
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																	Apr 2018	71.9	61.1	0.0	0.0	80.2	74.2		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																	Apr 2018	86.4	93.2	0.0	0.0	93.0	90.9		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																	Apr 2018	92.5	82.4	0.0	0.0	93.7	91.3		
RTT	RTT - Backlog	<= No	0	0	1328	1514	1344	1153	1167	1304	1204	1293	1293	1385	1443	1447	1264	1271	1348	1370	1397	1333	Apr 2018	536	436	0	0	361	1333		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	1	0	2	2	4	1	1	1	5	9	4	7	5	2	0	4	3	Apr 2018	3	0	0	0	0	3		
RTT	Treatment Functions Underperforming	<= No	0	0	14	16	16	16	14	14	16	18	16	17	17	16	17	16	15	17	15	16	Apr 2018	9	5	0	0	2	16		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																	Apr 2018	4.3	0.0	0.0	0.0	0.0	4.26		
Data Completeness	Open Referrals	No			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	149,307	Apr 2018	51,441	16,704	0	6,011	75,151	149307		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requ	No			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	75,110	Apr 2018	28,430	8,886	0	4,005	33,789	75110		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																	Apr 2018	61.0	78.7	67.2	66.5	68.3		66.8	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																	Apr 2018	88.1	78.79	0	80.77	92.86		85.8	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15																	Apr 2018	4.5	6.0	6.3	4.3	2.1	4.7	4.7	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15																	Apr 2018	4.4	5.2	7.0	3.5	1.7	4.4	4.4	
Workforce	Sickness Absence - Long Term - In Month	No			50	53	52	33	32	30	41	38	51	50	47	49	47	34	47	42	48	43	Apr 2018	12.0	10.0	12.0	6.0	0.0	43.0	43.0	
Workforce	Sickness Absence - Short Term - In Month	No			173	181	166	149	138	61	50	55	96	96	119	159	170	172	151	160	131	123	Apr 2018	39.0	30.0	31.0	22.0	0.0	123.0	123.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100																	Apr 2018	84.9	82.0	94.1	90.2	89.7	87.8	87.8	
Workforce	Mandatory Training	=> %	95.0	95.0																	Apr 2018	88.5	87.3	93.7	92.2	89.0		90.1	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	2.78	-	-	-	6.13	-	-	Feb 2018	7.5	6.0	7.7	4.8	4.1		2.9	
Workforce	New Investigations in Month	No			0	0	2	1	2	2	0	0	2	2	2	4	1	0	2	1	1	3	Apr 2018	0	0	3	0	0	3		
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						-	-	
Workforce	Your Voice - Response Rate	No			-->	-->	30	-->	-->	-->	-->	-->	15.3	-->	-->	-->	-->	-->	16.2	-->	-->	-->	Jan 2018	18.9	12.8	8.1	15.3	21.8	16.2		

Surgical Services Group

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	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P			
Patient Safety - Inf Control	C. Difficile	<= No	0	0																			Apr 2018	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Apr 2018	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.00	80.00																			Apr 2018	89.9			89.9		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80.00	80.00																			Apr 2018	0	98.1		98.1		
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	0	Apr 2018	0	0	0	0	0	
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	0	Apr 2018	0	0	0	0	0	
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	0	Apr 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	0	Apr 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	0	Apr 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	0	Apr 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	0	Feb 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Falls	<= No	0	0	1	1	2	1	1	0	3	1	0	0	0	1	1	0	0	0	0	0	Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 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	1	0	0	0	0	0	0	0	0	Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Apr 2018	99.2	89.5		93.1		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			Apr 2018	100	100		100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Apr 2018	95.8	100		96.3		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Apr 2018	95.8	100		96.3		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Apr 2018	0	1	0	1	1	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate G	M	P	Month	Year To Date
Patient Safety - Obstetrics	Caesarean Section Rate - Total	<= %	25.0	25.0																			Apr 2018		26.9		26.9	26.9
Patient Safety - Obstetrics	Caesarean Section Rate - Elective	%			11	8	7	9	8	9	8	9	7	8	8	9	9	5	7	10	8	10	Apr 2018		9.96		10.0	10.0
Patient Safety - Obstetrics	Caesarean Section Rate - Non Elective	%			17	20	15	17	17	17	15	17	18	15	19	21	18	21	15	19	18	17	Apr 2018		16.9		16.9	16.9
Patient Safety - Obstetrics	Maternal Deaths	<= No	0	0																			Apr 2018		0		0	0
Patient Safety - Obstetrics	Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Apr 2018		0		0	0
Patient Safety - Obstetrics	Admissions to Neonatal Intensive Care	<= %	10.0	10.0																			Apr 2018		1.2		1.2	1.2
Patient Safety - Obstetrics	Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Apr 2018		7.97		8.0	
Patient Safety - Obstetrics	Stillbirth (Corrected) Mortality Rate (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	1	1	2	1	1	2	3	Apr 2018		5.98		6.0	
Patient Safety - Obstetrics	Neonatal Death (Corrected) Mortality Rate (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	2	1	0	0	1	0	1	Apr 2018		1.99		2.0	
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	85.0	85.0																			Apr 2018		90.2		90.2	
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0																			Apr 2018		125		125.2	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100.0	97.0					N/A	N/A	N/A			N/A	N/A					N/A	-	-	Feb 2018	0	0	0	0.0	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			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	4.7	-	Mar 2018				4.7	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			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	4.6	-	Mar 2018					4.7
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0	#DIV/0!																	-	Mar 2018	98.7		0	98.7	
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Mar 2018	100			100.0	
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Mar 2018	95			95.0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			4	3	2	4.5	3.5	4.5	3	2	2	5.5	5.5	1.5	6	1	1.5	3.5	1	-	Mar 2018	1	-	0	1	37
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	0	0.5	1.5	3.5	3	1	0	0	3	1	0	0	0	0	0	2	-	Mar 2018	2	-	0	2	10
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			98	98	120	150	162	126	139	95	102	184	141	90	0	86	74	99	133	-	Mar 2018	133	-	0	133	
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	Apr 2018	0	-	0	0	0

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	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	Apr 2018	0			0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			9	12	14	14	12	13	8	12	6	12	8	8	7	4	19	7	16	12	Apr 2018	8	3	1	12	12	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			16	21	24	24	22	19	12	15	14	14	17	15	13	19	29	23	27	26	Apr 2018	0	0	0	26		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Apr 2018	3.28		-	2.3		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2018	0			0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	6	10	6	12	10	12	5	17	4	8	3	10	8	14	11	8	5	6	Apr 2018	6			6	6	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	79	71	80	83	81	83	82	82	80	79	77	73	79	75	73	80	70	74	Apr 2018	74.2	-		74.2		
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	Apr 2018	0	-	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			38	38	20	23	15	9	10	7	11	4	13	15	32	27	21	0	11	9	Apr 2018	6	0	3	9	9	
RTT	RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Apr 2018	84.8			84.8		
RTT	RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Apr 2018	94.2			94.2		
RTT	RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Apr 2018	93.3			93.3		
RTT	RTT - Backlog	<= No	0	0	161	160	111	96	96	98	81	97	91	91	90	81	77	56	47	50	90	94	Apr 2018	94			94		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	2	5	1	1	Apr 2018	1			1		
RTT	Treatment Functions Underperforming	<= No	0	0	3	3	2	1	2	1	1	1	1	1	2	2	1	2	2	2	1	2	Apr 2018	2			2		
RTT	Acute Diagnostic Waits in Excess of 6-weeks	<= %	0.1	0.1																			Apr 2018	0			0.0		

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate G	M	P	Month	Year To Date	
Data Completeness	Open Referrals	No			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	38,615	Apr 2018	9,595	19,445	9,575	38615		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			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	23,118	Apr 2018	6,034	13,524	3,560	23118		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Apr 2018	78.6	68.6	76.3		72.9	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Apr 2018	85.7	100	82.4		87.0	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Apr 2018	3.08	5	3.91	4.3	4.3	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Apr 2018	1.55	4.38	4.01	3.9	3.9	
Workforce	Sickness Absence - Long Term - in month	No			43	30	30	23	29	27	36	28	31	30	29	34	30	30	38	35	35	25	Apr 2018	0	18	7	25.0	25.0	
Workforce	Sickness Absence - Short Term - in month	No			125	114	142	83	105	50	41	40	88	89	91	128	135	131	137	127	106	95	Apr 2018	13	61	21	95.0	95.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Apr 2018	83.2	78.8	78.5	79.08	79.08	
Workforce	Mandatory Training	=> %	95.0	95.0																			Apr 2018	88.2	91.4	0		90.9	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	2.4	-	-	-	6.3	-	-	Feb 2018	5.55	6.38	0		2.4	
Workforce	New Investigations in Month	No			0	0	0	0	1	3	1	0	0	0	0	1	1	1	0	0	0	0	Apr 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	-->	-->	-->	-->	-->	17	-->	-->	-->	Jan 2018	15.3	16.1	17.6	17		
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	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		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			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	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	88.8	-	Mar 2018		-		88.79	86.66	
WCH Group Only	HV (C3) - % of births that receive a face to face new birth visit by a HV >days	%			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	6.61	-	Mar 2018		-		6.61	9.73	
WCH Group Only	HV (C4) - % of children who received a 12 months review by 12 months	=> %	95.0	95.0	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	93.8	-	Mar 2018		-		93.81	93.06	
WCH Group Only	HV (C5) - % of children who received a 12 months review by the time they were 15 months	%			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	97.1	-	Mar 2018		-		97.14	85.92	
WCH Group Only	HV (C6i) - % of children who received a 2 - 2.5 year review	=> %	95.0	95.0	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	93.6	-	Mar 2018		-		93.58	89.43	
WCH Group Only	HV (C6ii) - % of children who receive a 2 - 2.5 year review using ASQ 3	%			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	92.7	-	Mar 2018		-		92.66	86.41	
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	-	-	-	-	-	-	-	Sep 2017		-		1	1	
WCH Group Only	HV (C8) - % of children who receive a 6 - 8 week review	=> %	95.0	95.0	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	99.1	-	Mar 2018		-		99.06	99.12	
WCH Group Only	HV - % of infants for whom breast feeding status is recorded at 6 - 8 week check	=> %	100	100	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	99.1	-	Mar 2018		-		99.06	98.66	
WCH Group Only	HV - % of infants being breastfed at 6 - 8 weeks	%			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	22.6	-	Mar 2018		-		22.57	33.42	
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	-	-	-	-	-	-	-	-	-	-	-	-	-	-	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			132	306	377	-	357	365	390	361	401	403	329	386	388	343	342	290	336	-	Mar 2018		-		336	4334	
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	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			330	310	342	-	322	205	197	212	210	326	263	223	246	209	290	94	99	-	Mar 2018		-		99	2574	
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	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			339	323	343	-	-	26	20	19	28	317	24	21	27	20	26	305	225	-	Mar 2018		-		225	1058	
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	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			34	31	63	-	-	125	171	151	134	193	125	135	141	102	174	64	68	-	Mar 2018		-		68	1583	
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 N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate HA	HI	B	M	I	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Apr 2018	0	0	0	0	0	0	0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2018	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2018	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2018	-	-	-	-	-	-		
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			3	2	4	1	2	1	1	1	0	1	0	3	1	3	2	1	1	0	Apr 2018	0	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			3	1	3	4	4	3	2	2	3	3	3	4	2	3	4	2	3	0	Apr 2018	0	0	0	0	0	0		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2018	-	-	-	-	-	-	-	
Data Completeness	Open Referrals	No			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	7,907	Apr 2018	2,360	0	2,734	0	2,813	7,907		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			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	4,003	Apr 2018	1,363	0	1,372	0	1,268	4,003		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Apr 2018	93	84	84	84	100		87.35	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Apr 2018	100	88	100	100	100		95	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Apr 2018	3.3	1.6	4.6	3.5	2.3	3.65	3.65	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Apr 2018	1.5	1.7	4.1	0.5	6.1	2.74	2.74	
Workforce	Sickness Absence - Long Term - In Month	No			14	6	5	6	8	6	6	6	8	5	3	9	5	10	12	12	6	4	Apr 2018	1.0	0.0	2.0	0.0	1.0	4	4	
Workforce	Sickness Absence - Short Term - In Month	No			49	41	36	35	45	30	30	39	40	51	49	50	48	45	50	40	41	37	Apr 2018	3.0	4.0	16.0	3.0	2.0	37	37	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Apr 2018	86	100	78	99	96	86.9	86.9	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Apr 2018	95	94	93	95	98		95.1	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	3.4	-	-	-	14.1	-	-	Feb 2018	13	14	14	18	17		3.2	
Workforce	New Investigations in Month	No			0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 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	-->	-->	-->	-->	-->	16.2	-->	-->	-->	Jan 2018	7.4	18	18	23	28	16		
Workforce	Your Voice - Overall Score	No			-->	-->	3.82	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.5	3.3	3.9	4	3.9	3.82		

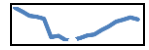
Imaging Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		DR	IR	NM	BS			
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Apr 2018	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Apr 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	2.0	-	Mar 2018					7.1		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	=> %	0	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	21.0	-	Mar 2018						5.25	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			Apr 2018			75.47		75.47	75.47	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.00																			Apr 2018			98.11		98.11	98.11	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2018	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2018	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 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	Apr 2018	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			4	5	4	1	1	4	2	2	3	1	3	2	1	1	4	2	1	3	Apr 2018	3	0	0	0	3	3	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			4	9	3	2	2	1	3	4	5	2	4	3	3	1	4	4	2	3	Apr 2018	2	1	0	0	3		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2018	-	-	-	-	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			60	55	66	54	100	102	128	94	106	100	97	122	111	140	84	0	85	93	Apr 2018	93	0	0	0	93	93	
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Apr 2018	3.19				3.19		
Data Completeness	Open Referrals	No			428	438	461	481	498	512	532	545	560	577	608	623	666	707	736	749	774	790	Apr 2018	790	0	0	0	790		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			373	386	403	421	438	454	474	492	506	531	553	570	596	621	645	659	679	706	Apr 2018	706	0	0	0	706		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Apr 2018	51.1	90.9	50	70.5		53.6	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Apr 2018	90	0	100	0		90.6	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Apr 2018	2.6	9.9	2.0	2.9	3.67	3.67	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Apr 2018	3.2	3.2	1.2	0.9	3.28	3.28	
Workforce	Sickness Absence - Long Term - in month	No			13	10	15	13	9	6	10	7	7	4	6	8	6	4	6	8	11	5	Apr 2018	2.0	0.0	0.0	0.0	5.00	5.00	
Workforce	Sickness Absence - Short Term - in month	No			41	40	53	36	32	29	22	24	22	22	34	31	39	36	41	38	41	38	Apr 2018	17.0	2.0	2.0	6.0	38.00	38.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Apr 2018	90.1	0	62.1	83.8	82.1	82.1	
Workforce	Mandatory Training	=> %	95.0	95.0																			Apr 2018	88	92.9	94.6	96.8		91.3	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	2.8	-	-	-	6.0	-	-	Feb 2018	3.5	5.65	5.01	7.96		2.6	
Workforce	New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	Apr 2018					0		
Workforce	Your Voice - Response Rate	No			-->	-->	20	-->	-->	-->	-->	-->	24	-->	-->	-->	-->	-->	20	-->	-->	-->	Jan 2018	15	20	58	16	19.7		
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			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								

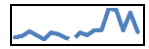
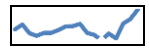
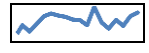
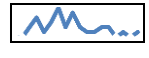
Primary Care, Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		AT	IB	IC			
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.0	80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Apr 2018	10	0	0	10		
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	7	Apr 2018	0	7	0	7	7	
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	7	Apr 2018	0	7	0	7	7	
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	0	Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			1	1	2	0	0	3	2	3	0	3	0	2	1	4	5	2	4	2	Apr 2018	0	2	0	2	2	
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	0	Apr 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	1	0	0	0	0	0	0	0	Apr 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	2	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Falls	<= No	0	0	30	27	20	19	31	23	21	36	36	38	30	33	32	38	27	34	49	45	Apr 2018	0	41	4	45	45	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	1	2	1	0	1	0	0	0	0	2	Apr 2018	0	2	0	2	2	
Patient Safety - Harm Free Care	Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	1	3	2	2	1	5	1	1	1	0	3	1	1	0	2	1	0	2	Apr 2018	0	2	0	2	2	
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Apr 2018	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Apr 2018	0	2	0	2	2	
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	Apr 2018	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			8	4	6	1	1	4	3	8	4	10	2	7	6	4	14	5	5	3	Apr 2018	0	3	0	3	3	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			5	6	6	6	6	9	10	12	9	11	8	8	8	9	14	11	10	10	Apr 2018	7	3	0	10		

Primary Care, Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		AT	IB	IC			
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Apr 2018	76.4	75.8	79.8		77.3	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Apr 2018	3.08	5.07	3.91	4.11	4.11	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Apr 2018	4.13	4.38	2.55	3.71	3.71	
Workforce	Sickness Absence - Long Term - in month	No			23	29	32	24	24	24	19	19	15	24	21	26	36	35	36	32	32	29	Apr 2018	10	-	-	29	29	
Workforce	Sickness Absence - Short Term - in month	No			104	101	102	93	82	57	60	57	78	84	76	121	128	135	146	133	103	91	Apr 2018	14	44	33	91	91	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Apr 2018	83.5	87.1	83.3	85.21	85.21	
Workforce	Mandatory Training	=> %	95.0	95.0																			Apr 2018	0	94.4	0		94.4	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	2.1	-	-	-	3.7	-	-	Feb 2018	0	3.72	0		2.2	
Workforce	New Investigations in Month	No			0	1	0	0	0	0	0	1	0	0	0	1	0	0	0	0	1	0	Apr 2018				0		
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	-->	-->	-->	-->	-->	24.4	-->	-->	-->	Jan 2018	23.8	22.2	26.7	24.4		
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	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		AT	IB	IC			
Community & Therapies Group Only	DVT numbers	=> No	730	61	44	41	52	39	67	41	54	59	70	54	56	55	55	29	53	35	58	54	Apr 2018				54	54	
Community & Therapies Group Only	Adults Therapy DNA rate OP services	<= %	9	9	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	1.42	0.87	3.94	1.15	-	-	-	-	-	14.3	10.2	8.91	-	-	-	11.2	-	-	Feb 2018				11.2	10.6	
Community & Therapies Group Only	Therapy DNA rate S1 based OP Therapy services	<= %	9	9	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	11.2	Apr 2018				11.2	11.2	
Community & Therapies Group Only	STEIS	<= No	0	0	1	0	0	0	0	0	0	-	1	2	3	0	-	0	0	2	-	0	Apr 2018				0	0	
Community & Therapies Group Only	Green Stream Community Rehab response time for treatment (days)	<= No	15.0	15.0	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	25.6	Apr 2018				25.58	25.58	
Community & Therapies Group Only	DNA/No Access Visits	%			2	2	1	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	Apr 2018				0.74		
Community & Therapies Group Only	Baseline Observations for DN	=> %	100	100	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	88.6	Apr 2018				88.58	88.58	
Community & Therapies Group Only	Falls Assessments - DN Intial Assessments only	%			77	69	60	62	58	69	63	57	58	57	54	50	60	60	67	78	91	91	Apr 2018				90.79		
Community & Therapies Group Only	Pressure Ulcer Assessment - DN Intial Assessments only	%			80	71	63	65	63	77	68	63	65	66	62	59	72	70	78	81	92	93	Apr 2018				92.82		
Community & Therapies Group Only	MUST Assessments - DN Intial Assessments only	%			52	46	48	36	46	58	52	46	49	49	49	43	54	55	61	77	90	91	Apr 2018				91.34		
Community & Therapies Group Only	Dementia Assessments - DN Intial Assessments only	%			53	53	52	62	44	55	50	43	60	38	63	41	50	47	59	70	89	83	Apr 2018				83.26		
Community & Therapies Group Only	48 hour inputting rate - DN Service Only	%			93	93	69	93	94	92	90	93	92	93	93	94	96	94	95	94	96	94	Apr 2018				94.09		
Community & Therapies Group Only	Making Every Contact (MECC) - DN Intial Assessments only	%			251	369	308	382	460	488	467	453	428	420	369	556	398	337	424	365	461	496	Apr 2018				91.34	91.34	
Community & Therapies Group Only	Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload acquired)	No			2	5	6	8	6	5	8	4	7	4	3	6	4	4	2	4	4	4	Apr 2018				4	4	
Community & Therapies Group Only	Avoidable Grade 2 Pressure Ulcers (DN caseload acquired)	No			2	2	4	6	3	5	8	4	7	4	3	3	4	4	2	3	2	3	Apr 2018				3	3	
Community & Therapies Group Only	Avoidable Grade 3 Pressure Ulcers (DN caseload acquired)	No			0	3	2	2	2	0	0	0	0	0	0	1	0	0	0	1	2	1	Apr 2018				1	1	
Community & Therapies Group Only	Avoidable Grade 4 Pressure Ulcers (DN caseload acquired)	No			0	0	0	0	1	0	0	0	0	0	0	2	0	0	0	0	0	0	Apr 2018				0	0	

Corporate Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate							Month	Year To Date	Trend
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		SG	F	W	M	E	N	O			
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			11	12	11	11	14	3	9	5	10	2	8	4	9	8	12	8	8	5	Apr 2018	0	0	0	0	0	0	5	5	5	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			18	13	12	17	19	16	17	10	13	5	10	7	11	15	16	11	15	11	Apr 2018	3	0	0	0	1	3	4	11		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Apr 2018	61	56	57	74	53	81	68		68.5	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Apr 2018			95					50.0	50	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Apr 2018	3.07	2.81	2.70	3.99	3.74	5.57	5.36	4.59	4.59	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Apr 2018	2.63	3.10	1.39	4.24	2.21	5.23	4.33	3.86	3.86	
Workforce	Sickness Absence - Long Term - in month	No			64	79	0	1	0	2	1	2	2	2	2	1	2	1	1	2	2	2	Apr 2018	1.00	0.00	0.00	0.00	0.00	1.00	0.00	2.00	2.00	
Workforce	Sickness Absence - Short Term - in month	No			224	191	7	8	8	3	2	3	1	4	10	4	5	7	15	11	12	4	Apr 2018	4.00	0.00	0.00	0.00	0.00	0.00	0.00	4.00	4.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Apr 2018	86.4	59.6	78.7	74.2	88.2	84.2	78.9	80.3	80.3	
Workforce	Mandatory Training	=> %	95.0	95.0																			Apr 2018	0	95	0	98	96	92	96	93.9	94	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	2.7	-	-	-	15.5	-	-	Feb 2018	0	18	0	12	19	18	10	15.5	3	
Workforce	New Investigations in Month	No			0	2	1	1	4	6	0	2	1	1	0	0	1	1	0	2	2	0	Apr 2018	0	0	0	0	0	0	0	0		
Workforce	Your Voice - Response Rate	No			-->	-->	18	-->	-->	-->	-->	-->	21	-->	-->	-->	-->	-->	30	-->	-->	-->	Jan 2018	57.8	46.9	54.6	35.2	36.4	23.4	18.5	29.7		
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 (06/18) 024

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Financial Performance – P01 April 2018		
Sponsoring Executive	Tony Waite, Director of Finance		
Report Author	Tim Reardon, Associate Director of Finance (Compliance) Dinah McLannahan, Deputy Director of Finance		
Meeting	Trust Board	**Date**	7th June 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 P01 April 2018.
Headline performance is reported as being in line with plan on an aggregate basis.

The Board is recommended to challenge and confirm the key components of that plan and prospective outlook to deliver Control Total compliance including specifically:

- Planned Care Production Plan
- CIP programme
- Bed closure trajectory

The Board is reminded that the financial impact of delay to Midland Met and any consequent interim service re-configuration is a specific exclusion to that plan.

The Board is recommended to challenge & confirm the position in respect of the assessment of such impact and progress in securing funding such that those costs do not fall on the local health economy to resolve.

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]*	

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

4. Recommendation(s)

The Trust Board is asked to note the P01 performance and to challenge and confirm:

a.	the plausible route to control total and require any mitigating actions to reduce costs to be expedited
b.	The assessment & funding of costs consequent to the delay to Midland Met

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	

Financial Performance – P01 Cover Sheet Supplement

Key Headlines:

Headlines

Before PSF, theTrust has reported hedline performance that it is on plan. The recovery of PSF is moderated for a failure of the ED performance component in P01.

Cash is ahead of plan by £9m at 30 April due to working capital management.

Financial Performance to Date

- Headline I&E deficit of £4.0m, behind NHSI plan by £0.069m as a result of ED failure resulting in lower PSF
- I&E deficit £4.7m before non-recurrent and technical support, being in line with plan. No unplanned technical support has been utilised in achieving the reported delivery.
- Capital spend is nil in P01 but forecast to achieve plan. Orders placed against capital codes is being interrogated but is minimal.
- Cash at 30th April £16.4m being £9m more than plan. This is due mainly to reduced levels of payments during Month 1 following new system implementation. Future cash forecasts assume catch up.
- However, P01 does include £0.47m PSF and £0.225m of taper relief net contribution on a presumption that these will be secured. This is consistent with NHSI plan submission. PSF requires consistent delivery to headline financial plan and improvement in ED performance to key milestones.

Savings

- P01

CIP summary [excluding margin]	P01	
TPRS - savings profile [exc. Margin]	1211	
NHSI plan - savings profile [exc. Margin]	1109	-388
Actual - CIP delivered [exc. Margin]	721	
Planning gap	102	-388
Delivery gap	-490	

-
- There is no adjustment to the forecast at this stage as it is judged that time and opportunity provides for a plausible prospect of recovery & remediation. This will be kept in view on a monthly basis.

Capital

- Capital expenditure to date in P01 is reported as nil against a full year plan of £34.6m. A rate of monthly spend in excess of £2.8m is expected per the plan. This is subject to continual review in the light of MMH developments and progress in relation to EPR. There will be a full update at Month 2.

Cash

- The cash position is £9m above plan at 30th April. This is due to reduced creditors payments during April.

- Based on the revised operational cash forecast for 2018/19 the revenue borrowing requirement anticipated for June is now expected to crystallise in July 2018/19. This requirement is based on not receiving 2017/18 PSF in July. If this is received any loan requirement will be deferred to October 2018. This has been communicated to NHSI.
- EFL compliance is subject to delivery of the I&E financial improvement programme delivering cashable savings during H2 2018/19.

Better Payments Practice Code

- Performance in April is expected to improve following the drive to clear down creditors in March. However, it is expected that this target will not be achieved in FY 2018/19 given pressures on the cash position.

Group level performance

- The finance team have introduced group level analysis for the beginning of the new financial year, with a view to improving the impact of operational and clinical performance on the overall Trust financial position, and with the expectation that this will focus action in the right areas, as well as the existing governance of Finance GPOs and Group Review meetings. It will be enhanced and evolved as we progress through the financial year.

Finance Report

Period 01 2018/19
April 2018

Trust Board
7 June 2018

Contents

Page Title

Finance Report

Summary & Recommendations

Period 01 2018/19

Statutory Financial Duties	Value	Outlook	Note
I&E control total surplus	£3.5m	√	1
Live within Capital Resource Limit	£34.6m	√	2
Live within External Finance Limit	£10.8m	√	3

1. **Forecast surplus £3.5m formally reported. Achievement subject to CIP delivery and capacity management to ensure budgeted income achieved.**
2. **CRL per plan submission. £20.8m requires NHSI approval.**
3. **EFL based on £3.5m surplus and opening cash of £9.7m.**

Outlook

- NHSI P01 return forecast surplus £3.5m, consistent with achieving control total agreed in 30th April NHSI plan submission.
- Achievement requires development of production planning and roster management as core competences.
- Required opex run rate change also depends on CIP delivery and additional efficiency delivery, which the Board and FIC are sighted on.

P01 key issues & remedial actions

- P01 headline performance reported as £0.1m behind plan due to PSF shortfall.
- PSF shortfall follows P01 ED failure. Plan sets out that ED performance will be recovered securing full year PSF.
- Delivery of financial efficiency to the value of £37.3m required in 2018/19. £21.9 plans in TPRS plus £6.8m of margin on income (Planned income > cost of contract reserve) in budgets.
- Therefore, £8.6m unidentified financial efficiencies.
- Shortfall in delivery against identified measures in P01. Plan step up in financial improvement from P02.
- Reduced agency spend in P01 compared to P12 but remains above plan trajectory.
- Delivery of planned agency spend will meet the agency ceiling provided by NHSI.
- Capex programme being pursued as plan at this point in time. CRL remains to be confirmed by NHSi. Review of capex could be required to reflect way forward with Midland Met as more is known, and CRL application will follow.
- Cash borrowing requirements subject to routine assessment. Loan requirement reviewed & application planned. Anticipated revenue loan requirement currently indicated in July 2018/19.

Recommendation

- Challenge and confirm:
  - reported P01 position
  - plausible route to control total and require mitigating actions to reduce costs to be expedited.

Finance Report

I&E Performance – Full Year – As reported

Period 01 2018/19

Period 01	CP Plan £'000s	CP Actual £'000s	CP Variance £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s	FY Plan £'000s	FY Forecast £'000s	FY Variance £'000s
Patient Related Income	32,929	33,670	741	32,929	33,670	741	423,744	423,744	0
Other Income	4,762	4,074	(688)	4,762	4,074	(688)	68,090	68,090	0
Income total	**37,691**	**37,744**	**53**	**37,691**	**37,744**	**53**	**491,834**	**491,834**	**0**
Pay	(26,683)	(26,635)	48	(26,683)	(26,635)	48	(314,351)	(314,351)	0
Non-Pay	(14,047)	(14,235)	(188)	(14,047)	(14,235)	(188)	(163,318)	(163,318)	0
Expenditure total	**(40,730)**	**(40,870)**	**(140)**	**(40,730)**	**(40,870)**	**(140)**	**(477,669)**	**(477,669)**	**0**
EBITDA	**(3,039)**	**(3,126)**	**(87)**	**(3,039)**	**(3,126)**	**(87)**	**14,165**	**14,165**	**0**
Non-Operating Expenditure	(907)	(877)	30	(907)	(877)	30	(10,889)	(10,889)	0
Technical Adjustments	18	6	(12)	18	6	(12)	213	213	0
DH Surplus/(Deficit)	**(3,928)**	**(3,997)**	**(69)**	**(3,928)**	**(3,997)**	**(69)**	**3,489**	**3,489**	**0**
Add back PSF	*(553)*	*(470)*	*83*	*(553)*	*(470)*	*83*	*(11,056)*	*(11,056)*	*0*
Adjusted position	***(4,481)***	***(4,467)***	***14***	***(4,481)***	***(4,467)***	***14***	***(7,567)***	***(7,567)***	***0***
Technical Support (inc. Taper Relief)	*(225)*	*(225)*	*0*	*(225)*	*(225)*	*0*	*(2,700)*	*(2,700)*	*0*
Underlying position	***(4,706)***	***(4,692)***	***14***	***(4,706)***	***(4,692)***	***14***	***(10,267)***	***(10,267)***	***0***

The trust reported a headline deficit for P01 of £4.0m being £69k behind plan having taken account of the PSF failure related to A&E 4hr waiting times performance.

This is consistent with plan for P01. P01 plan surplus is £3.9m and included £1.6m CIP delivery. This represents less than 4% of the total plan CIP for 2018/19.

The table shows performance against the **NHSI planned** levels of income, pay and non-pay spend. The full year plan includes delivery of a £37.3m financial efficiency including commercial and other non-operational improvements leading to £3.5m surplus. At P01 this plan surplus out-turn remains the SWBH forecast.

The underlying deficit for P01 is recorded as £4.7m. The following support is included:

- PSF (previously STF) of £470k. This assumes ED failure in P01 which explains the difference between actual and plan PSF values.
- Taper relief income of £483k and associated costs of £225k have been accrued. This is consistent with plan assumptions.

Finance Report

Pay bill & Workforce

Period 01 2018/19

Pay and Workforce	Current Period	Previous Period	Change between periods	%	Plan YTD	Actual YTD	Variance YTD
Pay - total spend	£26,635k	£26,333k	£302k	1%	£26,683k	£26,635k	-£48k
Pay - substantive	£23,394k	£21,459k	£1,935k	9%	£22,763k	£23,394k	£631k
Pay - agency spend	£1,324k	£1,468k	-£144k	-10%	£2,815k	£1,324k	-£1,491k
Pay - bank (inc. locum) spend	£1,917k	£3,406k	-£1,489k	-44%	£1,105k	£1,917k	£812k
WTE - total	6,863	7,008	-145	-2%	7,111	6,863	-248
WTE - substantive	6,109	6,077	32	1%	6,252	6,109	-143
WTE - agency	155	174	-19	-11%	694	155	-539
WTE - bank (inc. locum)	599	756	-157	-21%	165	599	434

Agency Ceiling	Current Period	Previous Period	Change between periods	%	Plan FY	Ceiling FY	Variance
As above: agency spend	£1,324k	£1,468k	-£144k	-10%	£10,649k	£10,649k	£0k
As above: agency WTE	155	174	-19	-11%	55	55	0

- Total workforce at the end of April of 6,863 WTE [being 248 lower than plan] and including 155 WTE of agency staff. Total pay costs (including agency workers) were £26.6m in April. NHSI plan pay spend for April is £26.7m.
- The shift month on month is in the right direction, being away from agency and bank and towards substantive costs.
- Significant reduction in temporary pay costs required to be consistent with FY 2018/19 plan assumptions. £0.37m step reduction in plan pay required in P02 and further step reduction in P07 to £26.068m. Delivery of objectives in relation to capacity and improved roster management required to secure plan levels of pay spend.
- The Trust did not comply with national agency framework guidance for agency suppliers in April. Shifts procured outside of this are subject to COO approval and is driven by strict commitment to maintaining safe staffing, in line with rules.
- The Trust's agency cap for 2018/19 is £10,649k (£11,672k in 2017/18). The Trust plan is in line with this ceiling. The agency spend for Period 1 was £1.105m, so the Trust is £219k behind plan.

Finance Report

Income Analysis

Period 01 2018/19

Performance Against SLA by Patient Type									
	Activity					Finance			
	Annual Plan	Planned	Actual	Variance		Annual Plan £000	Planned £000	Actual £000	Variance £000
A&E	221,449	19,249	17,510	-1,739		£25,438	£2,214	£2,074	-£140
Emergencies	47,769	3,679	3,897	218		£97,248	£7,525	£7,764	£239
Emergency Short Stay	7,517	552	630	78		£5,687	£417	£471	£53
Excess bed days	13,052	1,006	802	-204		£3,402	£263	£227	-£36
Urgent Care						**£131,775**	**£10,419**	**£10,536**	**£117**
OP New	199,973	15,198	14,677	-521		£30,351	£2,308	£2,158	-£150
OP Procedures	75,998	5,776	6,860	1,084		£12,265	£932	£1,114	£182
OP Review	347,135	26,382	26,447	64		£24,947	£1,898	£1,844	-£54
OP Telephone	17,586	1,337	1,262	-75		£422	£32	£30	-£2
DC	40,206	3,015	2,692	-324		£34,064	£2,555	£2,140	-£414
EL	6,111	483	436	-47		£14,576	£1,151	£1,058	-£93
Planned Care - production plan						**£116,626**	**£8,877**	**£8,345**	**-£532**
Planned care outside production plan	28,335	2,197	2,130	-67		£7,665	608	£647	£39
Maternity	19,597	1,627	1,583	-44		£18,741	£1,555	£1,499	-£57
Renal dialysis	672	44	106	62		£81	£5	£13	£7
Community	647,544	45,460	53,330	7,870		£37,216	£2,720	£2,788	£68
Cot days	14,366	1,077	988	-89		£7,299	£547	£483	-£65
Other contract lines	4,065,570	337,442	328,401	-9,041		£94,727	£7,863	£7,838	-£24
Unbundled activity	64,025	4,816	4,862	47		£6,912	£512	£539	£27
Other						**£172,641**	**£13,811**	**£13,806**	**-£4**
Sub-Total: Main SLA income (excl fines)						**£421,042**	**£33,107**	**£32,687**	**-£419**

Notes

- This table shows the Trust's year to date patient related income including SLA income performance by point of delivery as measured against the contract price & activity schedule. NB – this is not the full quantum of Patient Related Income and therefore does not agree exactly to slide 3.
- Planned care within the production plan is behind by circa £0.5m in P01 as measured against the [CCG] contract plan profile. This contract plan may be different from the internal production plan. This is subject to regular review and re-phased based on YTD performance. Internal information suggests that production plan income is circa £160k off plan for Month 1. Month 2 is predicted to be £180k ahead of plan.

Finance Report

CIP Board – P01 headline

Period 01 2018/19

Worked Up	Agreed/Groupified
Objective	£37,300,000
TPRS + Margin	£29,297,379*

Notes

- * the £6.8m margin is being input into TPRS;

Being worked up	
Other opportunities held centrally (working through)	£29,045,000**

Notes

- ** the two biggest areas of opportunity are: car parking and uncommitted reserves which represent ~£21m;

Total Opportunity	
Total scale of opportunity	£58,342,379

Notes

- The Month 1 overall financial position is on track;
- CIP delivery is off track by £491k against plan;
- 55% of the £491k CIP under delivery is caused by forecasting straight line benefits in some non pay categories through the year e.g. furniture, stationery and procurement;
- 15% relates to business rates and energy;
- Although the grip and control opportunity is still being worked up there is some evidence that it is working in practice;
- With the exception of the straight line forecasting issue for some non pay categories Q1 looks robust.

Finance Report

CIP achievement

Period 01 2018/19

Year to Date up to Period 1	18/19 In Year Target £'000s	In Year Actual and Forecast Delivery												In Year 18/19 YTD £'000s	In Year 18/19 Fcast Outturn £'000s
		Apr Actual 1 £'000s	May F/Cast 2 £'000s	Jun F/Cast 3 £'000s	Jul F/Cast 4 £'000s	Aug F/Cast 5 £'000s	Sep F/Cast 6 £'000s	Oct F/Cast 7 £'000s	Nov Actual 8 £'000s	Dec F/Cast 9 £'000s	Jan F/Cast 10 £'000s	Feb F/Cast 11 £'000s	Mar F/Cast 12 £'000s		
Medicine and Emergency Care	4,665	50	335	373	376	367	371	458	458	458	458	458	458	50	4,665
Surgical Services	2,437	34	176	176	204	204	204	223	223	224	227	227	227	34	2,437
Women and Child Health	1,604	41	108	116	120	121	126	151	151	151	151	151	151	41	1,604
Primary Care,Community and Therapies	1,559	39	122	122	122	122	122	148	148	148	148	148	148	39	1,559
Pathology	538	5	36	37	39	39	77	39	47	47	47	47	47	5	538
Imaging	846	39	56	62	71	71	73	78	78	78	78	78	76	39	846
Sub-Total Clinical Groups	**11,649**	**208**	**834**	**886**	**932**	**924**	**972**	**1,096**	**1,104**	**1,106**	**1,109**	**1,109**	**1,107**	**208**	**11,649**
Strategy and Governance	844	28	38	38	89	79	79	80	80	80	80	80	80	28	844
Finance	438	12	18	24	58	38	38	39	39	39	51	41	41	12	438
Medical Director's Office	918	39	68	68	68	81	81	81	81	81	81	81	81	39	918
Operations	1,530	59	95	85	91	92	92	117	119	173	173	198	198	59	1,530
People & Organisation Development	582	19	60	45	45	45	45	57	57	47	47	47	47	19	582
Estates and NHP	1,812	23	187	144	146	149	149	149	149	149	149	149	149	23	1,812
Corporate Nursing	544	38	45	45	45	45	45	45	45	45	45	45	45	38	544
Sub-Total Corporate	**6,668**	**217**	**511**	**449**	**544**	**529**	**529**	**568**	**570**	**614**	**626**	**641**	**641**	**217**	**6,668**
Central	3,548	296	296	296	296	296	296	296	296	296	296	296	296	296	3,548
		0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**21,864**	**721**	**1,641**	**1,631**	**1,771**	**1,748**	**1,797**	**1,960**	**1,970**	**2,016**	**2,030**	**2,045**	**2,043**	**721**	**21,864**
NHSI Plan		1,609	2,053	2,097	2,333	2,327	2,402	2,578	2,612	2,657	2,676	2,687	11,260	37,291	
£21.864m TPRS Plan		1,211	1,641	1,631	1,771	1,748	1,797	1,960	1,970	2,016	2,030	2,045	2,043	21,864	
Planning gap (inc. £6.8m of margin)		-398	-412	-466	-562	-579	-605	-618	-642	-641	-646	-642	-9,217	-15,427	
Delivery gap		-491												-491	
% Delivery Failure		-40%													

Notes

- In the assumed delivery of control total the £37.3m of financial improvements includes CIP delivery reflected on TPRS of £21.9m.
- Operational under-performance was reported in P01 against a low target. The intention is to recover this in the full year, however a run rate change is required to achieve the 2018/19 average of £1.8m/month.
- It should be noted that the income and expenditure budgets (if remained within) contain £6.8m of margin contribution to the financial challenge. This means the planning gap is therefore £8.6m. Board papers refer to proposals to close this gap.

Finance Report

SOCF

Period 01 2018/19

ACTUAL/FORECAST	April Actual £000s	May Forecast £000s	June Forecast £000s	July Forecast £000s	August Forecast £000s	September Forecast £000s	October Forecast £000s	November Forecast £000s	December Forecast £000s	January Forecast £000s	February Forecast £000s	March Forecast £000s
Receipts												
SLAs: SWB CCG	23,718	22,603	22,603	22,603	22,603	23,603	23,603	23,361	23,361	23,361	23,361	23,361
Associates	7,245	6,466	6,466	6,466	6,466	6,466	6,466	6,466	6,466	6,466	6,466	6,466
Other NHS	1,074	0	0	0	0	0	835	898	1,258	1,110	687	1,162
Specialised Services	3,327	3,896	3,896	3,896	3,896	3,896	3,536	3,787	3,364	3,161	3,879	3,816
STF Funding	0	0	0	12,822	1,659	0	0	0	2,211	0	0	0
Over Performance	0	0	0	0	0	0	0	0	0	0	0	0
Education & Training - HEE	378	0	4,476	0	0	4,476	0	0	4,405	0	0	4,405
Public Dividend Capital	0	0	0	0	0	0	0	0	0	0	0	0
Loans	0	0	0	0	0	0	3,000	4,500	0	0	0	0
Other Receipts	1,232	2,075	2,075	2,075	2,075	2,075	1,375	2,075	2,075	2,075	2,075	2,075
Total Receipts	36,974	35,040	39,516	47,862	36,699	40,516	38,815	41,088	43,140	36,174	36,468	41,285
Payments												
Payroll	13,821	14,103	14,103	14,154	14,103	14,154	12,604	12,759	12,904	12,604	12,353	12,604
Tax, NI and Pensions	10,090	10,080	10,080	10,080	10,080	10,080	8,976	9,087	9,190	8,976	8,797	8,976
Non Pay - NHS	1,550	1,550	1,550	1,550	1,550	1,550	1,550	1,550	1,550	1,550	1,550	1,550
Non Pay - Trade	1,030	10,789	11,616	11,846	11,841	11,602	11,694	11,918	11,262	9,687	9,653	10,393
Non Pay - Capital	236	4,221	2,394	2,164	2,169	2,408	4,303	4,305	4,538	2,623	2,622	2,689
PDC Dividend	0	0	0	0	0	4,350	0	0	0	0	0	4,350
Repayment of Loans & Interest	0	0	0	0	0	0	0	0	1,500	0	0	0
BTC Unitary Charge	440	440	440	440	440	440	440	440	440	440	440	440
NHS Litigation Authority	1,473	1,092	1,092	1,092	1,092	1,092	1,092	1,092	1,092	1,092	0	0
Other Payments	1,672	94	94	118	94	118	140	190	240	240	180	240
Total Payments	30,312	42,369	41,369	41,443	41,369	45,793	40,799	41,341	42,716	37,212	35,595	41,242
Cash Brought Forward	9,689	16,351	9,022	7,169	13,587	8,917	3,640	1,656	1,403	1,827	789	1,662
Net Receipts/(Payments)	6,662	(7,329)	(1,853)	6,419	(4,670)	(5,277)	(1,984)	(253)	424	(1,038)	872	43
Cash Carried Forward	16,351	9,022	7,169	13,587	8,917	3,640	1,656	1,403	1,827	789	1,662	1,705

- This cash flow incorporates P01 actual movements and H1 operational forecast. The Trust ended P01 with £16.3m in cash.
- The closing balance of £1.7m for 1819, following receipt of a £6m DH loan in year, is consistent with plan assumptions.
- In H2 CIP impacts result in:
    - Reduced Payroll and related tax, NI & pens
    - Reduced Trade payables
- The balance of 2017/18 STF is anticipated for July 2018. Although the NHSI plan indicated a £6m loan in June 2018, repaid in July, a recent review of cash balances indicates an expected June cash balance of £7m. Therefore, as long as 1718 STF/PSF is received in July 2018, in year borrowing will not be required until October 2018, partially repaid in year.
- The finance team's internal operational cash flow ignores the impact of CIPs and anticipates a later receipt of 2017/18 STF. It is this operational cash flow that has informed the view that a DH loan could be required in July 2018. This approach is adopted to ensure the Trust does not run out of cash.

Finance Report

SOFP

Period 01 2018/19

	Balance as at 31st March 2018 £000	Balance as at 30th April 2018 £000	NHSI Planned Balance as at 30th April 2018 £000	Variance to plan as at 30th April 2018 £000	NHSI Plan as at 31st March 2019 £000	Forecast 31st March 2019 £000
Non Current Assets						
Property, Plant and Equipment	226,889	226,881	228,295	(1,414)	245,162	245,162
Intangible Assets	698	698	106	592	106	106
Trade and Other Receivables	62,941	62,861	62,941	(80)	62,941	62,941
Current Assets						
Inventories	4,742	4,742	4,742	0	4,742	4,742
Trade and Other Receivables	52,897	54,914	55,185	(271)	47,174	47,174
Cash and Cash Equivalents	9,689	16,351	7,367	8,984	1,705	1,705
Current Liabilities						
Trade and Other Payables	(64,208)	(77,397)	(69,135)	(8,262)	(59,791)	(59,791)
Provisions	(1,855)	(1,855)	(1,855)	0	(1,855)	(1,855)
Borrowings	(2,166)	(2,166)	(1,062)	(1,104)	(6,062)	(6,062)
DH Capital Loan	0	0	0	0	0	0
Non Current Liabilities						
Provisions	(3,454)	(3,454)	(3,454)	0	(3,454)	(3,454)
Borrowings	(31,786)	(31,192)	(31,435)	243	(29,433)	(29,433)
DH Capital Loan	0	0	0	0	0	0
	254,387	**250,383**	**251,695**	**(1,312)**	**261,235**	**261,235**
Financed By						
Taxpayers Equity						
Public Dividend Capital	226,891	226,891	226,891	0	226,891	226,891
Retained Earnings reserve	8,693	4,689	4,739	(50)	11,961	11,961
Revaluation Reserve	9,745	9,745	11,007	(1,262)	13,325	13,325
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	254,387	**250,383**	**251,695**	**(1,312)**	**261,235**	**261,235**

Notes

- The table is a summarised SOFP for the Trust including the actual and planned positions at the end of April and the full year.
- Creditors payments were deferred as data was migrated onto Oracle fusion (open and receipted purchase orders as well as unpaid invoices).
- As a consequence of the deferred payments payables exceed plan and the cash balance at the end of April reflects this.

Finance Report

Use of Resources Rating

Period 01 2018/19

Finance and use of resources rating	Expected Sign	03PLANYTD Plan 31/03/2018 YTD Number	03ACTYTD Actual 31/03/2018 YTD Number	03VARYTD Variance 31/03/2018 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	+	1	1		1	1		PRR0160
Liquidity rating	+	4	2		4	2		PRR0170
I&E margin rating	+	1	1		1	1		PRR0180
I&E margin: distance from financial plan	+		1			1		PRR0190
Agency rating	+	2	3		2	3		PRR0200

Overall finance and use of resources risk rating	Expected Sign	03PLANYTD Plan 31/03/2018 YTD Number	03ACTYTD Actual 31/03/2018 YTD Number	03VARYTD Variance 31/03/2018 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	+		1.60			1.60		PRR0202
If unrounded score ends in 0.5	+		0.00			0.00		PRR0204
Risk ratings before overrides	+		2			2		PRR0206
Risk ratings overrides:								
Any ratings in table 6 with a score of 4 override - if any 4s "trigger" will show here	Text		No trigger			No 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	+		2			2		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	+		2			2		PRR0220

Notes

- The Trust's latest* use of resources rating year to date is 2 (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 previously this was recorded as a 4. Consequently the Trust's overall rating was limited to a 3. However, with the improved position and additional STF the capital service cover has improved and the Trust's overall rating no longer limited to 3.
- Agency spend remains more than plan resulting in a score of 3.

*This is P12 and is consistent with P11. 2018/19 information is not yet available.

Appendices

Finance Report

Appendix 1 - Technical support

Period 01 2018/19

Contingency & flexibility utilised in delivering actual FY performance

	P01 Month	P01 YTD
Unplanned contingency & flexibility	**£k**	**£k**
Unplanned	0	0
	0	0
Planned contingency & flexibility		
Taper relief - timing - income to fund prior year/non-revenue items	225	225
Other contingency & flexibilities utilised	0	0
	225	225
Total contingency & flexibility utilised	**225**	**225**

Notes

This details the non-operational support that has been utilised to achieve the reported I&E positions. Note:

- Taper relief income is being accrued, in line with plan assumptions and previous treatment. The improvement to the position relates to the net position.
- No unplanned balance sheet or other technical flexibility has been utilised to achieve the reported position.

Finance Report

Appendix 2 - Reserves

Period 01 2018/19

RESERVES POSITION MONTH 1

	Group/Dir	Pay	Non Pay	Non Operational Costs	Total
Startpoint					
Taper Relief Income/Expenditure	Central - Reserves		(100)		**(100)**
National Inflation	Central - Reserves	(5,926)	(3,017)	(1,232)	**(10,175)**
Local Inflation	Central - Reserves	(600)	(127)	(1,000)	**(1,727)**
Developments (£1050 to EPR)	Central - Reserves		(1,950)		**(1,950)**
Investments	Central - Reserves	(1,000)			**(1,000)**
Planning Contingency	Central - Reserves		(2,000)		**(2,000)**
Gynae Onc Stranded Costs	Central - Reserves	(332)			**(332)**
Additional STF Cost Reserves (CNST)	Central - Reserves		(1,449)		**(1,449)**
Cost of Contract	Central - Reserves	(4,031)	(3,485)		**(7,516)**
Total		**(11,889)**	**(12,128)**	**(2,232)**	**(26,249)**
Month 1 Changes					
Cost of Contract increase (revised contract)	Central - Reserves		(3,950)		**(3,950)**
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			0	**0**
Total		**2,027**	**1,225**	**0**	**3,252**
Month 1 Balance Carried Forward					
Taper Relief Income/Expenditure	Central - Reserves		(100)		**(100)**
National Inflation	Central - Reserves	(5,926)	(3,017)	(1,232)	**(10,175)**
Local Inflation	Central - Reserves	(600)	(127)	(1,000)	**(1,727)**
Developments (BTC Imaging)	Central - Reserves		(900)		**(900)**
Investments	Central - Reserves	(1,000)			**(1,000)**
Planning Contingency	Central - Reserves		(2,000)		**(2,000)**
Gynae Onc Stranded Costs	Central - Reserves	(332)			**(332)**
Additional STF Cost Reserves (CNST)	Central - Reserves		0		**0**
Cost of Contract	Central - Reserves	(2,004)	(4,759)		**(6,763)**
Total		**(9,862)**	**(10,903)**	**(2,232)**	**(22,997)**

The Month 1 changes left us with an annual budget of £22.3m. Of these, the following may be uncommitted.

TR £100k

Developments (if BTC imaging is delayed - £900k

Investments and planning contingency £1.9m (Subject to funding of cost pressures)

Gynae Onc stranded costs £332k

The balance of the cost of contract £6.763m – subject to any additional calls on this over and above the month 1 adjustments, and any under-performance on contracted income that could be a call on this

Total currently uncommitted (subject to the issues above and also the inflation reserves being sufficient) **£9.95m**

Finance Report
Medicine and Emergency Care

Appendix 3 - Group Analysis
Period 01 2018/19

	Annual	WTE		Current Period		
MEDICINE & EMERGENCY CARE	Budget	Budget	Actual	Budget	Actual	Variance
1 - Patient Related Income	134,803	0.00	0.00	10,653	10,676	23
2 - Other Income	679	0.00	0.00	57	57	0
Total Income	**135,482**	**0**	**0**	**10,709**	**10,732**	**23**
3 - Pay	-75,900	1,453.40	1,572.78	-6,619	-6,650	-31
4 - Non Pay	-24,480	0.00	0.00	-2,040	-1,694	346
Total Expenditure	**-100,379**	**1,453**	**1,573**	**-8,659**	**-8,344**	**315**
Net I&E	**35,102**	**1,453**	**1,573**	**2,050**	**2,388**	**338**

Narrative

The pay pressure relates to CIP slippage against Medical Locums & Admin. There is also premium pressures of vacancies across the wards, including additional bed pressures for unfunded beds.

Non pay Underspend relates to pass through drugs in oncology. This is offset against CIP slippage relating to Procurement led schemes.

	ACTIVITY			INCOME		
Commissioner Income	Plan	Actual	Variance	Plan	Actual	Variance
				£000's	£000's	£000's
A&E Attendances	17,702	15,991	-1,711	2,089	1,860	-229
Emergencies	2,065	2,242	177	4,259	4,429	170
Electives	60	82	22	107	143	37
Day Case	580	609	29	433	447	14
Outpatients	9,855	11,106	1,250	1,536	1,790	254
Community	0	0	0	0	0	0
Maternity	0	0	0	0	0	0
Other	10,476	10,851	375	3,124	3,103	-21
	40,739	**40,881**	**141**	**11,547**	**11,772**	**225**

Narrative

Income over performance driven by OP activity in Gastro and emergency activity in Haematology & Respiratory.

This is offset against underperformance in Oncology pass through income and ED attendances.

Finance Report
Surgical Services

Appendix 3 - Group Analysis
Period 01 2018/19

	Annual	WTE		Current Period		
SURGICAL SERVICES	Budget	Budget	Actual	Budget	Actual	Variance
1 - Patient Related Income	114,726	0.00	0.00	8,876	8,642	-234
2 - Other Income	2,426	0.00	0.00	196	220	24
Total Income	**117,152**	**0**	**0**	**9,072**	**8,862**	**-210**
3 - Pay	-71,948	1,376.71	1,356.26	-6,069	-5,942	127
4 - Non Pay	-23,500	0.00	0.00	-1,958	-1,906	52
Total Expenditure	**-95,448**	**1,377**	**1,356**	**-8,027**	**-7,848**	**180**
Net I&E	**21,704**	**1,377**	**1,356**	**1,045**	**1,014**	**-31**

Narrative

The adverse position is driven by patient contract under delivery which is only partially offset by resultant favourable expenditure variances.

CIP slippage of £90k has been masked by low non pay expenditure overall.

	ACTIVITY			INCOME		
Commissioner Income	Plan	Actual	Variance	Plan	Actual	Variance
				£000's	£000's	£000's
A&E Attendances	1,546	1,519	-27	151	215	64
Emergencies	891	1,065	174	1,534	1,790	257
Electives	370	318	-52	959	851	-109
Day Case	1,839	1,564	-275	1,801	1,435	-366
Outpatients	26,883	26,799	-84	2,644	2,558	-86
Community	0	0	0	0	0	0
Maternity	0	0	0	0	0	0
Other	3,646	3,627	-19	1,573	1,536	-37
	35,176	**34,892**	**-284**	**8,662**	**8,385**	**-276**

Narrative

Indicative period 01 contract income shows planned care in deficit by £560k with only partial mitigation through emergencies and BMEC A&E over-performance.

Finance Report
Women and Child Health

Appendix 3 - Group Analysis
Period 01 2018/19

WOMEN & CHILD HEALTH	Annual Budget	WTE Budget	Current Period Actual	Current Period Budget	Current Period Actual	Current Period Variance
1 - Patient Related Income	77,532	0.00	0.00	6,219	5,806	-413
2 - Other Income	950	0.00	0.00	79	63	-16
Total Income	**78,482**	**0**	**0**	**6,299**	**5,869**	**-429**
3 - Pay	-38,317	916.07	838.81	-3,211	-3,195	16
4 - Non Pay	-10,224	0.00	0.00	-860	-982	-122
Total Expenditure	**-48,541**	**916**	**839**	**-4,071**	**-4,177**	**-106**
Net I&E	**29,940**	**916**	**839**	**2,227**	**1,692**	**-535**

Narrative

The adverse income position is driven by under-performance against Births, Ante-Natal Maternity Pathway, Paediatric emergency activity and Gynaecology & Gynae Oncology Day Case and Elective activity.

The adverse non-pay variance is driven by expenditure to deliver the Gynae Oncology service , for which funding is awaited from Reserves, and an over-spend on Maternity Pathway recharges from other organisations due to non-delivery of the TSP to seek agreement to local SLA terms.

Commissioner Income	ACTIVITY Plan	ACTIVITY Actual	ACTIVITY Variance	INCOME Plan £000's	INCOME Actual £000's	INCOME Variance £000's
A&E Attendances	0	0	0	0	0	0
Emergencies	1,268	1,215	-53	2,149	2,006	-143
Electives	105	79	-27	280	230	-50
Day Case	175	173	-2	110	98	-12
Outpatients	3,153	2,645	-507	453	379	-74
Community	2,002	2,045	43	697	697	0
Maternity	1,627	1,583	-44	1,555	1,499	-57
Other	1,608	1,464	-144	903	847	-57
	9,939	**9,204**	**-735**	**6,148**	**5,756**	**-392**

Narrative

The adverse variance against Emergency activity is related to under-performance against Births and Paediatric activity.

The Elective activity under-performance relates to Gynaecology and Gynae Oncology; the Outpatient under-performance is driven by Paediatrics, Gynaecology and Maternity and Maternity activity relates to Maternity Pathway under-performance.

Finance Report PCCT

Appendix 3 - Group Analysis

Period 01 2018/19

	Annual	WTE		Current Period		
PRIMARY CARE, COMMUNITY & THERAPIES	Budget	Budget	Actual	Budget	Actual	Variance
1 - Patient Related Income	59,967	0.00	0.00	4,569	4,652	84
2 - Other Income	819	0.00	0.00	68	65	-3
Total Income	**60,785**	**0**	**0**	**4,637**	**4,718**	**81**
3 - Pay	-36,151	964.78	927.06	-3,080	-3,064	15
4 - Non Pay	-18,973	0.00	0.00	-1,581	-1,563	18
Total Expenditure	**-55,125**	**965**	**927**	**-4,661**	**-4,627**	**33**
Net I&E	**5,661**	**965**	**927**	**-24**	**90**	**114**

Narrative

Pay surplus relates to reductions in medical staffing costs in Rheumatology and Diabetes, and reduced agency costs in ICares and due to the closure of eight beds on McCarthy ward.

Non Pay underspend relates to High Cost Drugs /Insulin pumps, offset by income underperformance. The rest of the underspend is driven by EOL, offset in part by underachievement of the property and other non-pay TSPs.

	ACTIVITY			INCOME		
Commissioner Income	Plan	Actual	Variance	Plan £000's	Actual £000's	Variance £000's
A&E Attendances	0	0	0	0	0	0
Emergencies	5	3	-2	14	7	-7
Electives	3	4	1	3	4	0
Day Case	292	285	-7	151	143	-8
Outpatients	6,648	6,576	-72	588	575	-12
Community	43,403	51,223	7,820	2,001	2,059	58
Maternity	0	0	0	0	0	0
Other	18,100	28,590	10,489	1,095	1,134	39
	68,452	**86,680**	**18,228**	**3,853**	**3,923**	**70**

Narrative

Income over performance driven by District Nursing £46k and Outpatient New appointments in Physio £28k.

Finance Report Pathology

Appendix 3 - Group Analysis

Period 01 2018/19

Pathology	Annual Budget	WTE Budget	WTE Actual	Current Period Budget	Current Period Actual	Current Period Variance
1 - Patient Related Income	16,432	0.00	0.00	1,332	1,191	-140
2 - Other Income	7,007	0.00	0.00	584	518	-66
Total Income	**23,440**	**0**	**0**	**1,916**	**1,709**	**-206**
3 - Pay	-12,315	336.82	305.41	-1,027	-1,012	15
4 - Non Pay	-11,101	0.00	0.00	-933	-964	-31
Total Expenditure	**-23,416**	**337**	**305**	**-1,960**	**-1,976**	**-16**
Net I&E	**24**	**337**	**305**	**-44**	**-267**	**-222**

Narrative

The Group's adverse variance is driven by income. Patient Related Income under-performance is driven by GPDA activity and Clinical Immunology Outpatient activity.

The adverse variance on Other Income is driven by low levels of activity to external customers compared to the prior year and non-delivery of an income generating TSP.

The non-pay over-spend relates to inflation and cost pressure funding to be confirmed.

Commissioner Income	ACTIVITY Plan	ACTIVITY Actual	ACTIVITY Variance	INCOME Plan £000's	INCOME Actual £000's	INCOME Variance £000's
A&E Attendances	0	0	0	0	0	0
Emergencies	0	1	1	0	0	0
Electives	2	0	-2	1	0	-1
Day Case	113	109	-4	45	43	-2
Outpatients	4,276	4,120	-155	352	277	-76
Community	0	0	0	0	0	0
Maternity	0	0	0	0	0	0
Other	297,992	279,150	-18,841	801	745	-56
	302,382	**283,381**	**-19,001**	**1,200**	**1,065**	**-135**

Narrative

The under-performance against Outpatient activity relates to Clinical Immunology Production Plan delivery.

The Other activity relates to GP Direct Access activity.

Finance Report Imaging

Appendix 3 - Group Analysis

Period 01 2018/19

Imaging	Annual Budget	WTE Budget	WTE Actual	Current Period Budget	Current Period Actual	Current Period Variance
1 - Patient Related Income	7,193	0.00	0.00	594	612	17
2 - Other Income	2,775	0.00	0.00	231	222	-9
Total Income	**9,968**	**0**	**0**	**825**	**834**	**9**
3 - Pay	-13,869	279.29	268.57	-1,173	-1,154	19
4 - Non Pay	-5,268	0.00	0.00	-444	-502	-58
Total Expenditure	**-19,137**	**279**	**269**	**-1,617**	**-1,656**	**-39**
Net I&E	**-9,169**	**279**	**269**	**-792**	**-822**	**-30**

Narrative

The favourable variance on Patient Related Income is driven by GP Direct Access activity. The adverse variance on Other Income relates to non-delivery of TSP schemes to increase income generation with other organisations.

The adverse variance on non-pay relates to inflation and cost pressure funding yet to be confirmed.

Commissioner Income	ACTIVITY Plan	ACTIVITY Actual	ACTIVITY Variance	INCOME Plan £000's	INCOME Actual £000's	INCOME Variance £000's
A&E Attendances	0	0	0	0	0	0
Emergencies	0	1	1	0	1	1
Electives	1	2	1	1	1	0
Day Case	27	29	2	23	17	-7
Outpatients	5	3	-2	0	0	0
Community	0	0	0	21	21	0
Maternity	0	0	0	0	0	0
Other	5,852	6,279	427	545	563	18
	5,885	**6,314**	**430**	**591**	**603**	**12**

Narrative

The favourable variance on Other activity reflects over-performance against GP Direct Access activity slightly off-set by under-performance on MPI activity.

The Day Case under-performance relates to Interventional Radiology.

Finance Report Corporate

Appendix 3 - Group Analysis

Period 01 2018/19

Corporate	Annual Budget	WTE Budget	WTE Actual	Current Period Budget	Current Period Actual	Current Period Variance
1 - Patient Related Income	7,282	0.00	0.00	573	501	-72
2 - Other Income	14,023	0.00	0.00	1,158	989	-169
Total Income	**21,305**	**0**	**0**	**1,731**	**1,490**	**-241**
3 - Pay	-54,750	1,524.52	1,594.37	-4,581	-4,577	4
4 - Non Pay	-42,865	0.00	0.00	-3,622	-3,883	-261
Total Expenditure	**-97,615**	**1,525**	**1,594**	**-8,203**	**-8,460**	**-257**
Net I&E	**-76,310**	**1,525**	**1,594**	**-6,472**	**-6,970**	**-498**

Narrative

Overall adverse variance driven by significant slippage in CIP delivery (minor works, cross cutting schemes etc.).

Additional risk due to delay of Unity project causing additional costs in scanning electronic documents (£80k).

Awaiting agreement of funded cost pressures in respect of inflation to Estates costs that would impact favourableyon position if agreed.

Commissioner Income	ACTIVITY Plan	ACTIVITY Actual	ACTIVITY Variance	INCOME Plan £000's	INCOME Actual £000's	INCOME Variance £000's
A&E Attendances	0	0	0	0	0	0
Emergencies	0	0	0	0	0	0
Electives	0	0	0	0	0	0
Day Case	0	0	0	0	0	0
Outpatients	0	0	0	0	0	0
Community	55	62	7	11	12	0
Maternity	0	0	0	0	0	0
Other				367	370	3
				378	**381**	**4**

Narrative

Paper ref:	TB (06/18) 025

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Midland Met – Financial Impact of delay & service re-configuration		
Sponsoring Executive	Tony Waite, Finance Director		
Report Author	Rod Knight, Commercial Accountant		
Meeting	Trust Board	**Date**	7th June 2018

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

This report provides a work-in-progress assessment of the potential financial impact of delay to Midland Met build-out and potential consequent requirement for service re-configuration.

The analysis is shown against two potential future options for the build-out of Midland Met and which reflects the current absence of a single cohered plan across the trust & HMG.

For both options the report indicates very significant revenue & capital requirements and which fall beyond the scope of local resources and currently committed central 'taper relief' funds. Those requirements shall need to be supported by central funding if they are not to fall on the local health economy the significant adverse impact of which has not be assessed.

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]*	

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

Taper Relief & delay impact routinely considered by the MPA Committee.

4. Recommendation(s)

The Trust Board is asked to:

a.	Challenge & confirm this draft analysis and require the analysis to be kept under review and routinely considered by the MPA Committee of the Board.
b.	Consider the funding requirement potential for adverse impact on the local health economy and to support the Executive in seeking to secure central funding support.
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	30.06.18
Quality Impact Assessment	Is this required?	Y	√	N		If 'Y' date completed	30.06.18

Option B	MMH- OPTION B - Timeline to MMH Opening- March 2022						
	18-19 £000's	19-20 £000's	20-21 £000's	21-22 £000's	22-23 £000's	23-24 £000's	Timeline £000's
Work-in-progress funding gap							
Base case - Taper Relief [Carillion]	£4,819	£3,767	-£1,817	-£9,457	-£3,912	£0	-£6,601
Impact of building delay	-£5,080	-£5,466	-£1,948	-£2,068	-£924	£0	-£15,486
Impact of service re-configuration	-£26,782	-£38,485	-£28,737	-£16,021	-£4,425	-£3,607	-£118,057
Net Funding Gap	**-£27,043**	**-£40,185**	**-£32,502**	**-£27,546**	**-£9,261**	**-£3,607**	**-£140,144**
Expressed as,							
Capital Resources	-£27,860	-£24,950	-£5,746	-£3,198	-£1,174	£0	-£62,928
Revenue Resources	£817	-£15,235	-£26,756	-£24,348	-£8,087	-£3,607	-£77,216
Net Funding Gap	**-£27,043**	**-£40,185**	**-£32,502**	**-£27,546**	**-£9,261**	**-£3,607**	**-£140,144**

Option C	MMH- OPTION C - Timeline to MMH Opening- June 2021						
	18-19 £000's	19-20 £000's	20-21 £000's	21-22 £000's	22-23 £000's	23-24 £000's	Timeline £000's
Work-in-progress funding gap							
Base case - Taper Relief [Carillion]	£4,824	£3,649	-£3,663	-£10,041	£0	£0	-£5,231
Impact of building delay	-£10,630	-£700	-£1,318	-£1,674	£0	£0	-£14,322
Impact of service re-configuration	-£26,577	-£38,445	-£27,174	-£11,840	-£3,464	-£3,565	-£111,064
Net Funding Gap	**-£32,383**	**-£35,496**	**-£32,155**	**-£23,555**	**-£3,464**	**-£3,565**	**-£130,617**
Expressed as,							
Capital Resources	-£33,205	-£20,534	-£4,848	-£1,938	£0	£0	-£60,525
Revenue Resources	£822	-£14,963	-£27,307	-£21,617	-£3,464	-£3,565	-£70,093
Net Funding Gap	**-£32,383**	**-£35,496**	**-£32,155**	**-£23,555**	**-£3,464**	**-£3,565**	**-£130,617**

NOTE

Costs excluded

There are a number of cost headings **NOT** covered in this analysis. They include,

- Any assessment of construction cost to complete Midland Met.
- Any assessment of EWC assumed to be funded via extant Midland Met capital contributions.
- Any consideration of accelerated depreciation in respect of capital investment with a shortened life, or any consideration
- Any unitary payment or PDC dividend considerations depending upon future funding model.

Value for Money

- Assessment of VFM is the subject of separate work.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC MEETING MINUTES

Venue: Training Room 1, Archer Ward, Rowley Regis Hospital **Date:** 3rd May 2018, 0930h – 1245h

Members Present:

Mr R Samuda, Chair	(RS)
Ms O Dutton, Vice Chair	(OD)
Prof K Thomas, Non-Executive Director	(KP)
Mrs M Perry, Non-Executive Director	(MP)
Mr H Kang, Non-Executive Director	(HK)
Mr M Hoare, Non-Executive Director	(MH)
Mr T Lewis, Chief Executive	(TL)
Mr T Waite, Finance Director	(TW)
Dr D Carruthers, Medical Director	(DC)
Ms R Barlow, Chief Operating Officer	(RB)
Mrs Paula Gardner	(PG)
Miss K Dhami, Director of Governance	(KD)

In Attendance:

Mrs C Rickards, Trust Convenor	(CR)
Mrs R Wilkin, Director of Communications	(RW)
Miss Clare Dooley, Head of Corporate Governance	(CD)

Board Support

Miss R Fuller, Executive Assistant	(RF)

Minutes	**Reference**
1. Welcome, apologies and declaration of interests	**Verbal**

Apologies were received from Cllr Zaffar.

Mr Samuda informed the Board all meetings will now be recorded for governance purposes along with a live broadcast stream planned for later in the year. Mr Samuda welcomed Mrs Paula Gardner who joins the Trust Board as Chief Nurse.

Declarations of Interests

No declarations of interest were recorded.

2. Patient Story	**Presentation**

Mrs Gardner introduced the story of an alcoholic patient and the support work of the Alcohol Team led by Dr Sally Bradberry.

The patient's partner joined the meeting and offered the patient's apologies for not attending the meeting as he has recently secured employment and was currently at work, which has been a valuable step/success. The patient's partner informed the Board that the patient had been a functioning alcoholic for many years but from September 2017 his needs became extreme with excess drinking of up to 40 units per day resulting in short term memory loss and mental health issues. The patient had become very frail and only mobile via "furniture walking". The patient's partner contacted the Reach Out team and noted she had to lie to speak to an assistant, their advice was to attend sessions at the local YMCA but her partner refused to attend. The patient required mental health support but many agencies will refuse to see an alcoholic until they cease drinking. Eventually the patient was seen by his GP and initially the GP was not very helpful but did refer him to the Alcohol Support Team. The patient was seen by Dr Sally Bradberry who, upon their first meeting, offered the patient personal acknowledgement support by holding his hand to discuss his problems closely and on a very human level. That intervention and kindness shown by the team enabled the patient to return and seek treatment/help. The patient's partner stated without that support he would have died. It was noted that the patient has now reduced his drinking to 6 units a day.

Mrs Perry thanked the patient's partner for attending noting areas that the system had failed in its support. Prof Thomas, speaking as a GP, stated it is difficult for GPs to provide support to families where alcoholism is a problem as it is often hard to engage with the patient, with many refusing to go to a hospital or dedicated agency for treatment. The patient's partner informed the Trust Board that her partner's childhood had been difficult and he has a difficult relationship with "institutions", with the YMCA being a reminder of that, but hospital did not evoke the same fear, so it was not difficult to encourage him to see the Alcohol Team in the hospital setting. The GP relationship was also difficult and the patient's partner was seen as a pushy carer when liaising with the surgery and whenever the GP met the patient with his partner the GP would direct/address queries to the patient's partner rather than him.

The patient's partner continued to inform the Trust Board that her partner has strong family support but the Alcohol Team Simone (Simone and Samantha especially) were only a phone call away if support was required. Mr Lewis commented some of the community provision in Birmingham and Sandwell is not always on a 7 day / 24 hour basis and often the need did not match the available hours. He therefore would be reviewing demand times as part of his discussions on integrated care with health and social care partners and would like evidence to support these conversations.

It was noted the occupational health team are also working with Dr Bradberry and the Team on alcohol arrangements to support staff members who requires it. Mrs Goodby noted options are being discussed including providing accelerated personal support to staff which Mr Lewis agreed to pursue as a matters arising.

Mr Lewis also commented accelerated work is still required regarding licencing and how the Trusts can assist the Council on this issue. Mr Lewis agreed to provide an update to the Trust Board on this in July 2018.

ACTION:

- Mr Lewis to provide an update to the July Trust Board on alcohol provisions to support staff and licencing arrangements

3. Questions from members of the public	**Verbal**

The following questions were asked by the public:

Maternity Services at the Halcyon Birthing Suite - Mr Bill Hodgetts of Healthwatch asked for an update following the announcement of proposals to consult on closing the Halcyon birthing suite. Mr Lewis confirmed the Halcyon served 16 families last year which, even though the centre provides a valuable contribution, led to consultation to close. Sandwell CCG has now agreed to approach the OSC to consult on this which will last approximately 12 – 16 weeks. Therefore, by October 2018 the centre could close. Until then the centre will remain open providing provision to birthing mothers when staffing permits. The Serenity Suite, one of the largest midwifery lead unit the UK, will remain open and is unaffected.

DNA in Outpatients - Mr Glen Jones, a Trust Volunteer, commented that during his role as a volunteer in outpatients he has been told many patients do not attend appointments. He was advised approximately 50% of appointments result in "Does Note Attend" (DNAs) and he suggested fines could be levied, similar to dental practices, to act as a deterrent for patients missing appointments. Ms Barlow advised it is the Trust's responsibility to give adequate notice when cancelling patient appointments, which is monitored by speciality, and ensuring new appointments offered also provide adequate notice; this includes using text messaging direct to mobile phones of patients. It is also evidenced that the mind-set of cancelling patient appointments several times may make a patient think the appointment is not important, so they do not attend. Ms Barlow continued to inform the Board that outpatient appointments are part of the performance report which is reviewed by the management leads. It was also stated in areas of persistent DNA rates a clinic is often overbooked to get the maximum use of a clinician's time; similarly all patients who attended would be seen by a clinician. Mr Lewis stressed the Trust will not ever consider fining patients who do not attend appointments as there is evidence that suggests 50% of DNAs happen due to information being sent to the wrong address. Therefore, the administration system needs to be addressed, which includes records held by GPs, as many patients inform their GP if they move house but the hospital is not informed given patients assume the GP practice would pass this information on. Prof Thomas, Non-Executive Director and local GP stated many practices will ring a patient if letters sent to them are not answered before they are discharged, but this is not an NHS standard procedure.

4. Chair's opening comments	Verbal

Mr Samuda reported on the following:

Midlands & East Chairs' meeting – NHS Improvement also joined this meeting and it was recorded that Sandwell & West Birmingham are amongst a minority number of Trusts reporting financial balance for the year, along with the success against cancer performance targets. Infection control data was discussed, as this is a key line of enquiry by the Care Quality Commission and finally, discussion also took place on closer alignment with NHS Improvement and NHS England towards the values of effective collaborative working.

Midland Met Hospital - Government officials are taking a pragmatic approach on the building, despite the effects of decay following building works pausing. There is a route to resolution but the process is complex and involves several parts of Government.

Mental Health Issues - A meeting has taken place with Sue Davis, Chair of Birmingham & Solihull Mental Health Trust on close working with routine mental health issues and both Trusts have agreed to co-operate towards a single operating framework.

5a. Update Major Project Authority held on 20th April 2018 and receive minutes from Major Project Authority meeting held on 23rd March 2018	TB (05/18) 001 & 002

Mr Hoare (chaired meeting on behalf of Richard Samuda) highlighted the following from the meeting:

IT Infrastructure - the meeting discussed the IT components and replacement of the technical debt, with the work in progress to reduce the 3 IT infrastructure risks on WAN, LAN and storage. The Trust Board will receive an update at its next meeting.

Unity Dress Rehearsal - the first rehearsal has received positive feedback but there is still significant work to push further with wards and speciality clinics. The second rehearsal takes place in June, with 15th June being the last official day for sign-off of the final Unity product.

Midland Met - work is continuing on the 3 available remedial/resolution options (previously considered by the Trust Board) to re-commence the build.

The minutes of the meeting on 23rd March 2018 were noted.

5b. Update Quality & Safety Committee 27th April 2018 & Quality & Safety Committee 23rd March 2018	TB (05/18) 003 & 004

Mrs Dutton highlighted the following from the meeting:

Many items discussed at the meeting are items on today's Trust Board agenda. The meeting did have a helpful discussion on sepsis, neutropenic sepsis and mortality. The IQPR and IQPR persistent reds were discussed including a more controlled way of dealing with the persistent reds towards improvement/resolution.

The complaints report was received and noted 73% of complaints are upheld or partly upheld, which gives a positive message that complaints are being acted upon and resulting actions implemented.

Purple Point - Mr Kang stated following the last Trust Board walkabout the team noticed a lack of awareness amongst staff on the purpose and introduction of purple point. It was suggested the patients had been briefed more successfully on the initiative than the staff. Miss Dhami expressed her disappointment on hearing this as purple point was established to create a unique rapid response channel for in-patients who had queries or compliments to highlight during their stay. In response to the communications gap the complaints team have visited all wards speaking to the nurse in charge and staff on purple point. All wards have also been given a stock of leaflets which are now prominently displayed, along with a multi-language poster visible at the entrance of the ward.

Miss Dhami reported the majority of the calls received through purple point take place during the week and none before 9.30am. Only 5 calls were to-date had been received after 5.00 pm. Wednesday is the most popular day for calling and calls themes are noted in the complaints report. Miss Dhami reminded the Trust Board the response times expected on calls was immediate to resolve issues and patients are kept informed if a call is not responded to immediately. In response to a query of what success looks like from Mr Kang, Miss Dhami advised this is yet to be determined but regular monitoring is taking place.

Mr Lewis commented purple point is now part of the patient introduction pack on wards and this action will be led by Miss Dhami and Mrs Gardner, with oversight and scrutiny provided at the Quality and Safety Committee.

The minutes of the meeting on 23rd March 2018 were noted.

5c. Update Finance & Investment Committee – 27th April & Finance & Investment Committee minutes 23rd March 2018	**TB (05/18) 005 & 006**

Mr Hoare highlighted the following from the meeting:

Tony Waite and his team were congratulated on closing out the year on target amongst a number of difficulties. The Trust overachieved on the control total by £5.1m and the cash balances were also recorded ahead of plan. The Trust has therefore secured its STF funding.

It was noted the accounting for the current Carillion payment was raised by the Audit and Risk Management Committee and they are reviewing how this will be reported in the2017/18 final accounts.

The minutes of the on 23rd March 2018 were noted.

6. Chief Executive's Summary on Organisation Wide Issues	**TB (05/18) 007**

Mr Lewis noted his report and drew attention of the Trust Board on the following:

Safety Award - the Trust is shortlisted for a national award on safety following the work completed over the last 12 months. This plan is one of the biggest achievements of the last year and the challenge now is to continue to be consistent and review/ensure data is accurate and completed on a timely basis. The new 23 hour surgical unit will be opening at the end of May. It is envisaged with the implementation of the Unity system the burden of duplicating data will be eliminated.

Dame Julie Moore – Dame Julie will be retiring from the University Hospitals Birmingham this autumn.

Breast Screening - following recent reports in the media there is, as yet, no local sense of numbers of patients treated in the West Midlands or in the area of Birmingham, Sandwell and Walsall where patients reside. Mr Lewis stated national advice for any callers who contact the Trust are to be directed to the helpline or NHS Choice.

Mrs Perry requested feedback/opinion on the control total and any additional costs incurred by the Midland Met Hospital delay. Mr Lewis referred to the taper relief (also called Carillion taper relief) on Midland Met which had been submitted on time to the regulators on Monday, noting this will be picked up by a weekly call with Mark Mansfield. The current costs are currently being absorbed by The Hospital Company but if Government decide to terminate THC any additional costs in operating the site have not been provided for in this financial year.

Ms Dutton queried the electronic medication prescribing. It was noted medication for residents in local CCG areas have been included, but provisions for a patient from outside the area were queried. Mr Lewis noted that the arrangements for be for regular GP partners regardless of geography.

Mr Lewis reminded the Trust Board of the Speak Up Day event taking place on the 16th May 2018. This is a follow up to the first speak up event that took place in September 2017. Mr Samuda asked if there is anything the Trust Board members could provide support with on Speak Up Day. Mrs Wilkin informed the Trust Board that there would be a presence across all 3 sites during the day with Freedom to Speak Up Guardians supporting the stands. Mrs Wilkin invited members of the Trust Board to contact her if they could volunteer to assist with support on the stands. It was noted however, it was still difficult for individuals to whistle-blow and work by the executive team and clinical leadership executive on communicating this important message is continuing.

7. Trust Risk Register	**TB (05/18) 008**

Miss Dhami reported:

- Risk no. 114 - workforce plan has been reviewed and updated the risk statement and mitigating actions.
- Risk no. 2955 - unfilled Middle Grade shifts in Emergency Department (new risk). It was reported the risk is currently being managed but is on the verge of becoming serious. Ms Barlow disagreed with the risk score as nationally recruitment into EDs, including senior doctors and consultants is low, but the Trust is investing into programmes such as CESR to address this. It was noted there are some rota management issues which made working at the Trust unattractive, Mr Lewis agreed to discuss this with Ms Barlow and Dr Carruthers outside of the meeting.
- Risk no. 566 - Senior ED Medical Staffing: this risk will be discussed at the May Risk Management Committee following changes since inclusion on the Trust Risk Register.
- Risk no. 1738 – ophthalmology: following discussion at the March Risk Management Committee, 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.

Mr Hoare disagreed with the risk score of risk no. 325 on cyber security. Mr Hoare echoed there is a greater risk of breach due to the infrastructure and the external risks to the health service. The Trust Board agreed for this risk to be delegated to the Digital Committee for further scrutiny/challenge.

The Trust Board discussed the issues of 2 site working and the financial risks associated with keeping the estates beyond current plans. The appendix included in the Chief Executive's report on the risk associated with Midland Met has highlighted this risk which includes financial and staff retention issues. This will become a greater risk if a decision is not reached by Government and THC contract is terminated. Mr Lewis further noted the issues as appended in his report.

ACTION:

- Miss Dhami to update relevant committees on actions noted.

8. Unity Countdown to August and December 2018	**TB (05/18) 009**

Mr Lewis stressed to the Trust Board work on the preparedness for a go live date of Unity in August 2018. Therefore, by the end of May 2018 we needed to have delivered the promise on the infrastructure and issue training invites to doctors, nurses and non-clinical staff for an August go live date.

Ms Barlow highlighted there were 110 days before go live and engagement has been good over March and April as some of the barriers have been broken down by the excellent team delivering the system. Unity now has a full time manager (Mr Dean Harris, Deputy CIO) to assist with hitting the previously agreed targets and milestones towards full implementation.

It was reported there are 2 very high risks and 6 high risks (including 2 new risks) which will be added to the risk log. All very 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. Some of the issues will be escalated to the external provider. The Major Projects Authority, Digital Committee and executive team continue to closely monitor Unity implementation progress including risks, hazards and incidents.

Ms Barlow continued to note the first dress rehearsal has been positively received with the risk and clinical hazards log to be completed over the next 3 weeks which are being monitored weekly by Ms Barlow. It was also noted further work is required on reporting items for the clinical hazards log as this had a low number of queries compared to other Trusts. It was advised that new Chair-people with senior clinical and operational experience have been appointed to manage these risks and report fortnightly to an integrated governance meeting chaired by Ms Barlow.

Ms Barlow will confirm queries raised by staff (called 'change requests') to ensure the design can be amended as necessary, which can be tracked with due diligence checked. Some of these change requests have could not be allocated and Cerner have been contacted for their assistance on this issue.

Ms Barlow confirmed further training will continue from June 2018 and at the next Trust Board she will provide a progress report and also via the May Major Projects Authority Committee meeting.

It was noted the lessons learnt from case note scanning would be linked as a checklist. Mr Lewis noted the concerns of the Trust Board and stated that he would be reluctant to sign off go-live until he was assured these issues would be addressed appropriately. He also requested sight of supplier diagrams to ensure the issues documented will be actioned and closed.

9. CQC Improvement Plan Closeout	**TB (05/18) 010**

Miss Dhami reported on the actions following the CQC inspection in March 2017. 131 recommendations were made, 106 have been implemented by the deadline of March 2018, of those remaining 2 continue with the Trust Board's approval as they require external assistance to close. 23 are behind schedule but are in the process of being implemented with some actions already in place. The actions which are behind schedule will be discussed at the Quality and Safety Committee and overseen by the Executive Quality Committee.

Miss Dhami detailed the changes in PCCT and was confident if this group were inspected today they would see the actions implemented/changes made since the inadequate rating. There is further work to do in medicine and the consistency of care meetings are monitoring progress. The Trust's plan is to achieve an overall Good rating at the next inspection, which is likely to take place in the Autumn/Quarter 4. There has also been an increase in staff engagement with lots of good practice shared learning around the organisation. However, it is critical that ED and the medical wards are supported to ensure improvement is reported at the next Inspection.

Prof Thomas asked about the training of doctors in ED. Dr Carruthers confirmed there was support for trainee doctors through consistency in practice and supervision within the department, but due to the national shortage in recruitment to ED, training posts have reduced.

Ms Barlow stated the implementation of the Consultant of the Week, Listening Into Action events, improvements in relation to rota/job plans are being embedded across wards and junior doctors have stated they want the ability to influence decision making on discharge moving of patients, and this will be followed up.

Mr Lewis discussed BMEC and would discuss with the executive team how to improve its rating. Ms Dhami confirmed the improvement plan was not owned by the group who ultimately did not have the grip and control expected. She would provide an update for the next meeting.

Prof Thomas informed the Trust Board that her GP practice was receiving poorly written letters, the majority were hand written, undated and the language used was sometimes poor/confusing. Mr Samuda was troubled by this and asked Ms Dhami to review and action relevant changes

Following a further discussion the following was summarised:

Executive team to nominate leaders in each clinical group to lead work on the work programmes noted in the paper.

IT to compile a list of items that would make working life easier and this should include a combination of top down and bottom up ideas and approached.

A repeat of the new ideas discussions that took place at the Trust Board Away day to be duplicated at the leadership conference.

Staff engagement work in collaboration with Wrightington, Wigan and Leigh NHS Trust to be discussed further by the board.

It was noted this item continues to be monitored by the Quality and Safety Committee.

ACTION:

- Miss Dhami to provide an update on BMEC's improvement plan to the next meeting.
- Miss Dhami to check how poorly worded handwritten letters are sent to GP surgeries without adequate patient information included.

10 Maternity Summit – Improvement Actions Update	**TB (05/18) 011**

Mrs Gardner provided an overview and asked the Trust Board to note the action plans that were discussed at the Quality and Safety Committee. The maternity summit actions are linked into the serious incident process and have related to the successful completion of the early reviews. The communications team will organise the learning reports on good practice to be disseminated to the wider organisation and Ms Rachel Carter, Director of Midwifery has already held a workshop to agree progress dissemination.

It was noted there are patient representatives siting on the Perinatal Review Board.

It was agreed the Quality and Safety Committee are asked to look at the outcome data to ensure the right results are being provided.

11. Amenable Mortality and Learning from Deaths Trajectory	**TB (05/18) 012**

Dr Carruthers updated the Trust Board on progress and confirmed the team are looking at the data and defining the processes. There is a natural overlap with the Quality Plan and the development of learning from deaths through the medical examiners roles, with the first cohort commencing at Sandwell. The advert has been re-released with a view to appointing examiners for the City site. These outputs will feed into the data received for amenable mortality and serious incident reports.

Dr Carruthers continued to report recruitment is continuing to appoint a mortality officer from within the organisation to this role. Mr Lewis stated there will be an increase in the amount of consultant appointments made and as part of the recruitment process discussions on undertaking sessions as a medical examiner should be part of that process. Mr Lewis would pick this up separately with Dr Carruthers outside of the meeting.

Mr Samuda asked for timescales the team are working to and it was noted that over the next month the actions from learning from deaths and the data analysis will be available. There are already discussions with the leadership on plans including to link with trainees to provide support on improvement projects that can be passed to other colleagues following the completion of a 4 month rotation.

The Trust Board discussed further and agreed to review again the focus on caring for families, improving end of life experiences, and intervening early when a patient's death is imminent. Dr Carruthers confirmed he wanted to review the data when it is received to see how the Trust can influence patient /family experience outcomes. Ms Dutton also commented the Quality & Safety Committee has discussed the sepsis data and neutropenic sepsis.

ACTION:

- Mr Lewis to discuss with Dr Carruthers how medical examiner roles could be part of the recruitment process for consultants and Dr Carruthers to provide an update to a future Trust Board meeting.

11.1 Sepsis Report	TB (05/18) 013

Dr Carruthers informed the Trust Board this item has been discussed at the Quality and Safety Committee and is part of the improvement in management of sepsis, and it contributes to the improvement in the Trust mortality data as key part of the Quality and Safety plans.

It was noted performance in A&E/AMU is improved on wards but the screening compliance was reduced in A&E due to some governance issues on the recording of information (not completed).

The Trust Board noted the need to improve its sepsis performance and this would be addressed at the Leadership Conference taking place on the 22nd May.

12. Responding and Learning from Serious Incidents	TB (05/18) 014

Miss Dhami reported 14 serious incidents (SIs) were reported during the year 2017/18 and the majority of actions from those investigations have been closed. It was agreed that SIs now involve patients and relatives who are part of the decision process were SIs are investigated within 50 working days compared to 60 working days in the national framework.

Miss Dhami informed the Trust Board that 12 SI leads are in place and the language in the reports are written to be read by the patient rather than management. Three themes have been identified which Dr Carruthers is taking the lead on. These are metastatic spinal cord compression (MSCC), head injuries and results acknowledgement. Miss Dhami continued to state there is room for improvement and groups should be writing their own action plans rather than the SI lead, as they need to take ownership of the action plan and if necessary, submit and be challenged by the Quality & Safety Committee.

The learning from this SIs will be directed to those areas that enquire it rather than a general cascade. It was noted a patient safety group will be formed to help with this initiative.

Dr Carruthers informed the Trust Board there are 4 head injury cases, 2 of these are being investigated and 2 are still ongoing. There have been 2 in-patient falls and the policy will be reviewed to ensure the pathway is not placing patients to unnecessary risks. The policy on metastatic spinal cord compression will be written for approval. It was confirmed a Quality Improvement Half Day (QIHD) will feature results acknowledgment for all staff to confirm their practices

Dr Carruthers reported the head injury NICE guidance is not always observed and treated as a serious incident. However, Miss Dhami noted there are processes in place to ensure NICE guidance is followed but she was unsure if NICE guidance was followed in all the head injuries recorded. Miss Dhami explained NICE is used when the Trust wants to check a process locally and the Executive Quality Committee have requested specialty leads to check if they were compliant with NICE guidance.

The Trust Board discussed the next steps as noted in the report and the non-executives highlighted the SI report of a patient being improperly identified in the community (No. 9). The action recorded regarding the positive patient identification policy was unclear along with the staff training. Ms Dhami would follow this up and discuss with Mrs Perry at their next scheduled meeting. Dr Carruthers noted his dissatisfaction of doctors not verbally passing valuable patient information to colleagues during handover, rather than only documenting this in records.

13. Financial Plan 2018-20	TB (05/18) 015

Mr Waite reported on the 2018/19 revised control total of a pre-PSF deficit of £7.5m and opportunity to earn £14.7m of PSF through financial control total circa £11m and ED 4hr wait (circa £4m) compliance. The tabled Finance and Investment Committee out-brief included noted the position including financial delivery of CIP which is expected to see results from Q1.

Mr Waite briefed the Board on the financial plan which requires savings/margin generation of approximately £37m and reiterated the essential focus/requirement to maintain financial balance from Q1.

Mr Lewis stressed groups, directorates and corporates area need mobilise their savings plan to commence delivery from June/July, however if a group missed its target and went over budget they will need to think what needs to be closed in order to recoup on that overspend in budget.

14. Bed Base Risk Mitigations/Closing Unfunded beds	**TB (05/18) 016**

Ms Barlow provided the Trust Board with an update on the bed base risk mitigations. 30 beds have been closed since April 2018 and the Surgery group are now back within their bed case. Medicine group has made progress in month 1, following the regular consistency of care meetings with nurses working more effectively, especially following the recent Learning Into Action event. Ms Barlow also stated bed base is still reducing and the intention is to close further at Sandwell with these plans currently on track.

Ms Dutton commented the quality impact assessment was dated 2017 and queried if this has been updated. Ms Barlow responded and confirmed the bed closure did not deliver but she would be take a view from Mrs Gardner and Dr Carruthers.

15. Reducing sickness absence and improving well being	**TB (05/18) 017**

Mrs Goodby updated the Trust Board on how the organisation is tackling the reduction of its sickness levels and improving the management of mental health wellbeing. Sickness recording noted a 20% improvement since the recommendations were made from January 2018, this includes the sickness hot spots were sickness levels is over 5.2%. The management of sickness is now group led and leaders are challenged monthly on their grip and control. All wards have their own individualised target of 3% to be met, and all the groups are being encouraged and supported to meet this target.

Mrs Perry challenged the expectation of achieving a 3% sickness target and asked how confident the team are on achieving this. Mrs Goodby recognised the challenge but there is a need to aim high to achieve a better position than the current rate. The figure was not an impossible challenge, noting the pathology group are regularly achieving 3%, and teams need to focus and maintain grip to reach targets set.

Sickness is still discussed at the corporate review meetings lead by the Chief Executive and the clinical review meetings led by the Chief Operating Officer. Following further discussions Mrs Rickards would speak to Mrs Goodby on instances were sickness was not being managed appropriately. Mr Samuda asked if any Board member had ideas or experience of reducing sickness they were invited to speak to Mrs Goodby outside of this meeting.

16. Integrated Quality & Performance Report	**TB (05/18) 018**

Mr Baker reported to the Board on the sustained delivery across the year in a number of key areas. The successes included infection control, RTT, cancer and some movement of persistent reds. The challenges to note are A&E performance, cancelled operations, compliance around sickness and nurse turnover rates.

Mrs Barlow commented on the acute diagnostic under delivering in 3 months over the year mainly due to cardiac CT diagnostics. Mrs Barlow was confident this would be recovered in Q1 as an improvement plan is in place.

The Board noted the theatre cancellations. Mrs. Barlow confirmed the target has been impacted by winter pressures, bed capacity and sickness by 2 doctors which was unusual. Mr Lewis commented 14 cancellations were noted as avoidable and queried if they were being escalated to the Group Director of Ops for authorisation to cancel. Mrs Barlow confirmed the cancellations had been authorised by the Group Director of Ops, Mr Lewis was disappointed by this and would discuss with Mrs Barlow outside of the meeting.

16.1 Persistent Reds	**TB (05/18) 019**

The Board reviewed the persistent reds and Mrs Goodby highlighted that the PDR data will be discussed at the next Performance Management Committee.

16.2 Financial Performance – P12 2017/18	**TB (05/18) 020**
Mr Waite highlighted the headline number. It was confirmed the underlying financial position for 2018/19 has been confirmed at £26m (included oncology stranded costs). The report was noted by the Board.	
17. Minutes of last meeting and action log (5th April 2018)	**TB (05/18) 021 & 022**
The minutes of the meeting on the 5th April were agreed as an accurate record following the removal of the 4th paragraph on page 6 regarding safeguarding. • **Action Log - c**omments were made on the following actions: • **5th April 2018 -** Mrs Barlow has met with Mr Hodgetts – this action can be closed • **5th October 2018 -** Mr Lewis confirmed he would be meeting with all Western Birmingham stakeholders at the end of May and would plan to seek write off of the debt. • **6th July 2017 -** A report would be provided to the Public Health Committee by Mr Alan Kenny.	
18. Matters arising	**Verbal**
There were no matters arising for discussion	
19. Q4 Complaints Report	**TB (05/18) 023**
Mr Lewis acknowledged some of the actions have been outstanding for a long time which need to be closed out.	
20. Trust Board Declarations	**TB (05/18) 024**
The Trust Board noted the fit and proper persons assessment declaration for 2017/18 and agreed the publication of the register of interests on the Trust website.	
21. General Data Projection Regulation (GDPR): Trust Preparedness	**TB (05/18) 025**
The Trust Board delegated authority to the Audit and Risk Committee to provide scrutiny of GDPR. A report will be presented to a future Trust Board meeting.	
22. Application of Trust Seal	**TB (05/18) 026**
The Trust Board agreed the affixation of the Trust Seal on the following documents: • Lease renewal of medical physics building with University of Birmingham. • Deed of Grant with Western Power (West Midlands) PLC for access to new high voltage sub-stations on City site. • License to assign premises know as Dudley Road Hospital – lease from National Grid Plan to Cadent Gas Ltd.	
23. Any other business	**Verbal**
No other items of business were received.	
24. Date and time of next meeting	**Verbal**
The next public Trust Board will be held on 7th June 2018 in the Anne Gibson Committee Room, City Hospital	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Public Trust Board Action Log – 3rd May 2018

	Action	Assigned to	Due Date	Status / Response
From Meeting held on 3rd May 2018				
1	Patient Story. Mr Lewis to provide an update to the July Trust Board on alcohol provisions to support staff and licencing arrangements	TL	July 2018	Complete – covered via Public Health committee of the Board
2	Trust Risk Register. Ms Dhami to update relevant committees on actions agreed	KD	June 2018	Verbal update to June Trust Board
3	CQC Improvement Plan Closeout. • Ms Dhami to provide an update on BMECs improvement plan to the next meeting • Ms Dhami to check how poorly worded handwritten letters are being sent to GP surgeries without adequate patient information being included on it.	KD KD	June 2018 June 2018	Paper provided for June Trust Board Verbal update to June Trust Board
4	Amenable Mortality and Learning from Deaths Trajectory. • Mr Lewis to discuss with Dr Carruthers how medical examiner roles could be part of the recruitment process for consultants and Dr Carruthers to provide an update to a future Trust Board meeting	TL/DC	June 2018	Paper provided for June Trust Board
From Meeting held on 5th April 2018				
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	Papers provided for June Trust Board
4	Decreasing Sickness Absence and Improving Employee Mental Wellbeing. • Examine changing contracts of employment for new employees to mandate attendance at stress assessments	RG	June 2018	Verbal update to June Trust Board

From Meeting held on 5th October 2017				
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~~ July 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~~ June 2018	Plan for deployment in place but Board discussion needed now on future strategy as per CEO report