

Meeting of the  
Board of Directors  
of Heart of England NHS Foundation Trust  
held in Public  
12.30pm on 23 October 2017  
Rooms 2, The Education Centre, Birmingham Heartlands Hospital

## AGENDA

### PUBLIC -12.30 NOON – 2.15PM:

1. **Apologies for Absence** (Oral)
2. **Declarations of Interest** (Oral)  
(for any items on the agenda for discussion)
3. **Minutes of Previous Meetings**  
3.1 24 July 2017 (Enclosure)
4. **Matters Arising** (Oral)
5. **Chairs Update and Emerging Issues (JS)** (Oral)
6. **Performance Report Q2(KB)** (Enclosure)  
inc 2017/18 Annual Plan
7. **Clinical Quality Monitoring Report Q2 (DR)** (Enclosure)
8. **Annual Medical Revalidation Report (DR)** (Enclosure)
9. **Care Quality Report Q2 (JT)** (Enclosure)
10. **Safeguarding Adults & Children's Annual Report (JT)** (Enclosure)
11. **Nurse Re-validation Report (JT)** (Enclosure)
12. **Finance Report Q2 (JM)** (Enclosure)  
inc Capital Programme Update
13. **Board Assurance Framework (DB)** (Enclosure)
14. **Compliance & Assurance Report Q2(DB)** (Enclosure)
15. **Information Governance Annual Report (DB)** (Enclosure)
16. **Emergency Preparedness - Update Report (JB)** (Enclosure)
17. **Audit Committee Annual Report (KK)** (Enclosure)
18. **Business Cases for Discussion (JB)**
  - 18.1 ACAD Outline Business Case (Oral)
  - 18.2 Development of Chemotherapy Capacity & Improved Environment (Enclosure)
  - 18.3 Conversion of Ward 2 at BHH to Short Stay Medical Ward (Enclosure)

**RECEIVE**

- 19. **Annual Workforce Report (HW)** *(Enclosure)*  
inc Staff Survey Action Plan and Bi-annual Education Report
- 20. **HEFT Charitable Funds Report** *(Enclosure)*

**APPROVAL**

- 21. **Quality Account Update Q2(DR)** *(Enclosure)*
- 22. **Business Cases for Approval**
  - 22.1 Amendments to Pre-authorized Business Cases *(Enclosure)*
  - 22.2 Replacement Anaesthetics Consultants *(Enclosure)*
  - 22.3 Respiratory Medicine Consultant *(Enclosure)*
  - 22.4 Ward 7, Good Hope, Business Case *(Enclosure)*
  - 22.5 Ophthalmology Business Case *(Enclosure)*
  - 22.6 T&O Business Case *(Enclosure)*
- 23. **Any Other Business**
- 24. **Next Meeting in Public - Monday 22 January, 2018**, Education Centre, Birmingham Heartlands Hospital

**NEDs INFORMAL MEETING WITH GOVERNORS**

**3.00-4.00pm**

**COUNCIL OF GOVERNORS**

**4.00-6.00pm**

David Burbridge  
Interim Director of Corporate Affairs  
9 October 2017

**Minutes of the Public Meeting of the Board of Directors  
of Heart of England NHS Foundation Trust  
held in Room 2, Education Centre, Birmingham Heartlands Hospital  
on 24 July 2017 at 12.30 pm.**

**PRESENT:** Rt Hon J Smith, interim Chair  
Mr J Brotherton, Director of Operations  
Mr Edwards, Non-executive Director  
Mrs S Foster, Chief Nurse  
Mrs J Hendley, Non-executive Director  
Miss M Lalani, Non-executive Director  
Mr J Miller, interim Finance Director  
Dame J Moore, interim Chief Executive Officer  
Dr D Rosser, interim Medical Director  
Prof Sheppard, Non-executive Director  
Mrs H Wyton, Director of Workforce & OD

**IN ATTENDANCE:** Ms F Alexander, interim Director of Communications  
Mr K Bolger, interim Deputy Chief Executive - Improvement  
Mr D Burbridge, interim Director of Corporate Affairs  
Mrs A Hudson, Senior Executive Assistant (Minutes)  
Mrs T Watkins, Administrative Assistant

**GOVERNORS** Mr S Baldwin, Governor  
Mrs S Hutchings, Governor  
Mrs V Morgan, Governor  
Mrs J Thomas, Lead Governor

**17.077 APOLOGIES & WELCOME**

The Chair welcomed everyone to the meeting. Apologies had been received from Mrs Alexander, Prof Glasby, Ms Kneller and Dr Kinski.

**17.078 DECLARATIONS OF INTEREST**

Changes to the Chair and CEO declarations were noted and the register updated.

**Resolved**

- To receive the report
- Update the register

**17.079 MINUTES OF PREVIOUS MEETING**

The minutes of the meeting held on 24 April 2017 were considered and approved as a true record.

**17.080 MATTERS ARISING**

There were none.

The Deputy Chief Executive – Improvement reported that, following the CQC inspection of our hospitals and community services in October 2016, the Trust had

received the regulator's resulting report and had reviewed it for factual accuracy. The majority of comments had been included in the updated report. An overall rating had not been included in the new published report as it was a focussed inspection; therefore the 2014 rating of 'requiring improvement' remained. However, the CQC had acknowledged that significant positive change had been made in a number of areas and the Trust was rated 'good' for 'well-led'. It was expected that the CQC would publish the report on 29 July 2017.

The CQC had not requested that the Trust hold a Quality Summit at the present time.

A communication for staff was planned for the day of publication.

The Board received assurance that actions to address issues identified by the CQC would be incorporated into appropriate action plans, rather than a stand-alone CQC action plan. Indeed, many actions had already been implemented.

**Resolved:** the report was received.

## 17.081 CHAIRS UPDATE

The Chair reported that it had been stated that Ian Paterson could have his prison term increased. Paterson had been sentenced to 15 years in May. The case was being reviewed under the Unduly Lenient Sentence scheme to examine if a longer sentence was appropriate following a concern raised by a complainant.

As part of the virtual MTD review of the mastectomy cohort of Paterson patients, all patients had now been reviewed by the independent review panel. The final group had been due to be seen in clinic during July, unfortunately due to sickness in the clinical team the remaining 17 patients would be seen by October.

The independent report was not yet complete and would be presented to the September meeting of the Board.

The content of the letter to be sent to wide local excision patients was being finalised along with the response process and it was expected that letters would be sent towards the end of August. All patients would be offered a range of options as part of the review process.

Case for Change. The Trust had submitted the full business case to NHSI. The Chair and CEO were holding a series of stakeholder briefings and would be attending the Birmingham and Solihull Scrutiny Committee to give an update on progress.

The first grading for STPs had been published – Birmingham had received advanced.

The Chair and CEO had attended the Trust's first awards ceremony for 50 of our long serving volunteers to recognise the huge contribution they made.

**Resolved:** to receive the report

## 17.082 PERFORMANCE REPORT

The Board considered the Performance Report presented by the interim Deputy CEO Improvement, summarising the Trust's performance against targets and indicators in the Single Oversight Framework, contractual targets and internal targets. Of the five operational performance indicators, the Trust had delivered against 4. The A&E 4 hour standard had not been met and remained a risk. Performance had improved slightly in June at 83.54% compared to 83.3% in May with 22,675 attendances in

June 2017 (an average of 756 patients per day).

In terms of the other performance targets, the Trust had met the 18 week referral to treatment target. The only specialty failing to meet the target in month was Trauma and Orthopaedics at 85.88%. Work was underway to address the problem.

The Trust had met the CCG ambulance handover target of 95% of patients waiting less than 30 minutes (97.19%) and 60 minutes (99.91%) in month. The Trust had implemented a new agreed joint validation process for ambulance delays which had been in operation since late May. This was supported by dedicated HALO presence on all three sites, combined with a daily validation process between the Trust and WMAS.

The Trust had failed to meet the DTOC target in month, achieving 2.70% against a target of 1.4%.

Of the 14 maternity screening indicators (reported quarterly in arrears), the Trust had failed to meet 4. Divisions were working with providers within the network to monitor and report monthly on progress. A report would be presented to a future meeting.

A letter from NHSI and NHSE Midlands and East had been sent to Trusts and CCGs in May 2017 regarding public reporting and quality review of cancer long waits. It set out two national objectives to increase the number of providers delivering the 85% cancer 62 day standard to over 70% and for all Trusts to achieve the standard from September 2017. In addition, immediate action had been put in place that required Trusts and CCGs to routinely report the number of <62 day and <104 day breaches, plus outcomes and learning from RCAs, to public board meetings. As at 30 June, the Trust had 3½ patients who had breached the <104 day cancer pathway, the half breach was where the trust shared patient care with another provider.

The Trust had achieved the Stroke target in May, achieving 86.9% against an 80% target.

The Trust had failed to achieve the target for the proportion of patients who present at A&E and are discharged with a TIA, and were scanned and treated within 24 hours, with 45% against a target of 63%. The service had reported that 90% of patients were seen within 30 hours.

The Board discussed the workforce indicators and it was noted that mandatory training, appraisal and recruitment were all above target. Sickness and absence was slightly up in month. The new on line exit monitoring tool trial, in conjunction with Picker Institute, was set to launch in July.

**Resolved:**

1. to accept the report
2. to note progress made.

## 17.083 CLINICAL QUALITY MONITORING REPORT

The Board considered the Clinical Quality Monitoring (CQM) report presented by the interim Medical Director. The report provided assurance on clinical quality and detailed action being taken following the CQM Group meetings held in June and July 2017. There were currently six investigations in progress into doctors' performance.

There had been two CCS (Clinical Classification System) diagnosis groups with higher than expected results in March 2017: Cardiac arrest and ventricular fibrillation (107) and 'Other gastrointestinal disorders (155)'. The case lists had been reviewed

and no clinical issues had been identified.

The Trust SHMI (Summary Hospital – Level Mortality Indicator) and HSMR (Hospital Standardised Mortality Ratio (HSMR) performance were within acceptable limits. The information presented now included comparison with UHB. The Board discussed the difference in results and it was noted that, as the majority of the case load at UHB was elective, it would always show as an outlier.

The Trust's CRAB (Copeland Risk Adjusted Barometer) 30 day surgical mortality O/E (outcome versus expected) ratio had been reviewed and was within the normal range.

The recent Board of Directors' unannounced visit to ward 3 (Renal) at Birmingham Heartlands Hospital on 20 June 2017 had been largely positive from a staff perspective and the visit team noted the positive culture on the ward.

**Resolved:** to accept the report

## 17.084 CARE QUALITY REPORT

The Board considered the Care Quality Report presented by the Chief Nurse. There had been no post 48 hour MRSA bacteraemia reported in June 2017. Two cases of pre-48 hour MRSA bacteraemia had been reported and, following a joint review with the CCG, both had been attributed to third party. There had been no lapses in practice identified from either the Trust or the community. There had been five cases of post 48 hour C.Diff reported in June 2017. This was within the Trust's monthly trajectory of five. The total number of cases this year was 10 against a year to date trajectory of 15 cases and an annual trajectory of 64 cases.

There had been an outbreak of Vancomycin-Resistant Enterococci (VRE) declared on ward 19 at Birmingham Heartlands Hospital in June 2017 with three patients identified as having VRE bacteraemia of the same strain. Screening of inpatients on the ward had revealed a high proportion of inpatients as being colonised with VRE, there was an on-going action plan being implemented.

There had been 2 avoidable grade 2 pressure ulcers and no reported hospital acquired pressure ulcers (grade 3) in June 2017.

The Trust dementia screening target was 90%, performance for June 2017 was 88.03%. Significant work within divisions was underway.

The Trust target that 90% of all Parkinson's medication was administered within 30 minutes had improved to 82% in June 2017.

Nurse staffing. There were no areas of concern for June 2017. Hot spot areas were Intensive Care Unit BHH, Neonatal Unit and Ward 4 HDU, assurance had been given by Head Nurses that staffing had been maintained at levels suitable for acuity of patients with no shortfalls.

The Trust was the lead partner in the Birmingham and Solihull Partnership that formed one of the national pilot sites for the Nursing Associate programme. Forty-one Nurse Associate Trainees had commenced the training programme in April 2017, with no leavers to date.

Compliance against the 30 day working standard for complaints in May 2017 was 57.3%.

The Friends and Family Test positive responders for May was 95%. The ED had shown a decrease of 3% at 84% for positive responders compared to the previous month.

**Resolved:** to accept the report

#### **17.084.1 Infection Prevention & Control Annual Report for 2016/17.**

Dr Abid Hussain, Consultant Microbiologist and Associate Medical Director for Infection Prevention & Control presented the Annual Report for 2016/17 and reported that, for 2016/17, there had been 7 MRSA Bacteraemia attributed to the organisation, there had been an over-performance of C.diff infection against trajectory and a clustering of multiple outbreaks in Q4 2016/17 due to organisation pressures, in terms of patient flow and footfall. There had been some failure of IPC procedure, work to improve the fabric of the wards was required and there was a lack of effective isolation facilities.

Corrective action undertaken in 2016/17 comprised a review of C.diff diagnosis and treatment, reinforcement of Trust cleaning strategies, deployment of new modalities, re-investment in patient bathing products and refurbishment of key clinical areas.

Priorities for 2017/18 included joint working with UHB IPCT, alignment of policies and practice, a review of internal governance structures and IPC delivery across all sites and trajectories.

**Resolved:** to accept the report.

#### **17.084.2 Adult inpatient acuity and dependency workforce review May 2017**

The Board considered the report presented by the Chief Nurse, setting out the findings and recommendations from the review undertaken in May 2017. The review included fourteen adult inpatient wards across Divisions 3, 4 and 5. The wards had been included due to concerns raised as part of the Trust wide review undertaken in August 2016 when immediate action had not been required but a further review was necessary.

Four out of the fourteen wards reviewed required further action and had been RAG rated red. Each of those four wards had high rates of vacancies and between 10-20% agency usage. Each of the four areas had a Trainee Nursing Associate in post as part of the national pilot with a view to this role being developed to help to fill the skills gap in the future.

The Board discussed the impact on quality when using agency compared to substantive staff and it was advised that there should be no difference, however leadership and the ward manager role was key to ensuring quality was maintained.

**Resolved:** to accept the report.

### **17.085 FINANCE REPORT**

The Board considered the report presented by the interim Finance Director that provided an update on the Trust's financial position for period ended 30 June 2017 (month 3). The Trust had delivered an overall deficit of (£4.7m) for month 3 of the 2017/18 financial year, an adverse variance of (£2.3m) against the planned deficit of (£2.4m) pre STF. This moved the year to date deficit to (£13.5m) an adverse variance of (£6.3m) against the planned deficit pre STF of (£7.2m). As a result of under-delivering against the financial plan, the year to date allocation of £3.2m of STF had not been assumed.

The main components of the variance were healthcare income which was (£0.2m) in month / (£1.5m) YTD below seasonal plan. Activity related income was (£1.1m) in month / (£1.9m) YTD. Maternity spells / pathways accounted for 84% of the total variance, following a detailed review it had been identified that maternity spells income had been under recorded by £936k during Q1 due to births being incorrectly categorised between 'standard' and 'with complications'.

There had been some CIP slippage circa (£0.8m) YTD, further work was required to ensure that projects were being delivered upon.

The cash balance at the end of June was £21.7m against the plan of £10.3m at this point, a favourable movement of £11.4m.

**Resolved:** to accept the report.

#### 17.086 BOARD ASSURANCE FRAMEWORK

The Board considered and discussed the paper presented by the interim Director of Corporate Affairs. The Board Assurance Framework (BAF) provided assurance that the Board was aware of the risks to its key objectives and had a robust system of internal control. The BAF had been reviewed and updated in the first quarter of the year and there were currently 13 risks on the register of which 6 were scored as red and 7 as amber.

One new risk was proposed that related to reputational risk associated to the Paterson high profile court case.

**Resolved:**

1. to accept the report
2. to approve and add the risk identified.

#### 17.087 QUALITY ACCOUNT UPDATE Q1 2017/18

The Board considered the report presented by the interim Medical Director that provided an update on against each of the 4 priorities and progress was noted. The report had been presented to the Audit Committee earlier that day. The approved update report would be published on the Trust website.

**Resolved:** to accept the report.

#### 17.088 COMPLIANCE AND ASSURANCE REPORT

The Board considered the report presented by the interim Director of Corporate Affairs. The report set out the actions being taken on the internal and external assurance processes. As reported earlier in the meeting, the draft CQC report had been received in June and following a factual accuracy check, returned to CQC. The final report was awaited.

Quarterly Divisional Quality Governance reports now included newly published NICE guidance or updates and Directorate status. There had been a comprehensive review of NICE guidance. There had been 63 National Audits identified as applicable for 2017/18, the Trust was participating in 60.

There were a total of 74 local audits logged on the clinical audit database. It was considered that the number should be higher and divisions were being encouraged to log all audits. Work had been completed to close clinical audits dated pre-2014

logged on the database. The Board received assurance that there was now more rigour in the system to monitor clinical audits at the Trust.

**Resolved:** The report was received.

## 17.089 HEALTH & SAFETY REPORT

The Board considered the report presented by the interim Director of Corporate Affairs. The report set out the process to ensure that compliance against key requirements the Trust's Health and Safety Policy remained robust. The focus for the health and safety team over the reporting period had been to give continued support to operational colleagues by providing training, advice, inspection and audit; preparation for external visits (as and when required) including HSE inspection, ensuring compliance with the Trust Health And Safety Policy and giving increased support to investigating managers and handlers in order to improve learning from incidents.

The Board discussed the number of reported verbal and aggressive incidents against staff by patients and carers (356 and 283 respectively). The number included incidents by patients who lacked capacity. The Trust had issued 24 yellow cards and 6 red cards to patients and/or carers. Further investigation into how the Trust could manage incidents better was being undertaken. The difficulties in managing patients who lacked capacity was discussed and the Board was reassured to note that specific staff training was in place to enable them to do so.

**Resolved:** The report was received.

## 17.090 AUDIT COMMITTEE ANNUAL REPORT

The report was deferred to the November meeting.

## FOR APPROVAL

## 17.091 BUSINESS CASES FOR APPROVAL

The Board considered the following business cases

**15.1** Elderly Care Replacement Consultant

**15.2** Replacement Paediatric Medical Workforce

**15.3** BHH SID Expansion

**15.4** Diabetes Replacement Consultant

**Resolved:** to approve the proposed business case.

## 17.092 POLICIES

The Board received the following policies presented by the interim Director of Corporate Affairs.

- Risk Management Policy
- Patient Complaints and Concerns Policy
- Grievance Policy
- External Visits Policy

**Resolved:** The Board accepted and approved the policies.

**17.093 ANY OTHER BUSINESS**

The Chair reported that Sam Foster, Chief Nurse, would be leaving the Trust at the end of August and formally recorded a vote of thanks for her contribution and dedication during her time at the Trust and wished her well for the future.

**17.094 DATE OF NEXT MEETING**

The next public meeting of the Board of Directors was scheduled for Monday 23 October 2017, to be held in the Education Centre, Birmingham Heartlands Hospital.

The Chair reported that the planned private session of the Board had been cancelled.

Being no further business the meeting closed.

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**Chair**

**HEART OF ENGLAND NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS**

**MONDAY 23<sup>RD</sup> OCTOBER 2017**

<b>Title:</b> Performance Indicators Report							
<b>From:</b> Kevin Bolger, Interim Deputy CEO - Improvement				<b>To:</b> Board of Directors			
<b>The Report is being provided for:</b>							
Decision	N	Discussion	Y	Assurance	Y	Endorsement	Y
<b>Purpose:</b> To update the Board of Directors on the Trust's performance against targets and indicators in the Single Oversight Framework, contractual targets and internal targets.							
<b>Key points/Summary:</b> Exception reports have been provided where there are current or future risks to performance for targets and indicators included in the Single Oversight, national and contractual targets and internal indicators.  A&E 4 hour performance remains a risk for the Trust.							
<b>Recommendation(s):</b> The Board of Directors is requested to:  <b>Accept</b> the report on progress made towards achieving performance targets and associated actions and risks.							
<b>Assurance Implications:</b>							
Board Assurance Framework	N	BAF Risk Reference No.					
Performance KPIs year to date	Y	Resource/Assurance Implications (e.g. Financial/HR)			N		
Information Exempt from Disclosure	N	If yes, reason why.					
Identify any Equality & Diversity issues	None						
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							
None							

# HEART OF ENGLAND NHS FOUNDATION TRUST

## BOARD OF DIRECTORS

MONDAY 23<sup>RD</sup> OCTOBER 2017

### PERFORMANCE INDICATORS REPORT PRESENTED BY THE INTERIM DEPUTY CEO - IMPROVEMENT

#### 1. Purpose

This paper summarises the Trust's performance against national indicators and targets, including those in the NHSI Single Oversight Framework 6, as well as local priorities. Material risks to the Trust's Provider Licence, reputation or clinical quality resulting from performance against indicators are detailed below.

#### 2. HEFT Performance Framework

The Trust has a suite of Key Performance Indicators that includes national targets set by NHS Improvement and the Department of Health (DH) and local indicators selected by the Trust as priority areas, some of which are jointly agreed with the Trust's commissioners. This report is intended to give a view of overall performance of the organisation in a concise format and highlight key risks particularly around national and contractual targets.

#### 3. Material Risks

The DH sets out a number of national targets for the NHS each year which are priorities to improve quality and access to healthcare. NHS Improvement (NHSI) tracks the Trust's performance against a subset of these targets, enabling Trusts to access the Sustainability and Transformation Fund as long as agreed trajectories are achieved.

Table 1: Performance against National Contractual Requirements

Indicator	Threshold	Current Data Period	Performance
<b>Single Oversight Framework</b>			
18 week RTT – incomplete	92%	Sep-17	92.01%
A&E 4 hour access	95%	Sep-17	80.02%
Cancer 62 day - GP urgent referral	85%	Aug-17	87.92%
Cancer 62 day - national screening	90%	Aug-17	100.00%
6 weeks diagnostic test	99%	Sep-17	99.16%

Indicator	Threshold	Current Data Period	Performance
<b>Other National Targets</b>			
Cancer 2 week	93%	Aug-17	95.96%
Cancer breast - 2 week	93%	Aug-17	93.95%
Cancer 31 days- first treatment	96%	Aug-17	98.13%
Cancer 31 days- subsequent treatment -surgery	94%	Aug-17	97.62%
Cancer 31 days - subsequent treatment - drugs	98%	Aug-17	100.00%
Ambulance Handover $\geq$ 30 minutes	95.5%	Sep-17	98.6% (96)
Ambulance Handover $\geq$ 60 minutes	99.5%	Sep-17	99.8% (16)
12 hour Trolley waits A&E	0	Sep-17	0
52 week waits	0	Sep-17	0
Cancelled Ops rearranged 28 days	0	Sep-17	0
Urgent operation cancelled x 2	0	Sep-17	0
Sleeping Accommodation Breach	0	Sep-17	0
MRSA	0	Sep-17	0
C.difficile - (post 48 hours)	5	Sep-17	7
VTE risk assessment	95%	Sep-17	97.88%
Duty of Candour (2 months in arrears)	0	Jul-17	0
NHS Number acute	99%	Sep-17	99.66%
NHS Number A&E	95%	Sep-17	98.47%

### 3.1 Single Oversight Framework

#### 3.1.1 A&E 4 Hour Waits

Performance for the A&E 4 hour wait target has declined in September to 80.02% compared with 82.82% in August 2017.

Table 2: A&E Performance by Site September 2017

	Performance	Attendances	Daily Av
Heartlands	82.15%	11,592	386
Good Hope	67.33%	7,334	245
Solihull	99.32%	3,542	118
<b>Trust</b>	<b>80.02%</b>	<b>22,468</b>	<b>749</b>

Table: 3 A&E Performance by Site August 2017

	Performance	Attendances	Daily Av
Heartlands	82.03%	11,366	367
Good Hope	76.43%	7,073	228
Solihull	98.47%	3,461	112
<b>Trust</b>	<b>82.82%</b>	<b>21,900</b>	<b>707</b>

The following actions/initiatives have been implemented to support ED performance:-

- Clinical Review Group - A clinical team from the Queen Elizabeth Hospital with support from the Chief Operating Officer & Chief Nurse at HEFT have been identified to review working practices and identify supportive measures/recommendations to improve performance.
- Frailty Admission Unit – Remodelling assessment at the front door for elderly frail people.
- Long stay to short stay – Following a bed modelling review, two general medical wards have been converted to medical short stay, one at GHH and one at BHH.
- Recruitment strategy – including the implementation of cross site rotation of ENPs, application the Deanery for increased training numbers, fast track of ACP trainees, 11 medics due to commence August – October, introduction of a Nurse Navigator, block booking of locums for 3-6 month periods as well as scoping utilisation international fellows to fill vacancy gap.

### 3.1.2 18 Week Referral to Treatment (Incomplete Pathways)

The incomplete pathway performance shows that the Trust has achieved at aggregate level in September with a performance of 92.01%.

There were three specialties that failed to meet the target in month as shown in the table below:

Table 4: 18 week RTT performance – specialties failing to meet the target in month

Specialty	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Dermatology	93.72%	95.14%	94.92%	93.97%	92.60%	91.54%
T&O	83.17%	84.16%	85.88%	85.60%	84.26%	83.65%
ENT	93.68%	93.84%	92.94%	92.15%	90.51%	90.23%

Within the category “other” a number of specialties has failed to meet the target.

Table 5: 18 week RTT performance – category “other”

Specialty	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Pain Relief	90.32%	92.46%	90.62%	92.35%	92.20%	89.37%
Community Paeds	95.14%	96.61%	96.94%	91.36%	84.40%	91.20%
Colorectal Surgery	83.33%	95.59%	91.21%	93.98%	85.90%	91.86%
Upper GI Surgery	64.55%	65.95%	61.90%	61.00%	63.19%	60.68%

**Dermatology** – Significant increased demand for suspected cancer referrals over the summer period put pressure on routine service capacity, backlogs developing in outpatients and for MOHS surgery. Additional clinic and theatre capacity has been identified from October to address these and recover the position.

**Trauma and Orthopaedics** - Demand for trauma surgery remains high, which has impacted on elective activity and bed capacity pressures have also resulted in a number of elective theatre lists (both inpatient and day case) being cancelled. There also remains a high vacancy rate at junior doctor level.

A number of actions are in place to address junior doctor vacancies, including use of international doctors and a renewed recruitment drive. Four ACPs have recently been appointed and this should result in less elective activity being cancelled due to rota vacancies. Redesign of trauma clinics is in progress to allocate appropriate number of new appointment slots in line with demand and discussions continue with other provider organisations around the transfer of elective activity during the winter period.

**ENT** – Demand on inpatient beds has resulted in cancelled elective procedures which, coupled with rising referral demand, has led to deterioration in RTT performance. Additional theatres have now been identified providing fortnightly and weekend WLI sessions from October to address backlogs. In addition, three consultants were recently appointed and theatre session cover is being prioritised.

**Pain Management** – Reduction in consultant capacity and notable increases in demand have led to backlogs developing in both outpatients and injection clinics. All clinics are being reviewed within the team to identify additional capacity for October and November. Additional injection lists have also been identified. This will be supported by WLI and locum usage.

**Community Paediatrics** – The service continued to experience reduced consultant capacity which impacted on RTT performance. A newly appointed consultant started in October and this is expected to improve the position.

**Colorectal** – The specialty narrowly failed the standard this month due to pressure on inpatient beds resulting in theatre cancellations. The service is working to identify additional theatre capacity and undertakes a regular review of upcoming lists to reduce the impact of late cancellations and to maximise the utilisation of any unused lists.

**Upper GI** – Whilst the position has improved, there remains ongoing pressure on both inpatient beds and theatre capacity making it a challenge to address surgical backlogs. Focussed work on level scheduling benign patients for Upper GI is ongoing. The Directorate are undertaking inter provider transfers for routine patients, particularly in light of bed pressures. A locum surgeon has also been recruited to start in November.

### 3.1.3 Cancer

The Trust met all national cancer targets in August 2017.

### 3.1.4. Cancer Long Waits

In August, the Trust was accountable for four breaches (six patients) for patients that had waited over 104 days.

Three of these patients were late tertiary referrals from other providers referred in beyond their breach date (0.5 breach for each). Three patients had complex pathways, involving multiple diagnostic tests before a diagnosis could be reached.

Following root cause analysis, it was determined that no avoidable harm was caused to these patients as a result of their extended pathways.

As at 30<sup>th</sup> September, the Trust had four patients waiting over 104 days on a cancer pathway. All patients have a treatment date scheduled in October. Three of these patients are tertiary referrals received late in the pathway (Worcester, Walsall and UHCW).

### 3.1.5 % patients waiting 6 weeks for 15 key diagnostic tests

The Trust met the 6 weeks diagnostic target (99%) in September (99.16%).

## 3.2 National Targets Monitored Locally Through CCG Contract

Of the 18 national targets that are not included as Operational Performance Metrics in the new Single Oversight Framework but are included in the CCG contract the Trust is on target for 18.

### 3.2.1 MRSA Bacteraemia

There has been no post 48 hour MRSA bacteraemia reported in September.

The total number of MRSA bacteraemia attributed to the Trust year to date is one.

### 3.2.2 Clostridium difficile

Seven cases of post 48 hour C.diff have been reported in September. This is against a monthly trajectory of five. The total number of cases this year is 31 against a YTD trajectory of 30 cases and an annual trajectory of 64 cases.

Two of the seven cases have been reviewed by the Infection Prevention Control (IPC) team with Microbiology and IPC colleagues from the clinical commissioning group.

One case has been deemed to be avoidable (Good Hope Ward 8) due to inappropriate antibiotic prescribing, and the second case is unavoidable (Heartlands Ward 12). Of the remaining five cases, three will be reviewed once ribotyping results are available and two are awaiting antibiotic reviews to be completed.

### 3.2.3 Ambulance Handover

The Trust met the CCG target of 95% of patients waiting less than 30 minutes (98.6%) and 60 minutes (99.8%) in September.

There were 96 patients who waited over 30 minutes and 16 patients who waited over 60 minutes for ambulance handover.

- The Division have agreed with WMAS and the CCG that the Solihull HALO will move to GHH in November to ensure increased HALO cover.
- Review of the demand profile has adjusted the HALO shifts in line with the peak arrival times as the Clinical Handover Breach Summary & CAD-Online Handover Recording Compliance has demonstrated significantly improved timely handovers and compliance when a HALO is in ED.
- The HALO, GHH Clinical Lead and Band 7 Nurse have met to reinforce the importance of timely handovers and the process that needs to be in place at all times including the escalation process.

Table 6: Ambulance handover 30 minute breaches by site

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
BHH	173	237	61	6	20	21
GHH	185	233	92	20	38	75
SH	16	21	3	1	0	0
<b>Trust</b>	<b>374</b>	<b>491</b>	<b>156</b>	<b>27</b>	<b>58</b>	<b>96</b>

#### 4. Local Indicators – acute contract

There are 67 local contractual indicators that the Trust's performance is measured against (31 are reported monthly, 32 of these are reported quarterly and the others either bi-annually or bi-monthly).

##### 4.1 Delayed Transfers of Care (DTOC) for health and joint delays

The Trust achieved the target for September, achieving 1.38% against a target of 1.4%, the site and patient numbers waiting are shown in the tables below. This is the first time that the target has been achieved since November 2016.

Table 7: DTOC HEFT and external NHS joint health delays

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
BHH	2.48%	2.73%	2.80%	1.48%	1.93%	1.11%
GHH	0.80%	1.02%	1.95%	1.05%	2.36%	1.75%
SH	4.72%	3.20%	4.03%	3.95%	4.39%	1.60%
<b>TRUST</b>	<b>2.27%</b>	<b>2.24%</b>	<b>2.70%</b>	<b>1.67%</b>	<b>2.40%</b>	<b>1.38%</b>

Monthly variance between August and September is in part attributable to reporting block periods (5 weeks for August and only 4 for September). In addition, Solihull SS had a particular focus on DTOC for September 17 which has also marginally improved the position on the Solihull site.

The tables below show performance for all delayed transfers of care and actual numbers i.e. those that are health and social delays (internal target 2.5% monitored at the HEFT Length of Stay Group)

Table 8: All DTOC delays

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
BHH	4.05%	4.14%	6.01%	3.45%	4.18%	2.97%
GHH	3.20%	3.06%	5.20%	2.50%	4.92%	3.30%
SH	8.18%	8.19%	8.43%	7.15%	6.39%	2.52%
<b>TRUST</b>	<b>4.39%</b>	<b>4.39%</b>	<b>6.11%</b>	<b>3.90%</b>	<b>5.06%</b>	<b>3.13%</b>

Table 9: All DTOC delays - bed days occupied

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
BHH	879	930	1306	825	999	688
GHH	433	427	703	365	719	466
SH	508	525	523	425	380	145
<b>TRUST</b>	<b>1820</b>	<b>1882</b>	<b>2532</b>	<b>1615</b>	<b>2098</b>	<b>1299</b>

#### 4.2 Pressure Ulcer Reduction

There has been no avoidable hospital acquired grade 4 pressure ulcers reported year to date, against a target of zero tolerance.

The Trust has reported no avoidable hospital acquired grade 3 pressure ulcers during August (September position yet to be reported). There have been four avoidable hospital acquired grade three pressure ulcers reported year to date against an annual target of 36.

Further detail can be found in the Care Quality Report.

#### 4.3 Quarterly Maternity Screening Indicators

There are 14 maternity screening indicators, all reported a quarter in arrears, and therefore the current performance reported this quarter relates to Q1 (2017/18). Of the 14 indicators, the Trust has failed to meet 5.

These are:

- Laboratory request forms 10+0 to 20+0 weeks gestation – new validation process instigated in September with daily monitoring in place showing an improved unvalidated October position.
- Newborn Bloodspot – Avoidable Repeat Tests – additional training and new validation process instigated in September showing an improved unvalidated October position.
- Newborn hearing assessment referrals – performed under regional contract with Sandwell and West Birmingham with poor performance attributable to the DNA rate (circa 8 pts). HEFT have requested SWBH implement a call reminder service to prevent further DNAs.
- Newborn Hip Abnormality – performance missed by 1 baby from a total number of referrals of 3. Failure was due to communication issues. A new process is in place to prevent this recurring.

### **5. Local Indicators – Community Contract**

The Trust has a number of community contracts, many of the indicators against these contracts are reported quarterly.

In Q2 2017/18 the Community Paediatric Waiting Times KPI failed to achieve the 92% target at 91.2%, and the Designated Doctor KPI is failing to achieve the 85% year-end target at 68.75% for Q2. All other indicators in this contract have been met.

Community Paediatrics has carried out three WLI sessions with a further two planned to resolve the backlog, with a new Consultant due to commence in post in October covering SARC services.

The Designated Doctor KPI has been affected by long term sickness and recruitment issues covering the SARC SLA which has now been appointed to. Job plans for Community Paediatricians have been reviewed and approved with time allocated for Designated Doctors. This now takes the establishment position up to 3.5 WTE to cover this role.

## 6. Internal Indicators – Performance

### 6.1 Dementia Screening

The Trusts performance against the dementia screening ‘FIND’ element of this metric has decreased in month to 83.39% in September and is failing to meet the 90% target as shown in the table below.

Divisions have been tasked with holding individuals to account for completion of the screening tool with an expectation to demonstrate how they have improved compliance. Additional specific actions have been taken by divisions; campaign carried out to reiterate the importance of dementia screening involving all Clinical Directors and Clinical Leads and nursing staff reminding doctors to complete dementia risk assessment fields.

Divisional performance is monitored through Trust wide Divisional Reviews where there will be an expectation to see improvement during the coming months.

Table 10: Dementia Screening Performance by Division

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Div 1	66.67%	100.00%	90.91%	100.00%	100.00%	100.00%	100.00%
Div 2	N/A	50.00%	N/A	100.00%	50.00%	100.00%	N/A
Div 3	88.90%	89.97%	87.45%	89.37%	88.25%	83.93%	83.37%
Div 4	93.67%	88.79%	92.92%	94.12%	93.22%	90.53%	87.50%
Div 5	79.64%	86.73%	82.38%	82.98%	85.09%	85.71%	81.62%
<b>TRUST</b>	<b>87.93%</b>	<b>89.31%</b>	<b>87.11%</b>	<b>88.76%</b>	<b>88.11%</b>	<b>84.72%</b>	<b>83.39%</b>

### 6.2 Information Governance Training

Performance against the Information Governance Mandatory Training target of 95% has continued to improve slightly in month, with performance at 86.97% in September. All clinical divisions and corporate areas still not achieving 95% compliance. Improved compliance was discussed at all divisional review meetings in September with methods for improving training shared across teams.

Table11: Information Governance Training - Cumulative performance

Division	Apr-17	Jun-17	Jul-17	Aug-17	Sep-17
Corporate	86.22%	87.46%	88.47%	88.66%	89.29%
Facilities	72.31%	87.73%	95.22%	96.87%	97.27%
Education Services	93.27%	93.20%	94.85%	97.98%	97.96%
Research Management	97.87%	93.48%	97.92%	97.96%	97.92%
Division 1	85.79%	89.67%	92.20%	94.46%	92.23%
Division 2	75.46%	81.63%	83.39%	84.80%	86.88%
Division 3	74.87%	80.23%	81.97%	82.20%	82.00%
Division 4	77.96%	82.83%	85.05%	85.68%	86.37%
Division 5	67.91%	72.92%	73.84%	74.81%	77.08%
<b>Trustwide</b>	<b>78.13%</b>	<b>83.38%</b>	<b>85.64%</b>	<b>86.08%</b>	<b>86.97%</b>

## 7. Local Indicators - Workforce

### 7.1 Mandatory Training

Mandatory Training performance remains above target (85%) and has improved this month to 91.07%, from 90.41% in August.

### 7.2 Appraisal

Appraisal completion rates have reduced slightly in September to 88.06%, but remains above the 85% target. An internal target of 90% has been agreed and plans are being discussed with Divisions to improve performance. Some corporate teams have shown reductions in particular ICT and rectification plans have been put in place.

### 7.3 Recruitment

Time to Hire (recruitment) performance is now 6.95 weeks against a target of 6 weeks. The performance of all Divisions against the sub 3 week target has been consistently strong, and management time to hire in September was 3.05 weeks. There have been some delays in clearance processes (i.e. DBS), which are being monitored by HR.

### 7.4 Voluntary Turnover

Trust turnover rates decreased for the third consecutive month to 10.57%, from 10.59% in August.

The staged reductions are encouraging given recent trends. With the addition of the new online exit monitoring tool the Trust have unexpectedly just missed the October KPI (40%) target by returning 39.60% performance. The Trust will now be focussing on returning 75% performance by March 18 as agreed by the Board of Directors, given the profile and importance attached to this KPI.

## 7.5 Sickness Absence

Sickness absence rates have increased in September to 4.61% in month and to 4.29% moving annual average against a target of 4.00%. This is compared to 4.18% (in month) and 4.32% (moving annual average) at the same point last year. Increases have been reported across both short and long term absence. Plans to accelerate the flu programme and health and well-being provision in response are now in place, supported by continued management of absence by operational teams.

## 8. **CQUIN Update Q1 2017-18**

With the exception of the CQUINs reference 2a & 2b, Timely identification and treatment for Sepsis in emergency departments and inpatient settings, the Trust fully achieved all CQUIN milestones for quarter one of 2017-18 for the Acute and Specialised Services CQUINs.

For Sepsis the Trust out turned at 72% and 59% respectively, against a 90% target. This is an improvement on the quarter 4 position of 56% and 56.8%.

## 9. **Recommendations**

The Board of Directors is requested to:

- 8.1 **Accept** the report on progress made towards achieving performance targets and associated actions and risks.

**Kevin Bolger**

**Interim Deputy Chief Executive - Improvement**

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**MONDAY 23<sup>RD</sup> OCTOBER 2017**

<b>Title: Clinical Quality Monitoring Report</b>							
<b>From:</b> David Rosser, Interim Executive Medical Director				<b>To:</b> Board of Directors			
Mark Garrick, Director of Medical Directors' Services							
<b>The Report is being provided for:</b>							
Decision	N	Discussion	Y	Assurance	Y	Endorsement	Y
<b>Purpose:</b> To provide assurance on clinical quality to the Board of Directors and detail the actions being taken following the Joint Clinical Quality Monitoring Group (JCQMG) 27 <sup>th</sup> September 2017 and the HEFT Clinical Quality Monitoring Group (CQMG) 3 <sup>rd</sup> October 2017.  To receive and note the contents of this report.							
<b>Key points/Summary:</b>							
The Board of Directors will consider: <ul style="list-style-type: none"> <li>• Investigations into Doctors' performance currently underway</li> <li>• Mortality indicators: CUSUM, SHMI and HSMR</li> <li>• Board of Directors' Unannounced Governance Visits</li> </ul>							
<b>Recommendation(s):</b>							
The Board is asked to consider the information set out in this report, discuss the contents and approve the actions identified.							
<b>Assurance Implications:</b>							
Board Assurance Framework		Y/N	BAF Risk Reference No.				
Performance KPIs year to date		Y	Resource/Assurance Implications (e.g. Financial/HR)		Y		
Information Exempt from Disclosure		N	If yes, reason why.				
Identify any Equality & Diversity issues							
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							
N/A							

## 1. Introduction

The aim of this paper is to provide assurance on clinical quality to the Board of Directors, detailing the actions being taken following the JCQMG and CQMG meetings. The Board of Directors is requested to discuss the contents of this report and approve the actions identified.

## 2. Update On Medical Staff Within The Remit Of Maintaining High Professional Standards (MHPS)

There are currently six Doctors subject to MHPS investigation. The investigations relate to four Consultant Grade Doctors, one Specialty Doctor and one Clinical Fellow.

## 3. Mortality – CUSUM

In June 2017 no CCS (Clinical Classification System) groups breached the mortality threshold. One CCS group had a higher than expected mortality. The group was 'Cardiac dysrhythmias' (106). A Deputy Medical Director has reviewed the caselist for this group and identified no further concerns. Please see Figure 1 below.

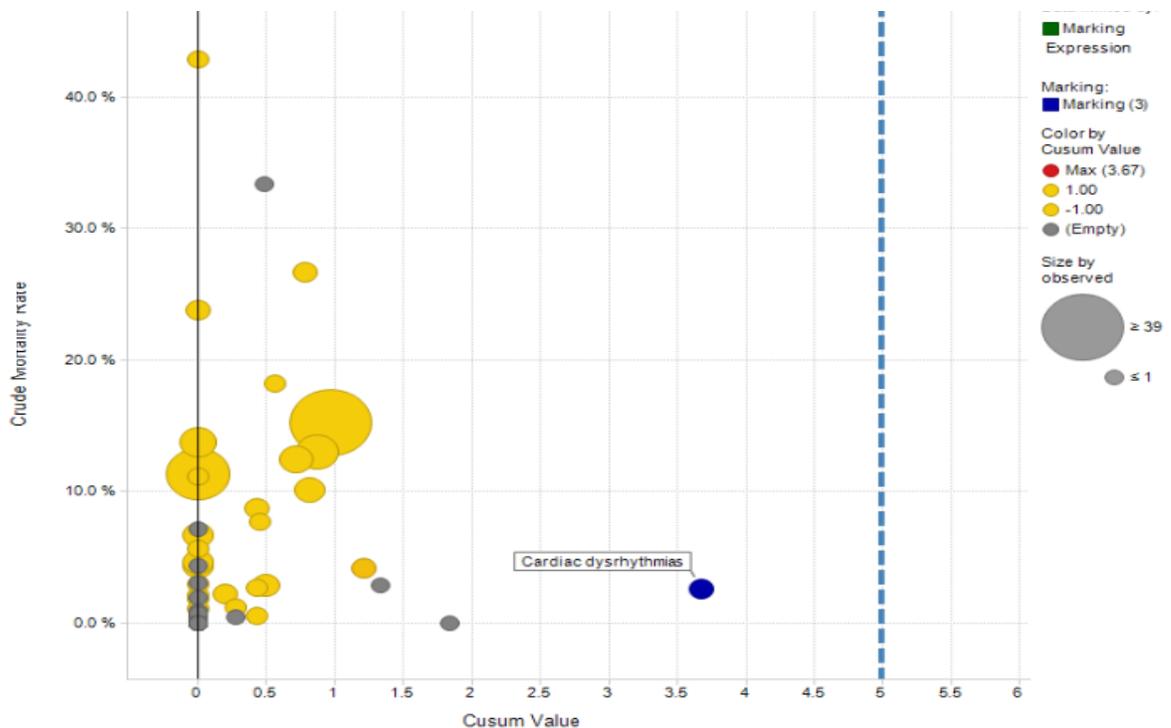


Figure 1: HEFT CUSUM in June 2017 for HSMR CCS Groups

The Trust's overall mortality rate as measured by the CUSUM for June 2017 is within acceptable limits as shown in Figure 2 below

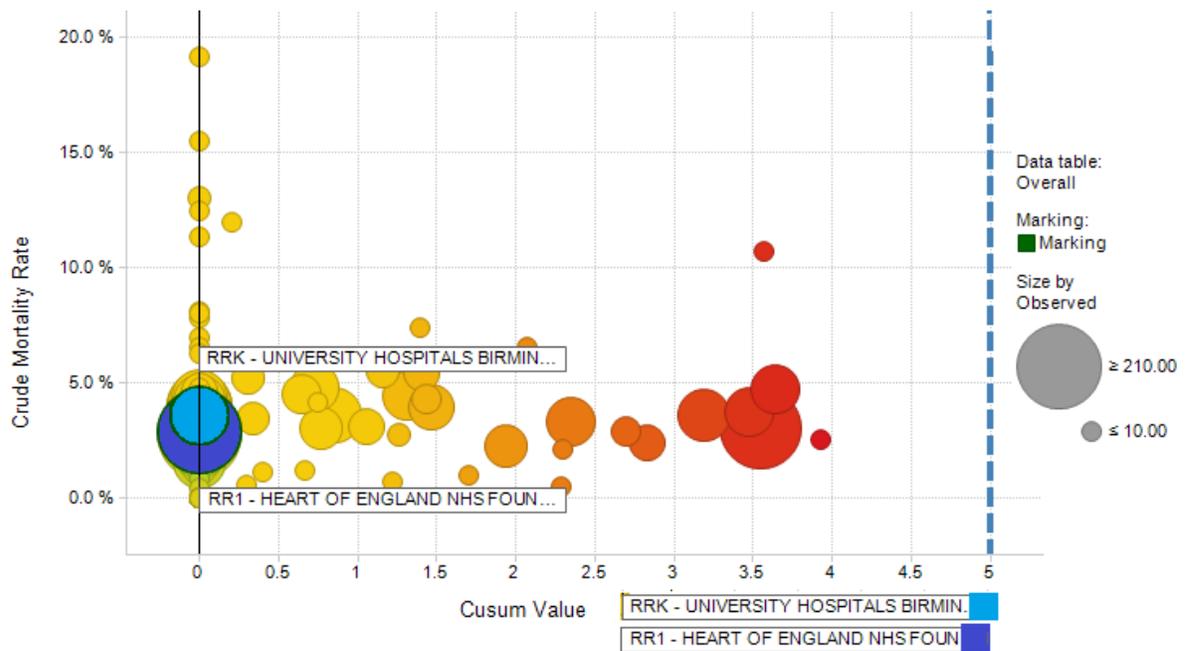


Figure 2: HEFT CUSUM in June 2017 at Trust level. UHB CUSUM included for benchmarking purposes.

#### 4. Mortality – SHMI (Summary Hospital-Level Mortality Indicator)

The Trust's SHMI performance for April 2017 to May 2017 was 86. The Trust has had 703 deaths compared with 819 expected. The Trust is within the acceptable limits as shown in Figure 3 below.

Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.

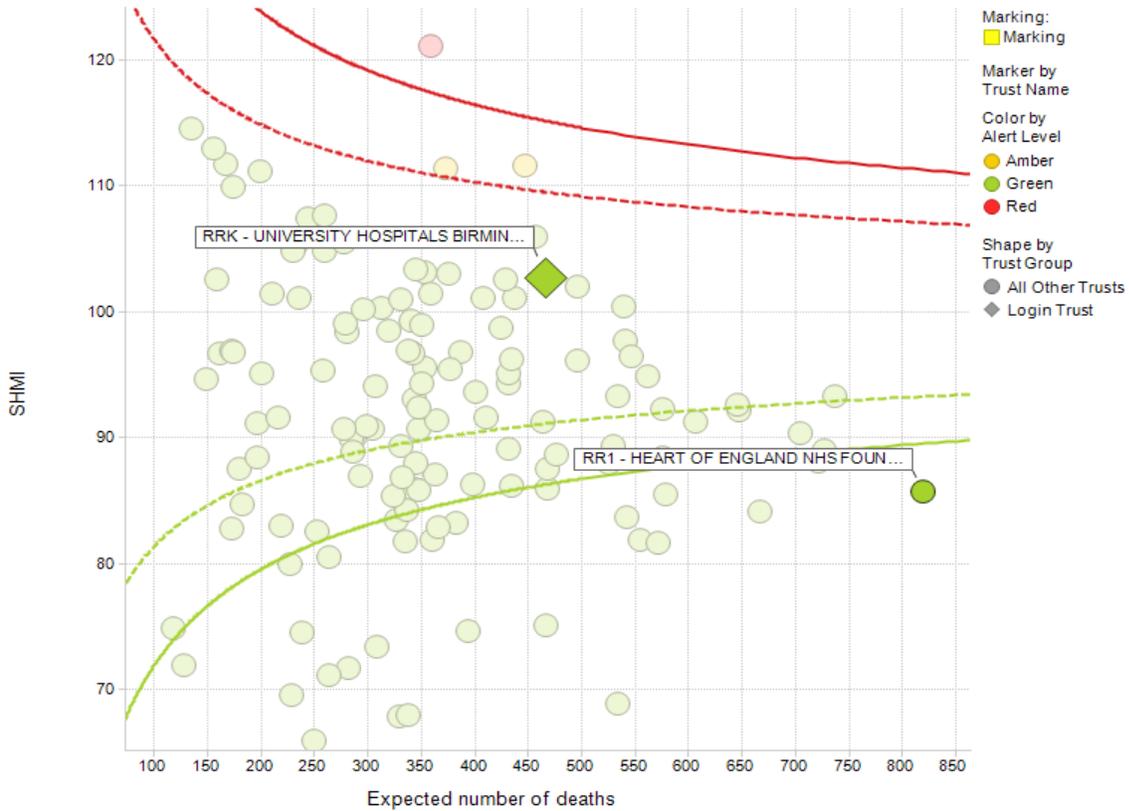


Figure 3: HEFT SHMI April 2017 to May 2017. UHB SHMI included for benchmarking purposes.

## 5. Mortality – HSMR (Hospital Standardised Mortality Ratio)

The Trust's HSMR for the period April 2017 to June 2017 was 98.97 which is within acceptable limits. The Trust had 656 deaths compared with 662 expected (see Figure 4 below).

Please note that the funnel plot is only valid when the overall HSMR score is around 100.

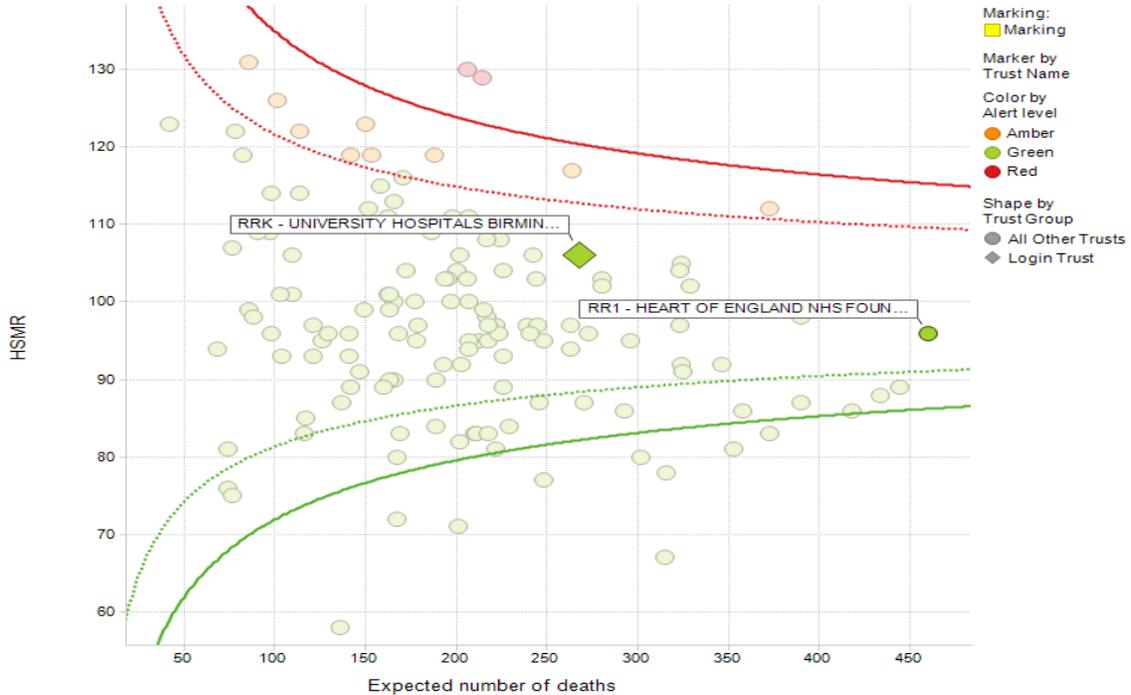


Figure 4: HEFT HSMR April 2017 to June 2017. UHB HSMR included for benchmarking purposes.

## 6. Board of Directors' Unannounced Governance Visits

The visit scheduled for September 2017 was cancelled.

The visit in October 2017 was to Ward 16 (Paediatrics) at Birmingham Heartlands Hospital. This visit will be reported in a future report.

## 7. Recommendations

The Board of Directors is asked to:

Discuss the contents of this report and approve the actions identified.

David Rosser  
Interim Executive Medical Director  
16<sup>th</sup> October 2017

**HEART OF ENGLAND NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS**

**MONDAY 23<sup>RD</sup> OCTOBER 2017**

<b>Title:</b> 2016-17 Annual Medical Appraisal and Revalidation Board Report							
<b>From:</b> Dr. David Rosser (Executive Medical Director & Responsible Officer) and Dr Adedeji Okubadejo (Associate Medical Director, Revalidation)						<b>To:</b> Board of Directors	
<b>The Report is being provided for:</b>							
Decision	<b>N</b>	Discussion	<b>Y</b>	Assurance	<b>Y</b>	Endorsement	<b>N</b>
<b>Purpose:</b>							
<p>The purpose of this report is to provide assurance to the Board that medical appraisal and revalidation systems and processes, including those of clinical governance, underpinning the Responsible Officer's (RO) recommendations of revalidation to the GMC, are robust and functioning effectively.</p>							
<b>Key points/Summary:</b>							
<p>This is the fourth annual detailed report to the Board of Directors on the development and maintenance of systems to support the appraisal and revalidation of medical staff. Revalidation is a process of providing assurance that doctors registered with a licence to practice are up to date and fit to practice. Annual medical appraisals form the bedrock of the revalidation process and the Responsible Officer (RO) is required to make a revalidation recommendation on every doctor to the General Medical Council (GMC) once every five years.</p> <p>This report covers the 2016/17 financial year and as year-end on the 31st March 2017, the Trust had 701 career grade doctors connected to it for the purpose of revalidation. In the year 2016/17 all of the doctors known and expected to undertake a medical appraisal completed their appraisal. 10 doctors were not expected to complete an appraisal last year as they had an approved absence from the organisation. An additional 30 doctors were new starters (new to the Trust and new to the NHS) who did not require an appraisal during the appraisal season. The Trust therefore reported a medical appraisal rate of 94.3% for the 2016/17 year. This compares with a Trust medical appraisal rate of 95.5% for 2015/16. The average medical appraisal rate for acute secondary care NHS hospitals in England in 2016/17 was 86.6%.</p> <p>Work is continuing to improve the processes and quality of medical appraisal and revalidation as well as the quality of the work of medical appraisers. Furthermore, work is taking place to further strengthen the recruitment process for doctors, provide robust clinical outcomes data and link clinical governance information to doctors' activities, outcomes and appraisals. Areas of synergy between medical appraisal and revalidation systems between Heart of England NHS Foundation Trust and University Hospitals Birmingham NHS Foundation Trust are also being scoped.</p> <p>The report forms part of the statutory Medical Director's duties as the RO.</p>							
<b>Recommendation(s):</b>							
The Board is asked to consider the information set out in this report							

<b>Assurance Implications:</b>			
Board Assurance Framework	Y/N	BAF Risk Reference No.	
Performance KPIs year to date	Y/N	Resource/Assurance Implications (e.g. Financial/HR)	Y/N
Information Exempt from Disclosure	Y/N	If yes, reason why.	
Identify any Equality & Diversity issues			
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>			

# HEART OF ENGLAND NHS FOUNDATION TRUST

## BOARD OF DIRECTORS

MONDAY 23<sup>RD</sup> OCTOBER 2017

### 1. EXECUTIVE SUMMARY:

This is the fourth annual detailed report to the Board of Directors on the development and maintenance of systems to support the appraisal and revalidation of medical staff. Revalidation is a process of providing assurance that doctors registered with a licence to practice are up to date and fit to practice. Annual medical appraisals form the bedrock of the revalidation process and the Responsible Officer (RO) is required to make a revalidation recommendation on every doctor to the General Medical Council (GMC) once every five years.

This report covers the 2016/17 financial year and as year-end on the 31<sup>st</sup> March 2017, the Trust had 701 career grade doctors connected to it for the purpose of revalidation. In the year 2016/17 all of the doctors known and expected to undertake a medical appraisal completed their appraisal. 10 doctors were not expected to complete an appraisal last year as they had an approved absence from the organisation. An additional 30 doctors were new starters (new to the Trust and new to the NHS) who did not require an appraisal during the appraisal season. The Trust therefore reported a medical appraisal rate of 94.3% for the 2016/17 year. This compares with a Trust medical appraisal rate of 95.5% for 2015/16. The average medical appraisal rate for acute secondary care NHS hospitals in England in 2016/17 was 86.6%.

Work is continuing to improve the processes and quality of medical appraisal and revalidation as well as the quality of the work of medical appraisers. Furthermore, work is taking place to further strengthen the recruitment process for doctors, provide robust clinical outcomes data and link clinical governance information to doctors' activities, outcomes and appraisals. Areas of synergy between medical appraisal and revalidation systems between Heart of England NHS Foundation Trust and University Hospitals Birmingham NHS Foundation Trust are also being scoped.

The report forms part of the statutory Medical Director's duties as the RO.

### 2. BACKGROUND

- 2.1. Medical Revalidation commenced in England on 3 December 2012 and was launched to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical profession.

### 3. GOVERNANCE ARRANGEMENTS

- 3.1 The Annual Organisation Audit (AOA) of medical appraisals forms part of Quality Assurance Framework arrangements and monitoring processes used by the Responsible Officer. It mainly focuses on what is happening, with what outcome, along with an assessment of the Trust's capacity to ensure a robust consistent system of Revalidation. The AOA was submitted to the higher level responsible officer at the regional NHS England Revalidation Team in May 2017.
- 3.2 The Trust has a responsible officer, Dr David Rosser, who has been the interim Executive Medical Director and Deputy Chief Executive with responsibility for clinical quality at the Trust since November 2015.

- 3.3 The Associate Medical Director, Revalidation has RO delegated responsibilities for managing the appraisal and revalidation processes in the Trust and submitting recommendation decisions on behalf of the RO to the GMC. Operationally the manager for appraisals and revalidation is responsible for the day to day management and support of all processes and systems supporting medical appraisals and revalidation within the Trust. This post has been vacant since October 2016 and this vacancy poses a risk to the effective implementation of medical appraisal and revalidation systems. A number of the duties of this post have been taken on by the personal assistant to the Deputy Medical Director and Associate Medical Director, Revalidation.
- 3.4 Progress of medical appraisals and revalidation is managed by the revalidation team on a monthly basis from both the online system for appraisals and the GMC site for doctors' prescribed connections to the Trust. An accurate list of prescribed connections is maintained by running monthly reports from the HR systems for leavers and starters and cross referencing them against the GMC connection list.
- 3.5 Monthly medical appraisals status reports are sent to the HR team to update ESR records with appraisal data and circulated to individual Clinical Directors and Divisional Directors.
- 3.6 The medical appraisals and revalidation policy has been operational since April 2013. It has been ratified twice to reflect minor operational changes to the processes of managing non-engagement cases. The policy is now overdue for renewal and an update to the policy is being developed.
- 3.7 This Board report is intended to provide assurance that the governance arrangements currently in place fully support medical appraisals and revalidation.

## 4. MEDICAL APPRAISAL AND REVALIDATION

### 4.1. Appraisal and Revalidation Performance Data

- a. The medical appraisal season runs at the Trust from 01<sup>st</sup> April till 30<sup>th</sup> September. All medical staff are required to complete their appraisal during this time. Unless otherwise agreed with line managers, the Trust policy requires all doctors to undergo an appraisal annually. This is also a GMC requirement and supports successful revalidation.
- b. The 2016 medical appraisal season finished on 30<sup>th</sup> September and the table below provides a highlight of the current status on 31<sup>st</sup> March 2017.

Type of doctor	Number of doctors	Completed Appraisals	Appraisal rate	Approved missed appraisal	Unapproved missed appraisal	Number of remediation or disciplinary processes
Consultants	480	470	97.9%	10	0	0
SAS Doctors	209	179	85.6%	30	0	0
Trust Locum <sup>1</sup>	9	9	100%	0	0	0
Responsible Officer	1	1	100%	0	0	0
Other doctors	2	2	100%	0	0	0
<b>Total</b>	<b>701</b>	<b>661</b>	<b>94.3%</b>	<b>40</b>	<b>0</b>	<b>0</b>

### 4.2. Exceptions – reasons for non-appraisal

- a. All exceptions requests are approved by line managers and submitted to the revalidation team for filing. Appendix A provides a summary of all exceptions.

<sup>1</sup> This includes Trust appointed locums but not doctors who are not employed by the Trust but work only on the Trust's locum bank and are therefore connected to the Trust as their designated body.

- b. All deferral requests are considered and approved by the Associate Medical Director, Revalidation.
- c. New starters who had a valid appraisal with their previous designated body or overseas doctors who did not require an appraisal during 2016. Compared to previous years there was a large increase in the number of overseas doctors joining the Trust during the year with no previous NHS experience and therefore no appraisal history.
- d. No doctors were subject to the trust's formal remediation, re-skilling and rehabilitation policies during the year.

#### 4.3 Appraisers

- a. The revalidation team currently maintains a register of 133 appraisers within the Trust who have been trained to national specifications and are able to undertake strengthened medical appraisals for revalidation. This provides a better than the recommended ratio of 1 appraiser to 6 doctors. The number of trained appraisers in the Trust remains a dynamic figure and plans will be put in place to train more appraisers.
- b. To further strengthen the appraisers' performance and in order for them to retain their appraiser role, appraisers are required to attend an update training session at least once every two years. 20 trained appraisers have attended this year's set of update training sessions arranged before the start of the 2017 appraisal season.
- c. Training needs for these update sessions were identified as a direct result of the annual quality assurance audit as well as appraisers' feedback reports. Findings of the audited one hundred appraisal folders suggested that the quality of appraisals has improved significantly.
- d. Appraisers' performance is closely monitored throughout the appraisal season and in particular during the Annual Quality Assurance Audit.
- e. Individual feedback is provided to all appraisers for all appraisals they undertook during the appraisal season. The revalidation team reviews the feedback before it is released to appraisers and they are strongly advised to reflect on the feedback reports and discuss it at their own appraisals.

#### 4.4 Quality Assurance Activity

Quality assurance mechanisms are embedded throughout the systems and processes that have been established to support medical appraisals and revalidation. Nationally approved, processes and tools have been adopted wherever appropriate.

The trust's framework for ensuring medical appraisals quality is based around certain key areas (please see further attached supplement reports for details)

- a. **Monitoring activity levels of appraisals and revalidation:** This involves proactively managing appraisals rates and revalidation recommendation decisions by running monthly status reports and actively managing outliers. These reports are shared with the Responsible Officer and the Clinical Directors. They are also circulated to the Human Resources team.

Both the attached Appendix A and C provide an overview of the current status for appraisals and revalidation recommendation decisions over the 12 months period.

- b. **Appraisers' individual performance review:** This involved carrying out an audit review of 100 randomly selected completed appraisal folders and checking the quality of input and output documentation. The audit tool was developed by the revalidation team and based on the Appraisal Summary and PDP Audit Tool (ASPAT) attached below.

This audit for 2016 was undertaken by the revalidation team at UHB and involved reviewing and scoring all sample folders as per the below:

- Review of the appraisal folders to provide assurance that the appraisal inputs - the pre-appraisal declarations and supporting information provided is available, appropriate and up to the recommended standards
- Review of the appraisal folders to provide assurance that the appraisal outputs - PDP, appraisal summary and sign offs declarations are complete and to an appropriate standard
- Review of the appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs
- Provide a benchmarking score against the Trust's overall average audit score
- Provide constructive feedback for individual domains scored

The audit resulted in an overall score of 90.76% with identified areas of very good practice and areas for organisational improvement. The results of this audit were feedback to the appraisers and appraisees whose work were reviewed. Overall appraiser performance was very good with 1 appraiser performing at a level that was less than 2 standard deviations from the mean. This was noted and managed as a random incident as the same appraiser performed well within peer range in another portfolio review of work undertaken by the same appraiser.

- c. Organisation process review:** This involved a process of receiving feedback from all doctors on aspects of the appraisal process and the appraisers' performance. This feedback review revealed that most doctors were satisfied with the organisational processes supporting appraisal, the skills of the appraisers and the quality of the appraisal discussion. Most appraisal meetings lasted not more than 2 hours. This feedback process was voluntary and was undertaken retrospectively separate from the appraisal meeting.
- d. Appraiser Update Training:** All appraisers in the trust are required to attend biannual update training in order to maintain their roles as appraisers. The content of the update training is informed partly by the outcomes of the appraisers' individual performance review and the organisational process review as described above, as well as new regulations, thinking and innovative practices nationally. Appraisers attending the update training are requested to provide feedback on the training. This feedback is further utilised to improve the quality and content of future years' training.
- e. Organisation Controls:** This includes a number of activities to ensure that systems are streamlined and fully supportive of medical appraisals processes. The revalidation team also continuously reviews lessons learnt from any complaints and significant events.
- f. Access, security and confidentiality:** The revalidation team take confidentiality and security of access to doctors' appraisal folders very seriously. The appraisal folders are accessed by the Responsible Officer and the Associate Medical Director, Revalidation to perform their duties under the Medical Profession (Responsible Officers) Regulations 2010 and to submit recommendations decisions to the GMC. The folders are also accessed by the medical appraisals, revalidation manager and PA to the Responsible Officer as part of his operational duties. Although we received concerns over access to doctors' appraisal folders as part of the quality assurance audit, there have been no reports of information management breaches or confidentiality issues. Doctors and appraisers alike are continuously reminded that patient identifiable data should be removed from the doctors' portfolios.
- g. Clinical Governance:** As part of their supporting information, doctors are required to provide clinical governance data and supporting information. Work to develop a centralised dashboard that would capture all the required governance data for doctors to present as part of their appraisal has been halted by recent organisational restructures and should restart very shortly.

#### 4.5 Revalidation Recommendations

The Executive Medical Director/Responsible Officer, with support from the Associate Medical Director, Revalidation, is responsible for submitting revalidation recommendations to the GMC. During the 2016/17 year 50 revalidation recommendations were made, as follows:-

- Recommendations to revalidate – 46
- Deferral of revalidation – 3
- Formal notification of non-engagement – 1<sup>2</sup>
- Missed or late submissions of recommendation – 2

The trust thus had a deferral rate of 6% for the 2016/17 year. The Trust has completed 673 recommendations since the start of revalidation in December 2012 with a deferral rate of 13.8% and a non-engagement rate of 1.04%

Nationally a total number of 218,375 recommendations about a doctor's revalidation were approved by the General Medical Council. Of these 175,428 (80.33%) were to revalidate the doctor, 42,386 (19.4%) were to defer the doctor's submission date and 561 (0.26%) were recommendations of non-engagement with revalidation.

The Trust has now completed the first cycle of revalidation recommendations and it is expected that the second cycle of revalidation recommendations will commence in March 2018 when the number of recommendations being made is expected to increase.

### 5 RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

A vetting process has been introduced into the pre-employment checks the medical workforce team have to carry out requiring new doctors to provide evidence of their previous appraisals and details of their previous designated body as well as their previous Responsible Officer. This process although fully embedded, good practice is yet to be audited in due course.

On-going strengthening of the process of contracting doctors on short-term or temporary contracts is equally crucial and remains of significant concern to the Trust. There is currently a lack of coherence and adherence to trust policy on the issuing of short term, temporary contracts or honorary contracts. Apart from the potential recruitment and employment issues that this raises, it also means that this group of doctors can be missed off the appraisal and revalidation systems. All agency locums are vetted through their agency processes and we are provided with assurance that they have undertaken all the necessary pre-employment checks.

A working framework has not been agreed and implemented by the medical workforce team to annually audit the appraisal and revalidation information of all locum doctors who work on the Trust locum bank. This will include information relating to their current designated bodies, Responsible Officers and proof of completion of appraisals.

### 6 RESPONDING TO CONCERNS AND REMEDIATION

The trust has good systems of responding to concerns. Concerns are managed along the processes outlined in the Maintaining High Professional Standards policy. The high level weekly Clinical and Professional Review of Incidents (CaPRI) decision making group is now established and supports the Executive Medical Director and Director of Workforce in the management of concerns with doctors. The current and developing caseload of the management of conduct, competence or health issues in doctors has however revealed that there is a need for the further development of a larger faculty of case investigators and case managers to support this process.

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<sup>2</sup> This doctor subsequently completed an appraisal during the year.

## 7 RISK AND ISSUES

There are ongoing risks to the development of appraisal and revalidation processes and the achievement of the aspiration that this development will drive the objective of the delivery of constant improvement in the quality of clinical care provided to patients. These risks include

- Failure to appoint to the vacant operations manager role for medical appraisal and revalidation
- A need to make a decision on an IT framework to support medical appraisal and revalidation going forward and especially after the merger by acquisition with the UHB
- Inability of the organisation to provide accurate and timely clinical outcomes information for individual doctors or teams – IT dependency for implementation.
- Need to integrate various items of clinical governance into the appraisal process e.g. incident reporting and management, complaints and outcomes
- Dependence on external providers for the IT framework to support appraisal and revalidation and failure of these to link in seamlessly to the trust's information systems. This may be overcome as the Trust will go through the procurement process of a new IT framework this autumn.

## 8 CORRECTIVE ACTIONS, IMPROVEMENT PLAN AND NEXT STEPS

As part of the Trust's phased approach to the implementation of medical appraisals and revalidation, the revalidation team will be introducing further quality assurance processes and measures in the coming appraisal season. Future developments will include not only an increase in the number of folders and portfolios that will be audited as part of the quality assurance activities but also more focus will be placed on the quality of the output documents. Especially personal development objectives alignment with strategic corporate objectives. A new tool, which has been validated by the deanery, will be utilised in the audit of the quality of appraisal folders.

Collaborative working with the Human Resources department through improved monitoring and implementation of the process of the Trust engaging with doctors and involving the Medical Director's office early where concerns are identified.

## 9 RECOMMENDATIONS

The Board is asked to note the further development of systems supporting medical appraisal and revalidation, the outcome of the first round of appraisals carried out in accordance with the Trust Medical Appraisals and Revalidation Policy and the further development activity planned for 2017/2018

The Board is asked to accept the report and to consider any needs and resources.

**The Board is asked to approve the statement of compliance which confirms that the Trust as a designated body is in compliance with its statutory duties under the RO regulations.**

It should be further noted that this report along with annual audit will be shared with the higher level RO.

## Annual Report Template Appendix A

### Audit of all missed or incomplete appraisals audit

<b>Doctor factors (total)</b>	Number
Maternity leave during the majority of the 'appraisal due window'	3
Sickness absence during the majority of the 'appraisal due window'	7
Prolonged leave during the majority of the 'appraisal due window'	1
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	47
New starter more than 3 months from appraisal due date	128
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	2
Doctor on career break	1
Doctor undergoing local HR processes	3
<b>Appraiser factors</b>	0
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
<b>Organisational factors</b>	0
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

## Annual Report Appendix B

### Quality assurance audit of appraisal inputs and outputs

Title	HEFT Annual Appraisal Audit
Report by	Gaynor Watters, Revalidation Support Manager
Contact	Mark Garrick, Director of Medical Directors' Services James Bentley, Management Assistant - Medical Directorate Amy Fowlie, Project Assistant
Date	9 <sup>th</sup> December 2016

#### 1. INTRODUCTION

The HEFT Annual Appraisal Audit consisted of the audit of a 100 randomly selected appraisals completed in 2016. The details of each appraisal was assessed by using the NHS England Appraisal summary and PDP audit tool (ASPAT).

#### 2. ASPAT

The ASPAT tools cover 4 areas within the appraisal;

- Setting the scene and overview of supporting information (9 sub-sections)
- Reflection and effective learning (3 sub- sections)
- The PDP and developmental progress (8 sub-sections)
- General standards and revalidation readiness (5 sub-sections)

Each area is scored with a maximum of 2 points per sub-section and overall possible score of 50 points per appraisal.

#### 3. OVERVIEW

##### 3.1 Setting the scene and overview of supporting information

The electronic system used (Revalidation Management System supplied by Equiniti 360 Clinical) is pivotal in forcing the user to enter the information required, as per the ASPAT tool. The sub-section referring to reference of mandatory training did score lower, as the information was either not available or not commented on. Overall however, this section scored well at 96.67%

##### 3.2 Reflection and effective learning

This section scored well. Again, the user is forced to enter their reflection and there is a whole document dedicated to it, Section score 98.16%.

### **3.3 The PDP and developmental progress**

This section scored slightly lower, mainly due to the standard of the objectives. The recommendation is that there are between 3 and 6 objectives and this sometimes fell short. There were also issues with some of the objective not being measureable or relevant. Section score 90%

### **3.4 General Standard and revalidation readiness**

This was the lowest scoring section of the audit. In some appraisals information had been copied and pasted into the appraisal making some of the information unreadable. The stage of revalidation was rarely commented on in any of the appraisals and 10% of appraisals in the audit contained patient identifiable information.

Section score 76.90%.

## **4. SUMMARY**

The majority of the appraisals were to a high standard and the system used assisted in ensuring that the Appraiser provided all the required information. However, the format of the appraisal made it difficult for the auditor to assess the number of CPD hours achieved as this was not calculated and the end appraisal is provided in multiple documents rather than a whole appraisal document.

There were some concerns around the appraiser not being aware of the individual's revalidation cycle and this not being mentioned during the appraisal. There was also an issue of patient identifiable information being uploaded as evidence for feedback and incidents. The user had ignored the clear warning on the system and this had not been picked up by the appraiser. This was particularly concerning as this is an online system.

Overall score of audit 90.76%.

## Annual Report Appendix C

### Locum/Bank doctors revalidation report 2016

#### April 2015 – March 2016

In order for us to ensure that all Drs commencing Locum shifts at HEFT have the correct revalidation history, it was agreed that we would conduct the following;

- Email all Drs currently registered with bank requesting their revalidation history along with the output file, Drs would have a deadline to send this to Medical Workforce if we had not received this by the 31<sup>st</sup> August, these Drs would be made non-compliant – Letter attached

On the 1<sup>st</sup> June / 1<sup>st</sup> July and the 1<sup>st</sup> August an email went to 718 Drs requesting the above information. We received responses steadily during this time including requests from Drs to be removed from Locum bank as they are currently not in the West Midlands.

On the 1<sup>st</sup> September we made 103 Drs non-compliant on the system either because they had requested to be removed from TempRe or because they had not supplied the information requested. Whilst 103 Drs have been made inactive, 95 of those had only worked between 1 -12 shifts within a 12 month period.

In total we have 602 active Drs registered with TempRe. 219 of those are employed by HEFT in substantive posts, 372 are training Drs and are therefore have their appraisals completed by the deanery the remaining 11 have submitted their output documents.

#### April 2016 - Present

102 Drs registered with Locum Bank from April 2016, when Drs join locum bank they receive the form attached, without completing this and sending the requested information, they are unable to join Locum bank. 37 of these are connected to HEFT as they are working on a FTC or substantive, 64 of these Drs are training Drs and therefore have their appraisals completed but the deanery the remaining 1 has submitted their output file.

Number of Training Drs Registered	436
Number of Drs registered on FTC or substantive with HEFT	256
Number of non-training or connected Drs registered	12
Number of input files received	12
Number of Drs working without revalidation history	0
<b>Total number of compliant Drs registered</b>	<b>704</b>

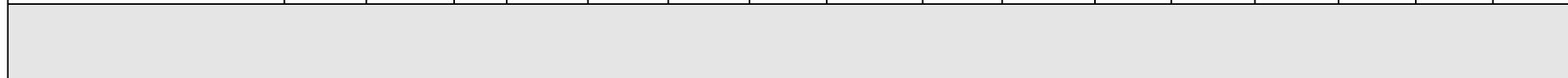
We will conduct this process annually to ensure that everyone submits their up to date information. This will be conducted on the 1<sup>st</sup> June and a final report will be sent in September providing a full update.

**Annual Audit Appendix D:**

**Audit of recruitment and engagement background checks**

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)																
Permanent employed doctors															41	
Temporary employed doctors															61	
Locums brought in to the designated body through a locum agency															530	
Locums brought in to the designated body through 'Staff Bank' arrangements															205	
Doctors on Performers Lists																
Other																
Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc																
TOTAL															AWAITING	
For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)																
	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	41	41	0	0	0	41	41	41	41	41		41	41	41		0
Temporary employed doctors	61	61	0	0	0	61	61	61	61	61		61	61	61		0

Locums brought in to the designated body through a locum agency	530	530	0	2	0	530	530	530	530	530		530	530	530		0
Locums brought in to the designated body through 'Staff Bank' arrangements	205	205				205	205	205	205	205		205	205	205		
Doctors on Performers Lists	NIL															
Other (independent contractors, practising privileges, members, registrants, etc)	N/A	M/A	N/A	N/A												
Total	***															



For Providers of healthcare i.e. hospital trusts – use of locum doctors:  
 Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)  
 The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery	256.89	2046		32379	5325
Medicine	368.39	2635		4683	7318
Psychiatry					
Obstetrics/Gynaecology	79.24	122		576	698

Accident and Emergency	69.58	530		3971	4501
Anaesthetics	124.27	1		1037	1038
Radiology	39.30	1534		43	1577
Pathology	23.90	0			0
Other	157.92	701		497	1198
Total in designated body (This includes all doctors not just those with a prescribed connection)					
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less					
3 days to one week					
1 week to 1 month					
1-3 months					
3-6 months					
6-12 months					
More than 12 months					
Total					

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## STATEMENT OF COMPLIANCE

### Designated Body Statement of Compliance

The board of Heart of England NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

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

Comments:

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

Comments:

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

Comments:

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

Comments:

5. All licensed medical practitioners<sup>3</sup> either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken; **Yes**

Comments:

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

Comments:

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<sup>3</sup> Doctors with a prescribed connection to the designated body on the date of reporting.

7. There is a process established for responding to concerns about any licensed medical practitioners<sup>1</sup> fitness to practise; **Yes**

Comments:

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

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners<sup>4</sup> have qualifications and experience appropriate to the work performed; **Yes** and

Comments:

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

Comments:

Signed on behalf of the designated body

Name: Dame Julie Moore  
Chief Executive

Signed: \_\_\_\_\_

Date: 23 October 2017

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<sup>4</sup> Doctors with a prescribed connection to the designated body on the date of reporting.

**HEART OF ENGLAND NHS FOUNDATION TRUST  
BOARD OF DIRECTORS  
MONDAY 23<sup>RD</sup> OCTOBER 2017**

<b>Title:</b>	<b>Care Quality Board Report</b>	
<b>Responsible Director:</b>	Kevin Bolger, Interim Deputy Chief Executive Improvement	
<b>Contact:</b>	Julie Tunney, Interim Chief Nurse (ext. 4-1323)	
<b>Purpose:</b>	The purpose of this report is to provide an exception report of performance against the key performance indicators in the Single Oversight Framework, in addition to contractual and internal targets delivered in August and September 2017.	
<b>Annual Plan Ref:</b>		
Links to Trust Clinical Strategy	Yes	
Links to Capacity/Demand and Annual Plan	Yes	
Links to Quality/Safety	Yes	
Other - Please Specify		
<b>Key Issues Summary:</b>	<p>Exception reports have been provided where there are current or future risks to performance against targets and indicators included in the Single Oversight Framework, national and contractual indicators and internal targets.</p> <p><b>Infection Control</b> - Seven cases of post 48 hour Clostridium difficile have been reported in September 2017. This is above the Trust monthly trajectory of five. The total number of cases this year is 31 against a year to date trajectory of 30 cases and an annual trajectory of 64 cases.</p> <p>Four cases of CPE were identified in September 2017. Two were identified from screening samples and two further cases were identified from clinical samples.</p> <p>There were no incidents or outbreaks of infection reported.</p> <p><b>Tissue Viability</b> - The number of avoidable grade 2 pressure ulcers reported in August 2017 was seven. There were no avoidable grade 3 hospital acquired pressure ulcers reported in August 2017.</p> <p><b>Dementia Screening</b> - Performance for September 2017 is at 83.39% and has not met the 90% Trust Target.</p>	

	<p><b>Parkinson's Medication</b> - Compliance in September 2017 has improved to 82.03% but has not met the 90% Trust target.</p> <p><b>Admissions, Discharges and transfers (ADT)</b> - Compliance against this standard has fallen slightly in month to 87.87% for September 2017, compared to 88.45% in August 2017. Performance remains non-compliant against the Trust target of 95%.</p> <p><b>Nurse Staffing</b> - There are no areas of concern for September 2017. Hot spot areas are ITU at Heartlands, ITU at Good Hope, Neonatal Unit (NNU) and Hyper Acute Stroke Unit (HASU). Assurance is given by Head Nurses that staffing is maintained at safe levels for acuity of patients in line with national guidelines.</p> <p><b>Complaints</b> - The response rate for August 2017 is currently at 48.1%. This performance figure is not validated and is expected improve on validation. However, the 85% target will not be achieved.</p> <p><b>Friends and Family Test (FFT)</b> - During September 2017, the percentage of positive responders has remained static in month at 94% for inpatients. For the Emergency Departments, the positive responder score was 79% and has decreased from last month (82% in August).</p> <p>Response rates have decreased for September to 33% compared to 37% in August for inpatients. Response rate has dipped for EDs at 12%.</p>
<p><b>Recommendations:</b></p>	<p>The Group is asked to consider the information set out in this report.</p>
<p><b>Signed:</b> Kevin Bolger</p>	<p><b>Date:</b> 16<sup>th</sup> October 2017</p>

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**MONDAY 23<sup>RD</sup> OCTOBER 2017**

**1. Purpose**

This paper summarises the Trust's performance against national indicators and targets, including those in the new Single Oversight Framework which commenced on 1<sup>st</sup> October 2016 as well as local priorities.

**2. Single Oversight Framework**

NHS Improvement (NHSI) has introduced a new Single Oversight Framework (SOF) for both NHS Trusts and Foundation Trusts which replaced Monitor's Risk Assessment Framework (RAF) for Foundation Trusts on 1<sup>st</sup> October 2016.

There are five themes within the framework as follows:-

- **Quality of Care:** The CQCs rating for the Safe, Caring, Effective and Responsive domains, delivery of the four priority 7-day standards and in-year information.
- **Finance and use of Resources:** Financial efficiency and progress in meeting the financial control total.
- **Operational Performance:** Progress with improving and sustaining performance against NHS Constitution and other standards.
- **Strategic Change:** How well providers are delivering the strategic changes set out in the Five Year Forward View.
- **Leadership and Improvement Capability:** A shares system view with CQC on what good governance and leadership looks like, including organisations' ability to learn and improve, building on the joint CQC and NHSI well-led framework.

NHSI will use the information they collect on provider performance to identify where providers need support across these five themes. NHSI have identified an initial set of measures and triggers which will assist them to determine the level of support required and this report will focus on one of the five themes that is Quality of Care.

Specifically NHSI will use the quality indicators outlined in table 1 to supplement CQC information in order to identify where providers may need support under the theme of quality:

**Table 1 : Quality Performance Metrics**

Measure	Frequency	Target
Mixed sex accommodation breaches	Monthly	0
Inpatient scores from Friends & Family Test - % positive	Monthly	≥95%
A&E scores from Friends and Family Test - % positive	Monthly	≥95%
Emergency C-Section Rate	Monthly	
Maternity scores from Friends & Family Test - % positive	Monthly	≥95%
VTE Risk Assessment	Quarterly	≥95%
Clostridium difficile - variance from plan	Monthly	≤5
Clostridium difficile - infection rate	Monthly	
MRSA bacteraemia	Monthly	0

**Quality of Care****3. Infection Control****3.1 MRSA Bacteraemia**

There have been no post 48 hour MRSA bacteraemia reported in September 2017.

The total number of MRSA bacteraemia attributed to the Trust year to date is one.

**3.2 Clostridium Difficile**

Seven cases of post 48 hour Clostridium difficile have been reported. This is over the Trust monthly trajectory of five. The total number of cases this year is 31 against a year to date trajectory of 30 cases and an annual trajectory of 64 cases.

Two of the seven cases have been reviewed by the Infection Prevention Control (IPC) Team with microbiology and IPC colleagues from the Clinical Commissioning Group.

One case has been deemed to be avoidable (Good Hope ward 8) due to inappropriate antibiotic prescribing, and the second case is unavoidable (Heartlands ward 12). Of the remaining five cases, three will be reviewed once ribotyping results are available and two are awaiting antibiotic reviews to be completed.

**3.3 MRSA Screening**

Compliance with MRSA screening achieved the target of 90% for the month of September 2017 with emergency screening achieving 91% compliance and elective screening achieving 90% compliance.

### **3.4 Carbapenemase Producing Enterobacteriaceae (CPE)**

Four cases of CPE were identified in September 2017. Two were screening samples: one from a patient presenting at Heartlands antenatal clinic who had undergone healthcare abroad, and one from the Castle Vale Renal Dialysis Unit patient who was screened at the request of his holiday dialysis unit. Two further cases were identified from clinical samples: one from a urine specimen (Heartlands ward 21) and the second from a sample of peritoneal fluid (Heartlands ward 12).

### **3.5 Outbreaks and Incidents**

There were no outbreaks of infection reported in September 2017.

## **4. Tissue Viability**

### **4.1 Avoidable Grade 2 Pressure Ulcers**

The number of avoidable grade 2 pressure ulcers reported in August 2017 was seven.

The Trust has reported a total of 44 avoidable grade 2 pressure ulcers year to date against a trajectory of no more than 102 for the year.

### **4.2 Avoidable Grade 3 Pressure Ulcers**

There were no avoidable grade 3 hospital acquired pressure ulcers reported in August 2017.

A total of 4 avoidable grade 3 pressure ulcers have been reported year to date against an annual trajectory of 36. This means that the Trust is currently on target to achieve the required 10% reduction in Grade 3 pressure ulcers.

### **4.3 Care Quality Metrics - Tissue Viability Assessment**

Tissue viability metrics were compliant at 97% in August 2017 with the metric for 'repositioning frequency adhered' to also compliant at 92%.

## **5. Dementia Screening**

It is an expectation of the Trust that all patients over the age of 75 are screened for dementia. The Trust target for this indicator is 90% and performance for September 2017 has reduced and is non-compliant at 83.39%.

Performance by division is as follows:-

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Division 1	66.67%	100.00%	90.91%	100.00%	100.00%	100.00%	100.00%
Division 2	N/A	50.00%	N/A	100.00%	50.00%	100.00%	N/A
Division 3	88.90%	89.97%	87.45%	89.37%	88.25%	83.93%	83.37%
Division 4	93.67%	88.79%	92.92%	94.12%	93.22%	90.53%	87.50%
Division 5	79.64%	86.73%	82.38%	82.98%	85.09%	85.71%	81.62%
<b>TRUST</b>	<b>87.93%</b>	<b>89.31%</b>	<b>87.11%</b>	<b>88.76%</b>	<b>88.11%</b>	<b>84.72%</b>	<b>83.39%</b>

Due to the overall non-compliance against this KPI, divisions have been tasked with holding individuals to account for completion of the screening tool with an expectation to demonstrate how they have improved compliance. In addition to this, division 3 and division 5 have commenced the following specific actions:

During September 2017, a campaign was carried out in **Division 3** to reiterate the importance of dementia screening involving all Clinical Directors and clinical leads. Junior Doctor's performance in dementia screening is also being reviewed as part of their appraisal portfolio assessments.

In **Division 5** nursing staff are reminding Doctors to complete the dementia risk assessment fields. Persistent non-compliance by individuals will result in those individuals being reported to the Head of the School of Medicine (HEWM), and will also require a meeting with the Divisional Director and Head of Operations which may result in formal performance management.

Divisional performance is monitored through Trust wide Divisional Reviews where there will be an expectation to see improvement during the coming months.

## 6. Parkinson's Medication

It is an expectation that 90% of all Parkinson's medication is administered within 30 minutes and compliance against this in September 2017 has improved to 82.03% (80.10% in August 2017).

The overall percentage figure has, to date, included a cohort of patients that require Parkinson's medication for clinical reasons other than Parkinson's disease. To ensure that the compliance figure is accurate, work has been undertaken to cleanse the data and remove any prescribed as required (PRN) doses. This has been fed back to divisions and the expectation is that they will focus on local actions to improve performance. Where individual performance is identified as a contributory factor, performance improvement notices have been issued and will be monitored by the Head Nurse(s).

## 7. Admissions, Discharges and Transfers (ADT)

Compliance against this standard has fallen slightly in month to 87.87% for September 2017, compared to 88.45% in August 2017. Performance remains non-compliant against the Trust target of 95%.

Performance by Division as of September 2017 is as follows:-

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Division 1	79.79%	80.14%	82.33%	80.11%	79.50%	78.93%
Division 2	92.37%	92.80%	92.78%	91.30%	92.05%	91.66%
Division 3	89.74%	89.75%	89.74%	88.99%	89.00%	86.91%
Division 4	82.46%	82.91%	83.53%	82.76%	82.16%	86.19%
Division 5	85.56%	89.17%	89.98%	90.61%	90.47%	89.88%
<b>TRUST</b>	<b>87.37%</b>	<b>88.58%</b>	<b>83.65%</b>	<b>88.32%</b>	<b>88.45%</b>	<b>87.87%</b>

Although compliance against the ADT standard is non-compliant, performance has improved overall when compared to the same period last year as shown in the table below:-

	2016	2017
August	84.83%	88.45%
September	83.82%	87.87%

Actions to continue to improve performance include:

- Divisional rectification plans across all divisions commenced in September 2017. Trajectories have been set within divisions for all wards with an increased uptake in training.
- Cascade training is planned for throughout October and November 2017. All Supervisory Ward Sisters will undertake training and become cascade trainers. Performance for this indicator will form part of the Supervisory Ward Sisters one-to-one meetings and is also being monitored at the monthly divisional confirm and challenge meetings.

## 8. Nurse Staffing

### 8.1 Compliance with UNIFY

There are no areas of concern for September 2017.

The following table outlines compliance with UNIFY for September 2017:-

Divisional Area	Qualified compliance	HCA compliance
Division 1 wards	97%	112%
Division 1 critical care	86%	93%
Division 2 Paediatrics	92%	127%
Division 2 O&G	91%	93%
Division 3	94%	110%
Division 4	99%	117%
Division 5	95%	108%
<b>Trust Overall</b>	<b>95%</b>	<b>110%</b>

Hot spot areas are ITU at Heartlands, ITU at Good Hope, Neonatal Unit (NNU) and Hyper Acute Stroke Unit (HASU). Assurance is given by Head Nurses that staffing is maintained at safe levels for acuity of patients in line with national guidelines.

Ward 9 Heartlands continues to have a number of qualified vacancies and reduced bank fill over September 2017. The ratio of Health Care Assistants (HCAs) was increased to mitigate risk.

## 8.2 Vacancy Position

There were 419 WTE qualified nursing / midwifery vacancies in August 2017, an increase of 68 in month. The increase in vacancies this month is largely because the funded establishments have now been realigned to include the 25% headroom.

There are 128 planned nursing / midwifery starters across November 2017 to January 2018. There is a Trust-wide recruitment event planned for December 2017.

## 9. Friends and Family Test (FFT)

During September 2017, the percentage of positive responders has remained static in month to 94% for inpatients. For the Emergency Departments, the positive responder score was 79% and has decreased from last month (82% in August).

Response rates have decreased for September to 33% compared to 37% in August for inpatients. Response rate has dipped for EDs at 12%.

Patient comments received via FFT are shared with Divisions and the themes evident for improvement are analysed and presented in a quarterly patient experience report.

## 10. Complaints

Performance against the Trust response rate within 30 days is not improving at the required pace and in line with the trajectory. The response rate for August 2017 is currently at 48.1%. This performance figure is not validated and is expected improve on validation. However the 85% target will not be achieved.

The un-validated August 2017 Divisional performance is currently as follows:

	Complaints Response Rate
Division 1	60.0%
Division 2	26.7%
Division 3	45.2%
Division 4	38.9%
Division 5	61.3%

The total number of complaints received during August was 106 and the total number closed was 86.

The total number of complaints received during September 2017 was 82 and the total number closed was 98.

The live complaints caseload is currently at a total of 205.

A whole systems review of complaints was undertaken in September 2017. This review focused on the complaints processes at Heart of England NHS Foundation Trust, aligning process against the current methodology used at University Hospitals Birmingham.

Key issues that have been identified within the process at HEFT are as follows:

- Consent - New complaints will be registered and investigation commenced as is normal practice, however the 30 working day period will not start until consent from the patient or appropriate person is received.
- Meetings - Heart of England NHS Foundation Trust current process is to attempt to meet with complainants within 30 working days of receipt of complaint. At times, however, there are circumstances in which a meeting cannot be arranged during this time. The new process will count such complaints as achieving the 30 day response time if a meeting is offered by the Trust within the 30 working days.

The above actions will take place with immediate effect with the expectation that performance will improve from September 2017 with closed cases. In practice, however, Divisions will be responsible for ensuring momentum with responding to such complaints in line with Trust policy.

The changes to the policy and practice are anticipated to show an immediate improvement in performance against the 30 working day response time.

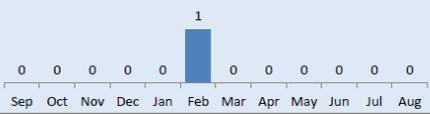
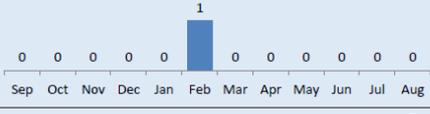
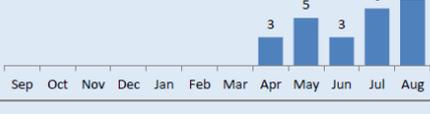
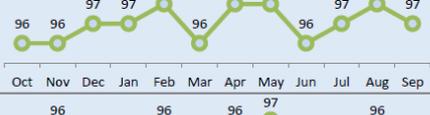
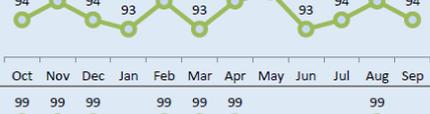
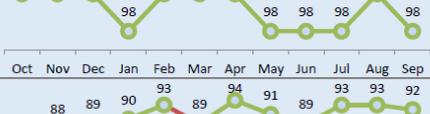
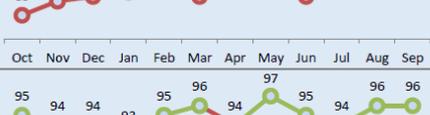
# Appendix Care Quality Dashboard - September 2017

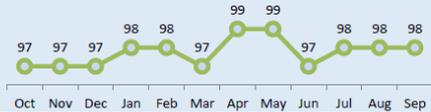
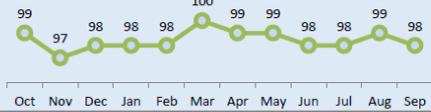
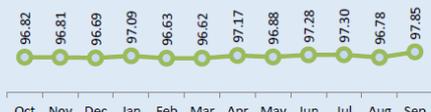
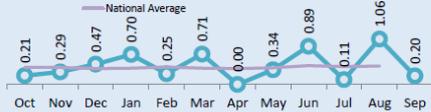
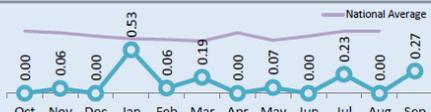
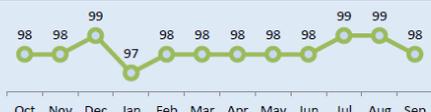
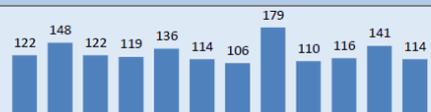
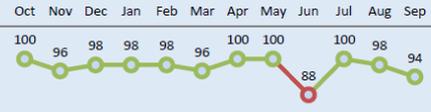
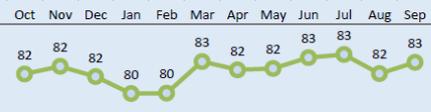
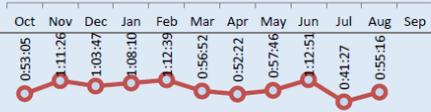
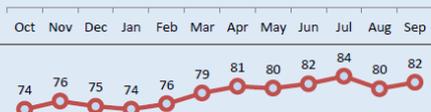
## Nursing & Midwifery Ward to Board Assurance Report



### TRUST LEVEL OVERVIEW

Ref	Indicator Name	Target	Performance	Wards / Areas Not Achieving Target
<b>Harm Free Care</b>				
1	Harm Free Care % of patients receiving harm free care recorded via NHS Safety Thermometer	≥95%		<b>In Month Position Sep-17</b> <b>94%</b> 17 SH (67%), 21 GHH (73%), 30 BHH (78%), 22 HDU / ITU GHH (80%), HDU BHH (83%), 27 BHH (86%), AMU SS GHH (86%), 21 BHH (88%), 7 GHH (89%), ITU BHH (90%), 20A SH (90%), 28 BHH (91%), 23 HASU BHH (93%), 24 BHH (93%), 10 GHH (93%), 14 GHH (93%), 17 GHH (93%)
2	Incidents Reported Number of incidents reported			<b>In Month Position Sep-17</b> <b>2551</b> Top categories in month: Tissue viability (724), Security (302), Admission transfer and discharge (266), Patient fall (246), Medication (141), Ongoing care monitoring and review (122), Maternity (122), Safeguarding (114), Lab investigations (71), Treatment or procedure (70)
<b>Infection Control</b>				
3	Clostridium Difficile Number of avoidable cases	≤5		<b>In Month Position Sep-17</b> <b>7</b> 8 GHH (2), 3 BHH (1), 12 BHH (1), 19 BHH (1), AMU SS GHH (1), 19 SH (1)
4	MRSA Number of cases	0		<b>In Month Position Sep-17</b> <b>0</b>
5	MRSA Screening (Emergency) % of patients screened	≥90%		<b>In Month Position Sep-17</b> <b>91.59%</b> 23 ASU BHH (0%), 12 GHH (46%), 7 GHH (50%), 20A SH (50%), 2 BHH (53%), 22 AMU 2 BHH (56%), 18 BHH (60%), 24 GHH (73%), 9 GHH (75%), 19 BHH (77%), 17 GHH (80%), 30 BHH (83%), 11 GHH (86%), 8 BHH (86%), 14 GHH (87%), 6 CCU BHH (88%), 16 GHH (88%)
6	Hand Hygiene Compliance % compliance with hand hygiene	≥85%		<b>In Month Position Sep-17</b> <b>98%</b> Endoscopy SH (60%), AMU GHH (71%)
7	Care Quality Metrics: Environment Score % compliance with environment indicators	≥90%		<b>In Month Position Sep-17</b> <b>97%</b> 5 BHH (75%), AMU SH (75%), 17 SH (80%), AMU SS SH (80%), 23 HASU BHH (86%), 21 GHH (86%)
<b>Tissue Viability</b>				
8	Pressure Ulcer Prevalence % of patients with a pressure ulcer (old and new) reported via NHS Safety Thermometer			<b>In Month Position Sep-17</b> <b>3.49%</b> Number of pressure ulcers: 30 BHH (5), 21 BHH (3), AMU SS GHH (3), 27 BHH (2), 28 BHH (2), 7 GHH (2), 10 GHH (2), 21 GHH (2), 22 HDU / ITU GHH (2), 20A SH (2), 3 BHH (1), 5 BHH (1), 6 BHH (1), 9 BHH (1), 10 BHH (1), 11 SAU BHH (1), 23 HASU BHH (1), 24 BHH (1), HDU BHH (1), ITU BHH (1), 8 GHH (1), 14 GHH (1), 17 GHH (1), 24 GHH (1), 17 SH (1), 19 SH (1), 20B SH (1), AMU SS SH (1)
9a	Avoidable Grade 2 Pressure Ulcers Number of avoidable cases	<102 at year end		<b>In Month Position Aug-17</b> <b>5</b>
9b	Avoidable Grade 2 Pressure Ulcers (Community) Number of avoidable cases	<4 at year end		<b>In Month Position Aug-17</b> <b>0</b>
10a	Avoidable Grade 3 Pressure Ulcers Number of avoidable cases	<36 at year end		<b>In Month Position Aug-17</b> <b>1</b>

Ref	Indicator Name	Target	Performance	Wards / Areas Not Achieving Target	
10b	Avoidable Grade 3 Pressure Ulcers (Community) Number of avoidable cases	<7 at year end		In Month Position Aug-17 0	
11a	Avoidable Grade 4 Pressure Ulcers Number of avoidable cases	0		In Month Position Aug-17 0	
11b	Avoidable Grade 4 Pressure Ulcers (Community) Number of avoidable cases	0		In Month Position Aug-17 0	
12a	Avoidable Suspected Deep Tissue Injury (SDTI) Pressure Ulcers Number of avoidable cases			In Month Position Aug-17 7	
12b	Avoidable Suspected Deep Tissue Injury (SDTI) Pressure Ulcers (Community) Number of avoidable cases			In Month Position Aug-17 0	
13	Care Quality Metrics: Tissue Viability % compliance with tissue viability indicators	≥95%		In Month Position Sep-17 97%	1 BHH (79%), PAU BHH (83%), SCBU GHH (84%), 10 GHH (85%), 12 GHH (87%), AMU SS SH (89%), 12 BHH (91%), NNU BHH (91%), 2 BHH (92%), 23 ASU BHH (92%), 22 HDU / ITU GHH (92%), 24 BHH (93%), 9 GHH (93%), 23 HASU BHH (94%)
14	Care Quality Metrics: SSKIN Bundle - Daily skin inspection A daily skin inspection is recorded if the patient is identified as being at risk	≥90%		In Month Position Sep-17 94%	1 BHH (33%), 12 BHH (50%), 6 BHH (70%), 21 GHH (71%), 23 HASU BHH (75%), 24 BHH (80%), NNU BHH (80%), PAU BHH (80%), AMU GHH (83%), 10 GHH (88%), 19 BHH (89%), 12 GHH (89%)
15	Care Quality Metrics: SSKIN Bundle - Repositioning frequency completed The repositioning frequency has been completed	≥90%		In Month Position Sep-17 98%	10 GHH (50%), ITU BHH (75%), AMU GHH (75%), AMU SH (75%)
16	Care Quality Metrics: SSKIN Bundle - Repositioning frequency adhered to The repositioning frequency has been adhered to for the past three days	≥90%		In Month Position Sep-17 92%	23 ASU BHH (43%), AMU SS SH (50%), 8 BHH (67%), 21 ECAU BHH (70%), SCBU GHH (70%), 5 BHH (75%), 23 HASU BHH (75%), 12 GHH (78%), 9 BHH (80%), 24 BHH (80%), 2 GHH (80%), 10 GHH (86%), 8 SH (86%)
17	Matrons Assurance: Overall Tissue Viability Score % compliance with matrons assurance metrics for tissue viability	≥95%		In Month Position Sep-17 96%	5 BHH (79%), 12 GHH (79%), 16 GHH (85%), 1 BHH (90%), 9 BHH (90%), 14 GHH (90%), 19 BHH (91%), 4 BHH (92%), 21 BHH (94%), HDU BHH (94%), 15 SH (94%)
<b>Inpatient Falls</b>					
18	Falls Rate Falls rate per 1,000 occupied bed days	≤6.36		In Month Position Sep-17 5.14	15 BHH (19.23), 12 BHH (14.59), 18 BHH (13.95), 21 GHH (13.83), 22 AMU 2 BHH (13.44), 1 BHH (12.85), 14 SH (10.05), 24 GHH (9.60), 20 AMU 1 BHH (8.71), 15 GHH (8.70), 7 BHH (8.45), 8 GHH (8.13), 7 GHH (8.05), 20A SH (7.84), 21 BHH (7.59), 30 BHH (7.23), 11 GHH (7.14), 9 GHH (7.01), 2 BHH (7.00), 10 GHH (6.98), AMU SS GHH (6.70), 10 BHH (6.85), 15 SH (6.56)
19	Falls Incidence Number of inpatient falls			In Month Position Sep-17 226	
20	Injurious Falls Number of falls resulting in a fracture or head injury			In Month Position Sep-17 5	8 BHH (1), 22 AMU 2 BHH (1), 11 GHH (1), 15 GHH (1), 20B SH (1)
21	Recurrent Fallers Number of patients falling twice or more during the same admission			In Month Position Sep-17 24	1 BHH (2), 22 AMU 2 BHH (2), 8 GHH (2), 12 GHH (2), 15 SH (2), AMU SS SH (2), 2 BHH (1), 3 BHH (1), 7 BHH (1), 18 BHH (1), 27 BHH (1), 28 BHH (1), 2 GHH (1), 11 GHH (1), 15 GHH (1), 21 GHH (1), 23 CCU GHH (1), AMU SS GHH (1)

Ref	Indicator Name	Target	Performance	Wards / Areas Not Achieving Target
22	Care Quality Metrics: Falls Assessment % compliance with overall falls assessment indicator	≥90%	 97 97 97 98 98 97 99 99 97 98 98 98	<b>In Month Position</b> Sep-17 98% AMU SS SH (69%), 23 HASU BHH (83%), ITU BHH (83%), 22 HDU / ITU BHH (86%)
23	Care Quality Metrics: Manual Handling % compliance with overall manual handling indicator	≥90%	 99 97 98 98 98 100 99 99 98 98 99 98	<b>In Month Position</b> Sep-17 98% 9 GHH (83%), 10 GHH (83%)
<b>VTE</b>				
24	VTE Screening % of patients screened for VTE	≥95%	 96.82 96.81 96.69 97.09 96.63 96.62 97.17 96.88 97.28 97.30 96.78 97.85	<b>In Month Position</b> Sep-17 97.88% 14 SH (78%), ITU BHH (80%), 2 GHH (84%), 14 GHH (85%), 15 GHH (87%), 10 BHH (92%), 8 GHH (92%), 16 GHH (92%), 5 BHH (93%)
25	VTE Screening Number of patients NOT screened		 595 614 595 538 581 661 492 591 515 506 607 395	<b>In Month Position</b> Sep-17 388 Top areas for number NOT screened: DSU GHH (57), 14 SH (46), DPU SH (39), 2 GHH (37), AMU GHH (15), 5 BHH (12), 14 GHH (10), 5 GHH (9), DSU BHH (9), 10 BHH (9), 15 GHH (7), 1 BHH (7), 17 GHH (6), 16 GHH (5)
26	Prevalence of New VTE % of patients with a new (hospital acquired) VTE reported via NHS Safety Thermometer		 0.21 0.29 0.47 0.70 0.25 0.71 0.00 0.34 0.89 0.11 1.06 0.20	<b>In Month Position</b> Sep-17 0.20% Number of new VTE: 27 BHH (1), 17 GHH (1), 21 GHH (1)
<b>UTI</b>				
27	CAUTI % of catheterised patients with a UTI reported via NHS Safety Thermometer		 0.00 0.06 0.00 0.53 0.06 0.19 0.00 0.07 0.00 0.23 0.00 0.27	<b>In Month Position</b> Sep-17 0.27% Number of CAUTI: 24 BHH (2), 30 BHH (1), 14 GHH (1)
28	Care Quality Metrics: Continance Assessment % compliance with overall continence assessment indicator	≥90%	 98 98 99 97 98 98 98 98 98 99 99 98	<b>In Month Position</b> Sep-17 98% HDU BHH (86%), 11 GHH (87%), 14 SH (89%)
<b>Medication</b>				
29	Medication Incidents Number of medication incidents reported via Datix		 122 148 122 119 136 114 106 179 110 116 141 114	<b>In Month Position</b> Sep-17 114 Number of medication incidents resulting in moderate, severe, or catastrophic harm: One incident resulted in Moderate Harm on Ward 9 BHH
30	Care Quality Metrics: Medication - Secure Medicines / Cupboard % compliance with indicator	90%	 100 96 98 98 98 96 100 100 88 100 98 94	<b>In Month Position</b> Sep-17 94% 5 BHH (0%), 17 SH (0%), 22 HDU / ITU GHH (75%)
31	Antibiotic STAT Doses % of antibiotic STAT doses administered within 1 hour	≥80%	 82 82 82 80 80 83 82 82 83 83 82 83	<b>In Month Position</b> Sep-17 83% 6 BHH (40%), 17 GHH (53%), 7 GHH (55%), 22 AMU 2 BHH (64%), 10 BHH (67%), 24 GHH (67%), 8 SH (67%), 9 BHH (69%), 2 BHH (70%), 10 GHH (72%), 17 GHH (73%), 2 GHH (76%), 14 GHH (76%), 23 CCU GHH (78%), 24 BHH (79%)
32	Antibiotic STAT Doses Average time taken for doses administered AFTER 1 hour	≤1 hour	 0:53:05 1:11:26 1:03:47 1:08:10 1:12:39 0:56:52 0:52:22 0:57:46 1:12:51 0:41:27 0:55:16	<b>In Month Position</b> Sep-17 Top maximum delay to administer AFTER 1 hr:
33	Parkinsons Medication % of Parkinsons medication administered within 30 minutes	≥90%	 74 76 75 74 76 79 81 80 82 84 80 82	<b>In Month Position</b> Sep-17 82%
34	Guardrails © Medication Safety Software (for IV systems) % compliance with use of Guardrails © medication safety software			<b>In Month Position</b> Sep-17

Ref	Indicator Name	Target	Performance	Wards / Areas Not Achieving Target				
<b>Care Quality Metrics</b>								
35	Care Quality Metrics: <b>Overall Clinical Score</b> % compliance with overall care quality metrics	≥95%	 97 97 97 97 98 97 98 98 96 98 98 97	<b>In Month Position Sep-17</b> 97% ED GHH (76%), Paeds ED GHH (83%), 10 GHH (88%), 23 HASU BHH (90%), NNU BHH (91%), 9 GHH (91%), AMU SS SH (92%), 21 BHH (93%), Delivery Suite BHH (93%), ED BHH (93%), 12 GHH (93%), Paeds ED GHH (93%), SCBU GHH (94%)				
36	Care Quality Metrics: <b>Observations</b> % compliance with observations indicator	≥90%	 97 96 98 97 98 97 98 98 98 98 97 97	<b>In Month Position Sep-17</b> 97% 10 GHH (82%), 9 GHH (89%)				
37	Care Quality Metrics: <b>Fluid Balance</b> % compliance with fluid balance indicator	≥90%	 92 93 94 93 95 92 93 94 90 94 93 93	<b>In Month Position Sep-17</b> 93% 5 BHH (71%), 21 GHH (72%), 23 ASU BHH (76%), 12 GHH (77%), 23 HASU BHH (78%), 9 GHH (81%), 17 SH (81%), 30 BHH (82%), 26 BHH (83%), 10 GHH (83%), 14 GHH (83%), 14 SH (83%), 17 GHH (89%)				
38	Care Quality Metrics: <b>Nutritional Assessment</b> % compliance with nutritional assessment indicator	≥90%	 94 94 93 94 95 95 97 96 94 95 97 93	<b>In Month Position Sep-17</b> 93% 23 HASU BHH (65%), 9 BHH (68%), 21 BHH (75%), 20 AMU 1 BHH (81%), NNU BHH (82%), 29 BHH (83%), 5 BHH (84%), 10 GHH (84%), PAU BHH (85%), 8 BHH (86%), 24 GHH (86%), ITU BHH (87%), 12 GHH (87%), 21 GHH (88%), AMU SS SH (88%), 22 AMU 2 BHH (89%), 26 BHH (89%)				
39	Care Quality Metrics: <b>Blood Glucose Monitoring</b> % compliance with blood glucose monitoring indicator	≥90%	 94 93 92 96 95 94 87 93 87 93 92 91	<b>In Month Position Sep-17</b> 91% 8 BHH (50%), 21 BHH (56%), 15 SH (67%), 9 GHH (71%), 10 GHH (71%), 16 GHH (71%), 15 SH (75%), AMU SH (75%), 14 SH (78%), 23 ASU BHH (79%), 24 BHH (79%), 12 BHH (81%), 7 BHH (82%), 6 BHH (84%), 20 AMU 1 BHH (88%), AMU GHH (89%)				
40	Care Quality Metrics: <b>Community Services Overall Score</b> % compliance with overall care quality metrics	≥95%	 100 100 100 99 99 98 97 100 100 100 98 95	<b>In Month Position Sep-17</b> 95%				
<b>Patient Flow</b>								
41	ADTs % of discharges completed within 2 hours	≥95%	 78.50 78.28 78.54 77.82 79.00 80.01 87.04 85.13 86.34 85.23 85.63 84.42	<b>In Month Position Sep-17</b> 84.42%				
42	Readmissions: 28 days Number of patients readmitted within 28 days of discharge Data One Month in Arrears		 992 975 1007 968 994	<b>In Month Position Aug-17</b> 994				
43	Discharges before 12pm % of patients discharged before 12 o'clock midday		 16.45 16.98 16.23 15.62 16.68	<b>In Month Position Sep-17</b>				
44	Discharge Lounge Utilisation % of patients utilising the discharge lounge		 22.7 23.0 22.9 25.8 26.4 29.1 Number: 945 1026 1018 1163 1219 1308	<b>In Month Position Sep-17</b> 29.1% Wards with lowest NUMBER of discharges to the discharge lounge in month: 26 BHH (0), 19 BHH (2), 23 ASU BHH (6), 21 BFAU BHH (10), 23 HASU BHH (10)				
<b>Dementia</b>								
45	Dementia Screening % of eligible patients screened for dementia	≥90%	 85.03 84.19 87.68 85.61 89.64 87.93 89.31 87.11 88.76 88.11 84.72 83.39	<b>In Month Position Sep-17</b> 83.39%				
<b>Nurse Staffing</b>								
46	UNIFY Compliance Overall compliance in month	≥90%	<table border="1"> <thead> <tr> <th>Qualified Compliance</th> <th>HCA Compliance</th> </tr> </thead> <tbody> <tr> <td>95%</td> <td>110%</td> </tr> </tbody> </table>	Qualified Compliance	HCA Compliance	95%	110%	Hot Spot Areas: ITU BHH, ITU GHH, NNU, HASU
Qualified Compliance	HCA Compliance							
95%	110%							

Ref	Indicator Name	Target	Performance	Wards / Areas Not Achieving Target																										
47a	Registered Vacancy Position Number of WTE Vacancies for registered nursing staff		<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>295.03</td><td>258.5</td><td>273.14</td><td>268.51</td><td>256.74</td><td>263.11</td><td>296.92</td><td>312.64</td><td>319.32</td><td>338.91</td><td>371.59</td><td>419.35</td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	295.03	258.5	273.14	268.51	256.74	263.11	296.92	312.64	319.32	338.91	371.59	419.35	In Month Position Sep-17 419.35
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	295.03	258.5	273.14	268.51	256.74	263.11	296.92	312.64	319.32	338.91	371.59	419.35																		
47b	Unregistered Vacancy Position Number of WTE Vacancies for unregistered nursing staff		<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>28.70</td><td>24.24</td><td>26.13</td><td>31.06</td><td>32.18</td><td>35.10</td><td>108.36</td><td>97.29</td><td>92.00</td><td>97.78</td><td>88.04</td><td>82.45</td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	28.70	24.24	26.13	31.06	32.18	35.10	108.36	97.29	92.00	97.78	88.04	82.45	In Month Position Sep-17 82.45
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	28.70	24.24	26.13	31.06	32.18	35.10	108.36	97.29	92.00	97.78	88.04	82.45																		
48	Care Hours per Patient Day Number of care hours per patient day		<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>7.38</td><td>7.48</td><td>7.49</td><td>7.39</td><td>7.52</td><td>7.73</td><td>7.68</td><td>7.70</td><td>7.79</td><td>7.80</td><td>7.61</td><td></td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	7.38	7.48	7.49	7.39	7.52	7.73	7.68	7.70	7.79	7.80	7.61		In Month Position Sep-17
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	7.38	7.48	7.49	7.39	7.52	7.73	7.68	7.70	7.79	7.80	7.61																			
49a	Sickness: Registered Staff % of nursing & midwifery sickness in month	≤4%	<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>4.09</td><td>4.18</td><td>4.62</td><td>5.02</td><td>4.52</td><td>4.18</td><td>4.48</td><td>4.43</td><td>4.13</td><td>4.03</td><td>4.23</td><td>4.30</td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	4.09	4.18	4.62	5.02	4.52	4.18	4.48	4.43	4.13	4.03	4.23	4.30	In Month Position Sep-17
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	4.09	4.18	4.62	5.02	4.52	4.18	4.48	4.43	4.13	4.03	4.23	4.30																		
49b	Sickness: Unregistered Staff % of nursing & midwifery sickness in month	≤4%	<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>6.29</td><td>6.30</td><td>7.79</td><td>7.74</td><td>6.72</td><td>6.86</td><td>6.81</td><td>6.78</td><td>6.71</td><td>6.64</td><td>7.80</td><td>7.94</td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	6.29	6.30	7.79	7.74	6.72	6.86	6.81	6.78	6.71	6.64	7.80	7.94	In Month Position Sep-17
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	6.29	6.30	7.79	7.74	6.72	6.86	6.81	6.78	6.71	6.64	7.80	7.94																		
50	Turnover % of staff turnover		<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>8.65</td><td>8.41</td><td>8.27</td><td>9.05</td><td>9.22</td><td>9.72</td><td>9.88</td><td>10.08</td><td>10.04</td><td>10.10</td><td>10.14</td><td>10.31</td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	8.65	8.41	8.27	9.05	9.22	9.72	9.88	10.08	10.04	10.10	10.14	10.31	In Month Position Sep-17
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	8.65	8.41	8.27	9.05	9.22	9.72	9.88	10.08	10.04	10.10	10.14	10.31																		
51	e-Rostering KPI: Unfilled Duties % of planned duty hours that were left unfilled	<30%	<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>11.9</td><td>12.5</td><td>13.1</td><td>14.8</td><td>13.0</td><td>13.4</td><td>12.8</td><td>11.4</td><td>11.3</td><td>10.6</td><td>12.5</td><td></td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	11.9	12.5	13.1	14.8	13.0	13.4	12.8	11.4	11.3	10.6	12.5		In Month Position Sep-17
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	11.9	12.5	13.1	14.8	13.0	13.4	12.8	11.4	11.3	10.6	12.5																			
52	e-Rostering KPI: Additional Duties Number of duties rostered in addition to planned staffing levels	0	<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>2232</td><td>2149</td><td>2507</td><td>2623</td><td>3041</td><td>2684</td><td>3286</td><td>3023</td><td>2969</td><td>2852</td><td>2747</td><td></td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	2232	2149	2507	2623	3041	2684	3286	3023	2969	2852	2747		In Month Position Sep-17
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	2232	2149	2507	2623	3041	2684	3286	3023	2969	2852	2747																			
53	e-Rostering KPI: Unavailability % of leave and unavailability		<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>28.1</td><td>28.8</td><td>30.9</td><td>27.3</td><td>28.5</td><td>29.7</td><td>27.8</td><td>27.7</td><td>27.3</td><td>28.0</td><td>30.8</td><td></td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	28.1	28.8	30.9	27.3	28.5	29.7	27.8	27.7	27.3	28.0	30.8		In Month Position Sep-17
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	28.1	28.8	30.9	27.3	28.5	29.7	27.8	27.7	27.3	28.0	30.8																			
54	e-Rostering KPI: Temporary Staffing % of duties filled by bank and agency staff	<20%	<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>19.1</td><td>19.1</td><td>21.6</td><td>17.4</td><td>21.2</td><td>21.5</td><td>20.8</td><td>21.5</td><td>21.4</td><td>21.7</td><td>23.7</td><td></td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	19.1	19.1	21.6	17.4	21.2	21.5	20.8	21.5	21.4	21.7	23.7		In Month Position Sep-17
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	19.1	19.1	21.6	17.4	21.2	21.5	20.8	21.5	21.4	21.7	23.7																			
<b>Patient Experience</b>																														
55	Live / Open / Active Complaints Number of active complaints		<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>132</td><td>90</td><td>79</td><td>86</td><td>95</td><td>122</td><td>73</td><td>111</td><td>100</td><td>102</td><td>106</td><td>82</td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	132	90	79	86	95	122	73	111	100	102	106	82	In Month Position Sep-17 205
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	132	90	79	86	95	122	73	111	100	102	106	82																		
56	New Complaints Received Number of new complaints received in month		<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>132</td><td>90</td><td>79</td><td>86</td><td>95</td><td>122</td><td>73</td><td>111</td><td>100</td><td>102</td><td>106</td><td>82</td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	132	90	79	86	95	122	73	111	100	102	106	82	In Month Position Sep-17 82
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	132	90	79	86	95	122	73	111	100	102	106	82																		
57	Complaints Response Rate % of complaints responded to within 30 days or less Data One Month in Arrears	≥80%	<table border="1"> <tr><th>Month</th><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td></tr> <tr><th>Value</th><td>26</td><td>26</td><td>39</td><td>52</td><td>45</td><td>58</td><td>49</td><td>67</td><td>56</td><td>52</td><td>53</td><td>48</td></tr> </table>	Month	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Value	26	26	39	52	45	58	49	67	56	52	53	48	In Month Position Aug-17 48%
Month	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug																		
Value	26	26	39	52	45	58	49	67	56	52	53	48																		
58	Complaints KPI: Complaints Sent to Divisions % of complaints sent to Divisions / Operational Teams within one working day	≥90%	<table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>95</td><td>89</td><td>96</td><td>98</td><td>99</td><td>99</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	95	89	96	98	99	99							In Month Position Sep-17 99%
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	95	89	96	98	99	99																								

NB: Data is taken from a live system and is accurate at the time of reporting. Complaints are closed on a daily basis meaning that monthly data will continue to change after reporting. Final monthly

Ref	Indicator Name	Target	Performance	Wards / Areas Not Achieving Target																										
59	Complaints KPI: Complaints Older than 50 Days <i>% of complaints older than 50 days without a response</i>		<p>Number:</p> <table border="1"> <tr><th>Month</th><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr> <tr><th>Value</th><td>42</td><td>38</td><td>38</td><td>29</td><td>26</td><td>39</td><td>17</td><td>15</td><td>10</td><td>9</td><td>19</td><td>7</td></tr> </table>	Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Value	42	38	38	29	26	39	17	15	10	9	19	7	<p><b>In Month Position Sep-17</b></p> <p>7%</p>
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep																		
Value	42	38	38	29	26	39	17	15	10	9	19	7																		
60	Friends & Family Test: Inpatients <i>% response rate</i>	≥30%		<p><b>In Month Position Sep-17</b></p> <p>33%</p> <p>4 GHH (0%), PAU BHH (3%), 15 BHH (5%), 24 BHH (5%), 26 BHH (7%), AMU GHH (9%), 2 BHH (10%), 16 BHH (10%), 7 BHH (12%), 24 GHH (12%), 20B SH (13%), 14 BHH (16%), NNU BHH (17%), 17 SH (17%), 5 GHH (19%), 14 GHH (22%), 20 AMU 1 BHH (20%), AMU SS GHH (21%), 14 GHH (22%), 20 AMU 1 BHH (24%), Cedar BHH (25%), 17 GHH (26%), 8 BHH (27%), 6 BHH (29%), 7 GHH (29%), SCBU GHH (29%), AMU SS SH (29%)</p>																										
61	Friends & Family Test: Inpatients <i>Positive responder score</i>	≥95%		<p><b>In Month Position Sep-17</b></p> <p>94%</p> <p>PAU BHH (71%), 16 BHH (73%), 8 BHH (76%), 18 BHH (80%), NNU BHH (80%), SCBU GHH (80%), 2 BHH (85%), 14 GHH (85%), 1 BHH (86%), 4 BHH (86%), 2 GHH (89%), Maple BHH (90%), 20B SH (90%), 8 GHH (91%), AMU GHH (91%), 11 SAU BHH (92%), 29 BHH (92%), 11 GHH (92%), 15 GHH (92%), 17 GHH (92%), AMU SH (92%), 3 BHH (93%), 20 AMU 1 BHH (93%), 28 BHH (93%), 5 BHH (94%), 9 GHH (94%), 21 GHH (94%)</p>																										
62	Friends & Family Test: Emergency Departments <i>% response rate</i>	≥20%		<p><b>In Month Position Sep-17</b></p> <p>15%</p>																										
63	Friends & Family Test: Emergency Departments <i>Positive responder score</i>	≥95%		<p><b>In Month Position Sep-17</b></p> <p>79%</p>																										
64	Care Quality Metrics: Patient Safety & Dignity <i>% compliance with patient safety and dignity indicator</i>	≥90%		<p><b>In Month Position Sep-17</b></p> <p>99%</p> <p>9 GHH (88%)</p>																										
65	Compliments <i>TBC</i>			<p><b>In Month Position Sep-17</b></p>																										
66	Wards / Departments with improvement plans																													
67	Areas of good practice																													

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**MONDAY 23<sup>RD</sup> OCTOBER 2017**

<b>Title:</b> HEFT SAFEGUARDING ANNUAL REPORT 2016-17							
<b>From:</b> JULIE TUNNEY				<b>To:</b> TRUST BOARD			
<b>The Report is being provided for:</b>							
Decision	N	Discussion	Y	Assurance	Y	Endorsement	Y
<b>Purpose:</b>							
<ul style="list-style-type: none"> <li>• To highlight achievements in relation to safeguarding within the Trust.</li> <li>• To provide internal organisational assurance of compliance with the statutory and regulatory requirements.</li> </ul>							
<b>Key points/Summary:</b>							
<b>Part 1</b> - Summary of Safeguarding Education Compliance <b>Part 2</b> - Summary of progress with the Safeguarding Children agenda <b>Part 3</b> - Summary of the progress with the Safeguarding Adults plan (provided by Lorraine Longstaff, Associate Head Nurse Safeguarding Adults) <b>Part 4</b> - Domestic Abuse - progress update (provided by Wendy Badger - Lead Nurse for Domestic Abuse) <b>Part 5</b> - Conclusion							
<b>Recommendation(s):</b>							
The Board is asked to consider the information set out in this report.							
<b>Assurance Implications:</b>							
Board Assurance Framework		Y	BAF Risk Reference No.				
Performance KPIs year to date		Y	Resource/Assurance Implications (e.g. Financial/HR)		N		
Information Exempt from Disclosure		N	If yes, reason why.				
Identify any Equality & Diversity issues			NA				
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							
Safeguarding Children Committee - July 2017							
Safeguarding Adult Steering Group - June 2017							

## **1. SUMMARY**

This annual report provides an overview of the activity and achievements in relation to safeguarding adults with care and support needs and children and an account of the priorities and plans for 2017 - 2018.

The areas of child and adult safeguarding continue to feature prominently as an issue of concern both with government and media. Organisations are required to ensure that they have a skilled workforce and robust systems that identify at risk groups and respond promptly, proportionately and appropriately to signs of abuse or neglect.

Improving safeguarding responses remains a priority for Heart of England Foundation Trust (HEFT). This report is in five sections.

1. Safeguarding Education
2. Safeguarding children
3. Safeguarding adults with care and support needs
4. Domestic Abuse
5. Conclusion

Each section will outline our achievements in the past year and will clarify priorities for next year. Subheadings will be used to add clarity to the report.

## **2. BACKGROUND**

As an NHS organisation the Trust is obliged to be fully compliant with the statutory requirements from:

Children Act 2004  
Children Act 1989  
Care Act 2014

The Care Quality Commission regulates all NHS organisations and considers, carefully, the robustness of safeguarding arrangements for adults and children as part of this process.

The Trust's contribution to the effectiveness of partnership working is reviewed by the Local Safeguarding Boards for Children and Adults which are independently chaired. Proposed new arrangements for the operation of Safeguarding Children Boards emphasise the particular importance of the partnership between the 3 'key' statutory agencies in safeguarding - Social Care, Police and Health.

## **3. ACTION**

The Board is asked to note the areas of progress during 2016-17 and to note the safeguarding priorities for 2017-18.

## **4. RECOMMENDATION(S)**

The Board is asked to consider the information set out in this report.

## **5. NEXT STEPS**

The Board is asked to consider the information in the Safeguarding Annual Report and the implications for assurance.

The Board is asked to endorse plans for future priorities.

**HEART OF ENGLAND NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS**

**MONDAY 23<sup>RD</sup> OCTOBER 2017**

<b>Title of the Report:</b>	Safeguarding Annual Report
<b>Author:</b>	Maria Kilcoyne - Head of Safeguarding
<b>Purpose of the Report:</b>	To highlight achievements in relation to safeguarding within the Trust and to provide internal and external assurance of compliance with the statutory and regulatory requirements.
<b>Date of the Report:</b>	28 <sup>th</sup> April 2017
<b>Structure of the report:</b>	Part 1 - Summary of Safeguarding Training Compliance Part 2 - Safeguarding Children Part 3 - Safeguarding Adults (provided by Lorraine Longstaff, Associate Head Nurse Safeguarding Adults) Part 4 - Domestic Abuse (provided by Wendy Badger - Lead Nurse for Domestic Abuse) Part 5 - Conclusion

**1.0 Background:**

Adult and Child Safeguarding in NHS organisations are statutory and regulatory requirements. The Trust is accountable for delivery in relation to safeguarding requirements and this is monitored closely by Local Safeguarding Children and Adult Boards, CCGs and the CQC.

Statutory requirements relate to:

- Children Act 1989
- Children Act 2004- specifically section 11
- The Care Act 2014

**National context**

**Children**

During 2016-17 the Government continued to explore reforms to the Child protection system due to anxiety that the current systems to protect children continue to allow too many children to come to serious harm.

The government have cited their rationale for reform which includes high profile cases:

**Jimmy Savile**; the television personality who abused his celebrity status and fundraising roles to gain access, influence and power to abuse vulnerable children;

**Daniel Pelka**; who despite being known to the authorities, was not adequately protected by practitioners who failed to share information and take appropriate action to keep him safe; and

**Rotherham, Rochdale and Oxfordshire**; where practitioners failed to see child sexual exploitation for what it was and subsequently failed to take action to stop and prevent it. In Rotherham there was also evidence which suggested that senior local officials had recklessly or deliberately covered up abuse.

Despite Local authorities reporting year on year increases in the numbers of children referred by partner agencies for social work services concern continues that too many children remain under the radar and 'invisible' to professionals who could help them.

The Children's Commissioner highlighted that only 1:8 children suffering sexual abuse will come to the attention of the police

<http://www.childrenscommissioner.gov.uk/learn-more/child-sexual-exploitation-abuse/protecting-childrenharm>

As part of their commitment to reform the government has:

- Enshrined in legislation a series of reforms to the social work profession (The Children and Social Work Act 2017)
- Carried out a national consultation in relation to the introduction of Mandatory Reporting of Child abuse and is currently analysing response
- Strengthened processes around recruitment and training of SW
- Focused on the delivery of improved multi-agency frontline practice with a focus on health and police in particular
- Recommended changes to the structure and function of Local Safeguarding Children Boards (Wood Review)
- Proposed changes to the Serious Case review Process with an aim to improve the quality and timeliness of reports and the dissemination of learning through a 'What Works Centre'.

Coordination of safeguarding arrangements for the health economy in Birmingham is managed through the Executive Health Forum attended by the Chief Nurses.

### **Adults**

The Care Act 2014 from 1st April 2015 provides a statutory framework for adult safeguarding, setting out the responsibilities of local authorities and their partners. It places a duty on Local Authorities to establish Safeguarding Adults Board and also stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect.

The role of all Safeguarding Adults Boards (as detailed in schedule 1 of the Care Act 2014) is to help and protect adults in the board's area. This is achieved by coordinating the actions of partner agencies, and seeking assurances from them that those actions are effective.

Boards are also able to instruct partner agencies to carry out any function considered necessary or desirable for the board to reach its objectives. In addition Safeguarding Adults Boards must publish a strategic plan for each financial year and as soon as is feasible after the end of each financial year, must publish an Annual Report.

During 2016-17 the DOLS law commission proposal was published highlighting plans to review processes in relation to the Deprivation of Liberty Safeguards in recognition of the unwieldy nature of current arrangements.

### **NHS**

It remains the responsibility of every NHS funded organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied, with the well-being of those adults and children at the heart of what we do. For adult

safeguarding this also needs to respect the autonomy of adults and the need for empowerment of individual decision making, in keeping with the Mental Capacity Act and its Code of Practice. Currently the NHS is experiencing a great deal of change in relation to the provision of services to children and adults with care and support needs and it is essential that impact on safeguarding arrangements is scoped carefully in order that risk can be mitigated.

## **HEFT**

Heart of England NHS Foundation Trust is large provider of a wide variety of scheduled and unscheduled health services for residents of Birmingham, Solihull and parts of Staffordshire. The Trust provides the following services to patients: Emergency Care, Maternity and Neonatal Services, Acute Services for Adults and Children, Community Services within Solihull.

The Trust employs approximately 10,000 staff and, annually, sees and treats 1.2 million people and has over 261,000 attendances to the Emergency Departments 63, 127 of which are under the age of 19 years, approximately 10,000 new births annually and sees 110,000 children (0-18 years across in and out-patient services).

The Trust has a Safeguarding Unit responsible for provision of advice, support, policy, supervision and education to the wider workforce on safeguarding matters. This Team support the multi-agency working groups within the LSCBs that the Trust relate to and coordinate the Safeguarding Audit Programme and our input into safeguarding reviews (including learning reviews, SCRs, SARs and DHRs). The Team are managed by the Head Nurse for Safeguarding who reports to the Chief Nurse and Executive Lead for Safeguarding providing Board oversight of safeguarding arrangements. During 2015-16 the Trust increased investment into the Safeguarding Unit, this has in turn increased support for front-line professionals. This includes the appointment of a Lead Nurse for Domestic Abuse reflecting the Care Act 2014 which included domestic abuse for the first time and creates a legal duty for safeguarding adults boards to respond safely to allegations of domestic abuse.

The Trust oversees the governance arrangements for safeguarding through a quarterly Safeguarding Children Committee and Monthly Safeguarding Adult Steering Group.

HEFT has continued to work closely with UHB in relation to safeguarding plans due to the proposed and planned acquisition by UHB in 2017-18.

HEFT has also fielded safeguarding representation to participate in the strategic and tactical 'BUMP' proposals which will modernise maternity services in the City in 2017-18.

### **Key achievements during 2016-17 include:**

- Increased specialist safeguarding support fielded to targeted children's and adult areas
- Increased access of key groups of staff in the Emergency Department, Maternity, Paediatrics and Neonatal Unit to Safeguarding Supervision.

- Review of key safeguarding policies and procedures.
- Increase in regular safeguarding audit internally and with our LSCB partners
- Increase in the Domestic Abuse infrastructure with an improved offer in relation to related training and advice.
- Hosting of an in house safeguarding adult conference which was well evaluated.

### Key areas for improvement in 2017-18

- Improvements in the ability of staff to articulate the implications of the mental capacity act to their practice
- Ensure that restraint and clinical holding processes are fully understood and followed
- Defining and delivery of an early help offer to families in receipt of maternity and community services.
- Increased scrutiny of attendances of high risk groups including frequent attenders and 16 -18 year olds.
- Exploring the safeguarding implications of transfer of services/ organisational changes.
- Maintaining the focus on audit to test out the effectiveness of safeguarding arrangements.

## Section 1 Safeguarding Education and Development - Training Compliance

### 1.2 Safeguarding Training Compliance

The capability of frontline staff in relation to safeguarding relies heavily on their access to suitable education and development activity.

The Trust is required by the Children Act 2004 and the Care Act 2014 to have suitable training packages in place and to monitor compliance rates and effectiveness of training.

The table below illustrates the current training compliance rates for safeguarding within the Trust at the end of quarter 4 2016-17. These are monitored and reported quarterly internally and to commissioners.

TRAINING TYPE	COMPLIANCE RATE AS A PERCENTAGE	COMPLIANCE IN COMMUNITY
Compliance with Adults Mandatory Safeguarding Training (all staff)	98.46%	99.6%
Mental Capacity Act/ Deprivation of Liberty Safeguards Training (as identified in TNA)	89.13%	71%
% Compliance with Adult High Level Training (as identified in TNA)	88.32%	86%
PREVENT Training	83.28%	92.3%
Children's Mandatory Level 1 Safeguarding Training	98.46%	99.6%

Children's Safeguarding - Level 2 Training or those staff identified in TNA	96.60%	97.23%
Children's Safeguarding - Level 3 Training for those staff identified in TNA	90%	92.73%
Children's Safeguarding - Level 4-6 Training for those staff identified in TNA (Specialist Safeguarding Staff).	90%	100%
Child Sexual Exploitation	76%	82.60%

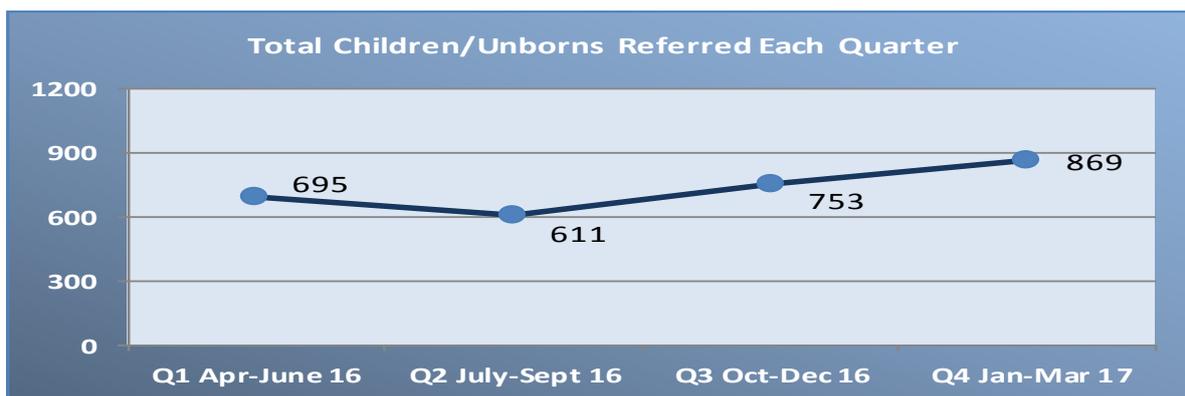
Please note the following:

- There are plans to increase the target audience for MCA training during 2017-18 and there is a moodle package to help ensure that the Trust can reach all the staff required.
- 
- CSE training rates are a priority for 2017-18. The target for PREVENT has increased to 90% for 2017-18. PREVENT training is provided on induction for new staff and there is a mechanism to increase the rates of pre-existing staff who are as yet untrained.
- The children's Level 3 workforce is approximately 1,100 staff and includes all ED staff; Maternity Staff; Paediatric Staff; Health Visiting and School Nursing Staff; Key staff in Infections Diseases working with TB and HIV.
- The Trust has a detailed Training Needs Analysis which also includes other elements of safeguarding related training for key staff. These include Domestic Abuse; Serious Case Review Training; Court Report Training and Training specifically for the Consultant Workforce as part of the Consultant Induction Programme.
- There is regular review of the content of education and learning packages. New packages have been developed in relation to restraint/ clinical holding and Modern Day Slavery.
- Audit suggests that staff are familiar and confident with safeguarding referral processes and who to contact for advice and support.

## Section 2 Safeguarding Children

### 2.1.1 Safeguarding Children Activity

This year the Trust saw an increase in the number of children referred by departments. The graph below illustrates the numbers of children referred by HEFT services over a 12 month period.

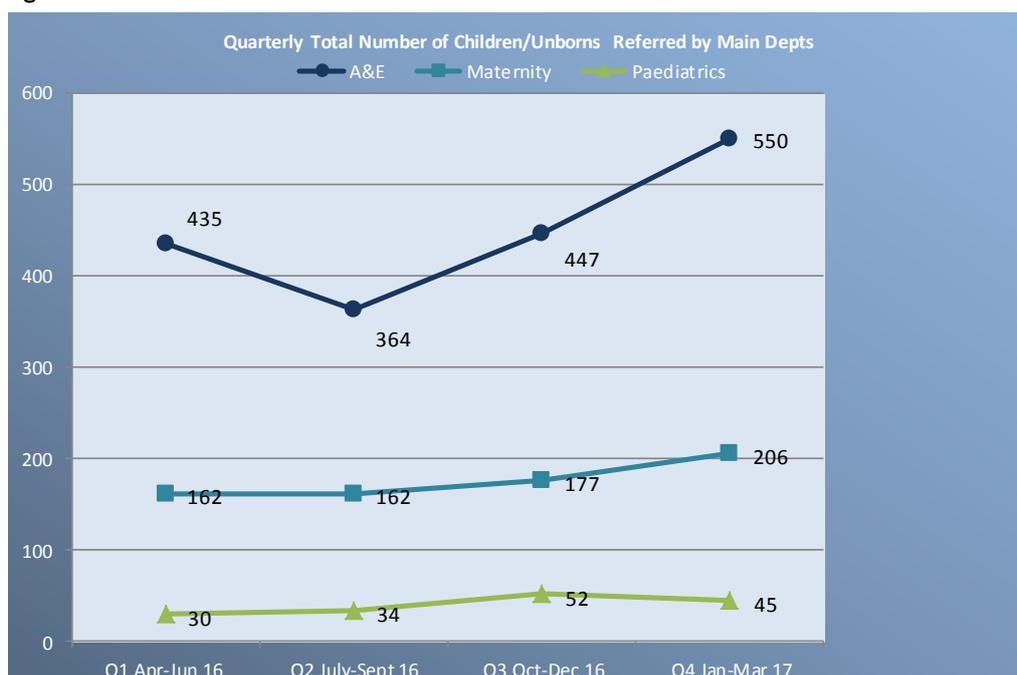


The table below shows the **average** number of referrals each quarter over the last seven years.

2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
150	445	446	601	653	610	732

### 2.1.2 Departmental Referrals

As demonstrated in the graph below the largest increase in referral numbers is seen in the Emergency Department and they are the department which consistently generates the highest numbers of referrals.



The Emergency Department has received increased safeguarding training at level 3 and the introduction of safeguarding supervision during 2016-17 which may have contributed in some way to this. The Emergency department is also however seeing an increased volume of patients year on year on the 0-16 age group. Growth was reported for the last years as 3.47% in 2013-14 v 2014-15 and of 6.12% in 2014-15 v 2015 -16.

Similar to previous years the Emergency Departments and Maternity Services generated the most significant numbers of safeguarding referrals for children at 63% and 24% respectively. Smaller numbers were generated in Paediatrics although this is not reflective of their safeguarding workload as they have on-going responsibility for many of the cases referred

by the Emergency Department until investigations are completed. During each quarter the Paediatric department will have around 110 inpatient cases where there are identified safeguarding concerns. Approximately 3-4 of these are specific investigations into non-accidental injuries.

Referral rates from community services are as do Community services. Referral rates from Community Services are reported as around 30 children each quarter however they will have involvement with over 500 children subject to Child Protection and Looked After Children Plans in addition to involvement with children subject to Child in Need Plans and families requiring early help assessment and intervention.

The Trust is generating approximately 9 referrals each quarter for concerns relating to **Child Sexual Exploitation** and 100% of these referrals were accompanied by the required screening tool in quarter 4 with 93% overall during the year.

Quarter	1 2015-16	2 2015-16	3 2015-16	4 2015-16	1 2016-17	2 2016-17	3 2016-17	4 2016-17	Total
Number of CSE referrals	5	5	6	8	13	13	13	9	72
Number accompanied by screening tool	1	4	4	5	12	13	11	9	59

The Trust will be increasing scrutiny of the attendances of 16-18 year olds as there is concern that CSE may not be reliably screened for in this age group.

In addition there will be further work to highlight whether these children and young people have been trafficked as part of their CSE experience as this assists partner agencies in dealing with perpetrators effectively.

### 2.1.3 Quality of Safeguarding Referral Information

Improving the quality of referral information was identified as a priority last year. The quality of referral information is key in determining the response that the child and family receive. The Trust has been able to demonstrate considerable improvement in the quality of referral information shared with Local Authorities based on internal audits.

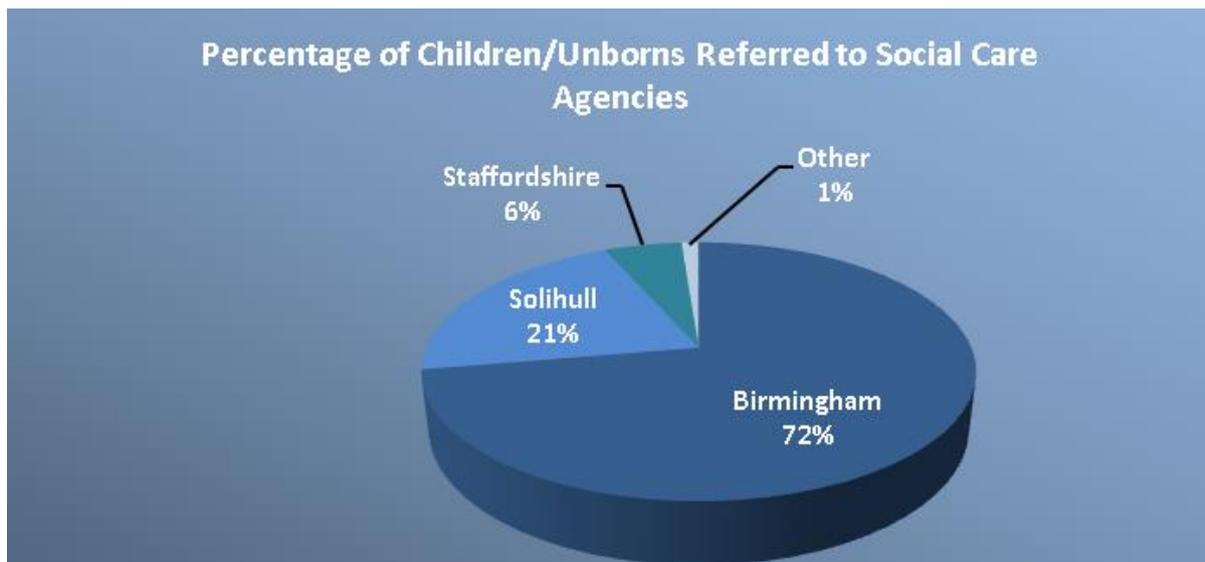
All referrals are reviewed against a set of quality criteria by a safeguarding specialist. Through systematic feedback and increased workshops to support frontline staff make good quality referrals the Trust can demonstrate a reduction in the numbers of referrals deemed to be poor - see below:

Qtr 3 2015-16	Qtr 4 2015-16	Qtr 1 2016-17	Qtr 2 2016-17	Qtr 3 2016-17	Qtr4 2016-17
19%	25%	9%	8%	4%	4%

The Trust is reviewing options to increase electronic transfer of referrals and to decrease reliance as fax as a mechanism as this is a risk in relation to Information Sharing and Information Governance.

### 2.1.4 Safeguarding Children Referrals per Local Authority

The graph below illustrates the referral rates per Local Authority with the majority of children being referred to Birmingham.



#### **2.1.4 Feedback from the LA in relation to the outcome of child safeguarding referrals**

Feedback continues to be a problematic area.

30% of referrals receive a social work led response.

In 50% of referrals outcomes remain unknown and these are primarily Birmingham LA referrals (92% of all cases where the referral outcome is unknown).

Those that do not receive a Social Work Led response - i.e. a lower level response in the form of Early Help are not routinely notified to us by Birmingham.

This has been made worse in Birmingham during the last year due to rearrangements at the front door of Social Care which have meant that less cases are deemed to meet the threshold for Multi-agency Safeguarding Hub discussion where feedback is part of the process. This is subject to discussion via the Birmingham MASH Partnership Meetings.

Annually the Trust completes a Training Needs Analysis and an Education and Learning Plan. The Trust has robust plans to manage compliance at Levels 1, 2 and 3 for safeguarding children. Training is reported quarterly to the Safeguarding Children Committee and the CCG.

Additional training for the Children's workforce includes that offered by the LSCBs, domestic abuse training, Serious Case Review Training (delivered to all HVs during 2016-17) and Early Help assessment training.

All safeguarding specialist staff for children are compliant with their training requirements.

#### **2.2 Safeguarding Supervision**

Safeguarding Children Supervision is provided by the Specialist Nurses in a variety of formats.

Safeguarding Supervision for staff is associated with better outcomes for children and support for staff who are handling difficult and complex safeguarding cases.

There is evidence that supervision increases the ability of staff to think objectively about cases and that it may assist in preventing 'burn out' and increasing staff retention and effectiveness.

Compliance with the requirements is monitored quarterly and reported via the Safeguarding Children Committee. The target is 85% and is a KPI for the Trust.

The table below illustrates the rates at the end of quarter 4 2016-17

<b>Staff Group</b>	<b>Compliance Achieved</b>	<b>Comments</b>

<b>Acute Overall</b>	<b>98%</b>	<b>KPI ALQR 32a</b>
Paediatric Nurses	99%	The supervisory framework requires daily supervision sessions in inpatient areas. The requirement is for one session each week to be provided to GHH and 4 each week to be provided to BHH. 100% compliance was received with BHH and 92% with GHH. <i>However it is worth mentioning that some cases were not discussed with the Safeguarding Team in supervision due to admission/ discharge out of hours this equated to a total of 19 cases in quarter 4. The total number of admissions during this period was 109. This equates to 17.4% of children with safeguarding concerns admitted.</i>
Maternity Specialist Midwives	90%	Quarterly supervision
Maternity Community Midwives	100%	Quarterly supervision
NCOT	100%	Quarterly supervision
NNU discharge planner	100%	Quarterly supervision
NNU	100%	<i>Weekly session of supervision - newly introduced in 2016-17</i>
ED	100%	Quarterly supervision
Clinical Nurse specialists (paeds)	94%	Quarterly supervision
<b>Community Overall</b>	<b>93%</b>	<b>KPI ALQR 32a</b>
Health Visitors	88%	<i>Quarterly All above 85% target</i>
School Nurses	87%	
FNP	100%	
LAC	100%	
Safeguarding Team Nurse overall supervision	100%	<b>KPI ALR 32b</b> Full compliance of Acute and Community Safeguarding Nurse Team who have all received quarterly supervision.

### 2.3 Complaints and Incidents

Complaints continue to tell us that parents of children undergoing the safeguarding process are unhappy with the information that they receive in relation to the safeguarding process post referral and the way in which this information is delivered.

This has led to specific changes to level 3 training which incorporates this feedback from families.

Leaflets have been developed and will be introduced to assist staff in communicating effectively with parents about the process that follows safeguarding referral. These will be implemented in early 2017-18 and will clarify the post referral process; what parents should expect and what needs to have taken place before a discharge plan can be implemented. Senior nurses in paediatrics will lead the communication with parents/ carers in these instances. There is also a leaflet clarifying the Skeletal Survey Process as complaints indicated that families found this unnecessarily traumatic at times and did not feel they were well prepared for it when they consented to it.

## 2.4 Incidents and learning reviews including Serious Case Reviews

During 2016-17 the Trust participated in the following number of reviews for children:

2 serious case reviews completed at the request of Birmingham LSCB and 2 more cases were scoped and currently being reviewed by the Birmingham SCR panel.

2 serious case reviews were completed by Solihull LSCB with a further 2 cases scoped for SCR and now being managed as lower level reviews with health uninvolved in one of these.

1 serious case review was launched by Staffordshire LSCB at the end of 2016-17.

1 serious case review was launched by Warwickshire and the Trust is currently completing an internal Management review for this case.

These review highlighted learning for the Trust in relation to:

a) Information sharing at key transition points in services including discharge. It is now a requirement that all children subject to investigations from non-accidental injury have discharge plans agreed by all agencies, the lead consultant and the safeguarding team.

b) Assessing and weighting of risk accurately. In particular recognition of the vulnerability of teenage parents; families who resist or refuse assessment or help; knowledge in relation to male partners/ fathers; stepping cases down in terms of level of intervention without due process and checks being carried out; recognition of the impact of neglect; recognition in relation to the impact of domestic abuse within families.

c) One of the cases highlighted an excellent safeguarding assessment carried out by Emergency Department personnel in relation to a presentation of a serious and unexplained injury in a child under the age of 1 year.

This year as a result of SCRs the Trust has:

- Reviewed the Record Keeping and Assessment Guidelines for Health Visitors
- Carried out training for all health visitors in relation to assessment
- Increased assessment training for all NNU staff
- Designed new assessment documentation for NNU
- Implemented additional supervision in Maternity and Neonatal Assessment, supporting information sharing between these services; challenging assessments and increasing the robustness of discharge planning processes and management of cases by community staff.
- Introduced a requirement for key staff to complete the Graded Care Profile to assist in the identification and response to Neglect.

The Trust has a current **SI** which is reviewing the response to positive toxicology on a child and the recognition of support or further assessment that may be required when children are presented frequently in acute settings.

This case is also being scoped at SCR and involves another provider of children's acute health care.

## 2.5 Recruitment and Disclosure and Barring Processes

The Trust has robust processes in place to ensure that staff are recruited appropriately and this includes policies and procedures outlining expectations in relation to Disclosure and Barring processes.

DBS checks at enhanced level are reviewed and repeated every 3 years and this is managed within HR.

The Trust Safeguarding Children Committee receives and quarterly report detailing the DBS checks completed; any outstanding checks and the resulting outcome following review of any positive disclosures.

This year the Trust has reviewed arrangements for young people coming to the Trust for work experience to ensure that these are standardised.

The Trust is reviewing some processes relating to agency and locum medical staff in 2017-18.

## 2.6 Managing Allegations against Staff Who Work with Children

Where an allegation is made against a staff member that indicates that they may be unsuitable to work with children there is a requirement to notify this to the Local Area Designated Officer employed by the Local Authority.

This occurs where a staff member works with or has contact with children under the age of 18 years and allegations suggest they may have harmed a child or that children could be unsafe in their care.

The process aims to allow full disclosure of information regarding concerns so that employers can complete a robust assessment of transferable risk with key partner agencies. Further details on the criteria for referral are contained in the Safeguarding Children Policy (see section 15).

Allegations may come from a variety of sources including: complaints regarding a staff member; as a result of an internal investigation; as a result of information shared by other agencies in relation to a member of staff (for example the police or Children's Social Care). Allegations regarding the suitability of staff to work with children may arise as a result of the professional or personal lives of staff.

During 2016-17 the Trust referred a total of 8 people to the Local Area Designated Officers. A total of 7 of these worked for the Trust and one referral related to a person treated by the Trust but employed elsewhere and in regular contact with children.

3 referrals related to nurses; 2 to midwives and 2 to medical staff.

1 member of staff has been excluded from working with us and restricted from working in their professional capacity whilst investigations continue.

3 other members of staff had short term restricted working whilst investigations were concluded.

## 2.7 Safeguarding Children Audit Activity

There is an annual audit programme in relation to safeguarding children activity.

This includes regular audits completed quarterly in relation to referral activity; quality and outcome; transfer of safeguarding information at the birth of a child; domestic abuse activity in maternity services. There are annual audits in relation to quality of safeguarding assessments and information sharing at key points of transition - including notification to the LA at the point a 90 day stay is reached.

On completion of audits the full audit plus a summary report are submitted including all recommendations that need to be carried forward.

Audit activity and findings are reviewed and discussed quarterly.

Key audits that are reported quarterly for child safeguarding are:

- Audit priorities for next year will include a quarterly focus on:
- Information shared with partners at the point of referral, transfer and discharge.
- Numbers of early help assessments generated in key areas.
- Quality of safeguarding assessments for vulnerable groups including frequent attenders and 16-18 year olds.

## 2.8 Risks - Safeguarding Children

There are three risks identified in relation to safeguarding children.

These are:

**Information and Information Governance** risk related to the reliance in the Trust on faxing of safeguarding referrals.

NHS not accounts have been established in the Emergency Departments to mitigate risks. This will be in place in paediatrics soon.

There is a risk in relation to the **de-commissioning of the pan- Birmingham Paediatric Liaison Service**. This service enabled onward notification of Emergency Department

Attendances, hospital admissions to relevant community services. A business case has been developed proposing how, with investment the risk could be mitigated.

The third risk is **inappropriate use of clinical holding/ restraint**. A moodle package and other learning resources have been developed and the Trust has worked with the Mental Health Trust to develop a package increasing awareness of common mental health conditions and how these may present in patients in paediatric care. There have been two incidents in paediatrics indicating inappropriate clinical holding and both resulted in staff training needs being identified.

There is an issue to address in relation HEFT assurance that relevant security staff have had access to adequate and appropriate specialist training.

## **2.9 New Developments**

During 2016-17 the Child Protection Information System CPIS was launched nationally and Birmingham Local Authority have successfully uploaded information in relation for children subject to both child protection plans and those children deemed to be in the Care of the Local Authority.

The Trust has implemented use of this system in Maternity and worked toward implementation in the ED. A final date for the full 'go live' in the ED is awaited.

During 2017-18 the Trust will seek to establish use of CPIS in the Paediatric Assessment Areas dependent on establishment of 24 hour clerical cover.

The CPIS system sends an automated message to the LA if a child presents to the unscheduled care setting.

Birmingham LA has rearranged the 'front door' of their children's social work services in order to attempt to ensure that where appropriate families are directed to Early Help rather than statutory social work services.

This decision is made based on a single agency screen of the referral that is received by them and is dependent on the family having consented to the referral.

Early Help Assessment has changed in all local authorities and a move away from the Common Assessment Framework and attempt to simplify early help assessment.

Initiation of early help assessment in maternity and health visiting is low. Staff who require training in relation to new assessment processes have been identified and targeted with additional training and this will continue in 2017-18.

The Trust has clarified its proposed early help offer to Birmingham LA and will seek to do the same to Solihull during 2017-18.

## **2.10 Partnership**

The Trust is a full member of the LSCB in Solihull and sends representation as required to Birmingham Safeguarding Children Board who have rationalised attendance during 2016-17. The Trust has staff placed on a daily basis in Multi-Agency Safeguarding Hubs in Birmingham and Solihull to ensure that where a child is deemed at risk of significant harm relevant information can be shared in as timely a way as possible.

The Trust provides regular specialist advice and support to a variety of LSCB groups to advance working together. This includes participation in multi-agency audit and review, plans for multi-agency training development, review of child deaths and strategic and operational groups tackling child sexual exploitation and FGM.

## **2.11 Section 11 Children Act Compliance**

The Trust has completed an annual audit against all section 11 requirements and reports a 93% compliance rate. The Trust recognises that this year there will be further work to do in relation to: restraint/ clinical holding; defining and delivery of an early help. Additional work will be required as regional policies and procedures are anticipated in 2017-18 and these will need to be linked to the HEFT internal ones.

The Trust undertakes a Peer Review Process with other health providers to quality assure the section 11 scoring and supporting evidence and this supported our internal assessment.

## **2.12 Summary of Safeguarding Children Arrangements**

In summary the Trust has a solid infrastructure in relation to safeguarding which includes accessible policies and procedures; education and development and access for front line staff to specialist safeguarding staff who provide advice and support to frontline staff.

The Trust has increased specialist advice support and supervision in the Emergency Department, Neonatal Units and Maternity during 2016-17.

The Trust is benchmarking continuously against statutory and regulatory requirements and utilising this information to set priorities for development.

The Trust has a rigorous audit programme to test the effectiveness of safeguarding arrangements.

The Trust participates in a variety of partnership activities to support effective safeguarding outcomes for children.

The Trust has further work to do in relation to embedding new early help assessment processes; supporting staff in the use of clinical holding; embedding standardised use of CPIS and reviewing the safeguarding needs of 16-18 year olds.

## **Section 3 Safeguarding adults with care and support needs**

**Author: Lorraine Longstaff - Associate head nurse adult safeguarding**

### **3.1 Adult safeguarding patient story:**

#### **Situation:**

The AHN for Adult safeguarding was contacted by the urology consultant who was seeking advice and support regarding a complex case. Mr Y- a 59 year old man with severe learning disabilities who required surgery under best interest principles. This involved a co-ordinated effort by acute and community services and his family and GP to ensure a safe and legal process.

#### **Background:**

Mr Y had a large package of care at home comprising 2 carers 24 hours per day, a learning disabilities health facilitation nurse and had a close family who lived nearby. In addition to his learning disabilities, Mr Y had autism and was extremely anxious when meeting new people or being exposed to any kind of medical intervention. When anxious he would

become aggressive and sometimes violent. In late 2016 it was diagnosed that Mr Y had a large hydrocele, rectal bleeding, and needed bloods taken. In addition his nails were very long and dirty which was causing him to scratch himself. Mr Y required surgery but was assessed as not having capacity to consent to this so a decision was made to do the surgery in his best interests, but ensuring that any procedure and care plan were the least restrictive options available. Meetings took place between Mr Y's carers, family and health care staff from primary care, the acute and community Trusts. It was imperative to admit Mr Y for the shortest time possible and minimise his distress as much possible during the procedure.

**Assessment:** The following action plan was agreed by all;

- Mr Y would be given a low dose diazepam and brought in the car by his carers, who would be given access by the Trust parking team to a staff car park located near a door which opened half way along the main hospital corridor. This would decrease the amount of time he would be exposed to strangers in the hospital
- Mr Y would be first on the surgical list and would be given a side room of his own with all removable furniture (such as clocks) taken away as he could smash things up when anxious.
- There would be one nurse who dealt with him for the entirety of his stay to provide consistency and his carers would also be with him and would accompany him to theatre. He would have his own music playing as this kept him calm
- He would be given a further sedative if needed then taken to theatre where he would undergo exploration of the hydrocele and rectal bleeding and bloods taken (the GP sent a blood form in with his carers) he would also have his nails cut at this time.
- Mr Y would be recovered in the anaesthetic room and discharged from there to prevent him having to return to the ward which would be another upheaval for him, causing him further distress.

The key issue for future learning is that a procedure such as this cannot be organised in a short time period, indeed it took 3 months to agree the care plan. There were a number of departments that had to be consulted such as parking that would not normally be involved in arranging for someone to undergo surgery. Another key point is remembering that the decision maker will change throughout the patient's journey so the best interest paperwork for Mr Y was completed by a number of people such as the surgeon and GP. Finally it is important to remember the concept of least restrictive practice and of involving the family where possible.

This was also a really good example of partnership working and ensuring that the patient remained at the very centre of the decision making.

### **3.2 Achievements:**

### **3.3 Collaboration and multi-agency working:**

Heart of England NHS Foundation Trust in the past year has continued to strengthen links with multiagency colleagues. The Chief Nurse has been the accountable officer for safeguarding adults and has delegated responsibility to the Head of Safeguarding, the Associate head nurse for adult Safeguarding and the Division 4 Head Nurse to attend the Solihull Local Authority Safeguarding Adults Board (SSAB) and the Birmingham

safeguarding Adult Board (BSAB). In addition, a number of members of staff from HEFT also sit on the operational sub committees related to education and training; quality and audit; Scrutiny and governance

The membership of HEFTs safeguarding adults steering group is chaired by the Associate Head Nurse Adult Safeguarding. It remains multiagency with members from SSAB, BSAB, representatives from educational leads, site head nurses and safeguarding adult's leads from both the Solihull and Birmingham CCGs

Standard agenda items at this board include:

- Reports relating to the number, location and themes of adult safeguarding incidents,
- Lessons learnt
- Progress on safeguarding adults education programmes,
- Partnership working
- Prevent

Other achievements in relation to multi-agency working include joint training initiatives. The Associate Head Nurse for adult safeguarding presented with Solihull local authority on "working with regulated providers" study session. This was an opportunity to enhance working relations with staff from social care and chance to understand each others role and responsibility within safeguarding. In November 2016 we also held a very successful safeguarding conference and had speakers from Action on Hearing Loss, Women's Aid, BLGBT (Birmingham Lesbian, Gay, Bisexual and Trans), Hope for Justice (Anti-Human Trafficking Organisation), Learning Disabilities Specialist Nurse, RSVP (Rape and Sexual Violence Project), West Midlands Police. This collaboration with our external colleagues is a further example of HEFTS commitment to work in partnership with others to safeguard and improve care for our patients that have care and support needs.

Building Relationships - The adult safeguarding team has also been working regularly and closely with:

- Birmingham & Solihull Women's Aid
- Lead Domestic Abuse workers' steering group
- Partnership working with the Risk, Abuse and Violence Programme team, University of Birmingham
- RSVP
- Solihull DA Operational Forum
- Street Community group

### **3.4 Policies and procedures**

HEFT has an up to date safeguarding adult policy and procedure in place which is aligned to the CQC regulatory standards and reflects the Care Act, the SSAB & BSAB policies and Pan West Midlands. The policy is available on the intranet site and the procedure has been uploaded on to the safeguarding adult web page. We have also been promoting and raising awareness of a number of key policies that fall under safeguarding such as missing person, self harm, enhanced observation and clinical holding policy.

We have also developed a number of practical guides for the staff around how to improve practice for patients that present with self harm, risk of absconding and mental health. In December 2016 we also began a trial within our acute assessment areas on GHH & Sol sites a new enhanced observation care bundle ( Key information from a number of policies to help staff manage risk and consequences), which has received very positive comments from the staff. The evaluation report is currently with our Chief Nurse and Head nurses and awaiting decision for its approval, we will then begin roll out across the organisation.

### **3.5 Incidents - Adult Safeguarding Incident data Acute Hospital**

In total **1183** safeguarding adult concerns were reported to date Q1 (307), Q2 (283), Q3 (320), Q4 (273), this was an increase of **136** from last year where there were **1047** safeguarding adult concerns were reported Q1 (260), Q2 (237), Q3 (252), Q4 (298).

The AHN for AS suggest that the increase could be due to a number of reasons - awareness has grown across the organisation and we get referrals from all grades/professional bodies from admin staff to consultants. The training packages that are in place are robust and are given for all levels and have various forms (face to face, moodle, e-learning, leaflets, newsletters etc.). Trust has also invested in the AS team and from July 2015 this went from 1WTE to 2 then December had further support with 2 further staff, this has enabled a stronger site presence and accessibility to the team. We also undertake audits to assess staff knowledge & understanding and this is also a chance to raise awareness and improve practice

<b>Quarter</b>	<b><u>2014 - 2015</u></b>	<b><u>2015 - 2016</u></b>	<b><u>2016 - 2017</u></b>
<b>Q1</b>	246	260	307
<b>Q2</b>	222	237	283
<b>Q3</b>	218	252	320
<b>Q4</b>	231	298	273
<b>Totals</b>	<b>917</b>	<b>1047</b>	<b>1183</b>

These were all categorised following initially reporting as either actual, potential or not safeguarding. An example of actual safeguarding would be financial abuse by a relative or physical abuse by partner/carer. Potential safeguarding can be a non-hospital acquired or hospital acquired pressure ulcers, these would require a root cause analysis and fact finding to determine the cause and it may be that they then become actual. An example of an incident that may be initially described as safeguarding by staff but is not would be a staff injury (caught arm on door) or a cancellation of a clinic.

<b><u>Category</u></b>	<b><u>Q1 - Q4</u> <u>2015-2016</u></b>	<b><u>Q1 - Q4</u> <u>2016 - 2017</u></b>
Actual	570	737
Potential	154	134
Not	323	312
<b>Totals</b>	<b>1047</b>	<b>1183</b>

Reporting is also now as per a Divisional breakdown rather than site specific as per below

<u>Division</u>	<u>Q1</u> <u>Apr - June</u> <u>2016</u>	<u>Q2</u> <u>July - Sept</u> <u>2016</u>	<u>Q3</u> <u>Oct - Dec</u> <u>2016</u>	<u>Q4</u> <u>Jan - Mar</u> <u>2017</u>	<u>TOTALS</u>
1	23	20	12	17	72
2	10	6	8	14	38
3	201	185	218	183	787
4	37	31	44	24	136
5	36	41	38	35	150

### **Deprivation of Liberty (DOLS) applications:**

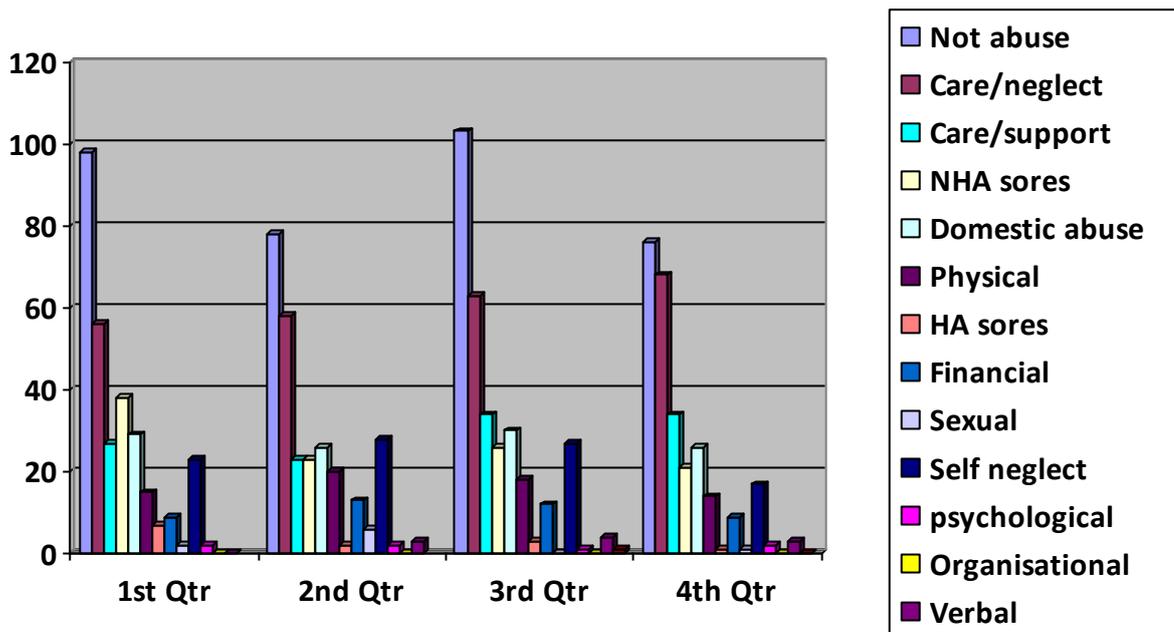
We have seen a steady increase in the number of applications over the year and detailed reports are completed quarterly and circulated to the members of the AS steering group, Head Nurses and champions. Copies are also uploaded onto the AS intranet page

<u>DOLS</u> <u>applications</u>	<u>2014 - 2015</u>	<u>2015 - 2016</u>	<u>2016 - 2017</u>
Q1	29	44	63
Q2	35	48	53
Q3	47	49	58
Q4	47	62	81
Totals	158	203	255

### **3.5.1 Themes and Lessons Learnt**

The high proportion of the reported safeguarding alerts primarily fall into the category of care/neglect, physical abuse, financial, non-hospital acquired pressure ulcers. Monthly divisional reports have been developed and these are copied to the Head Nurses for them to share with Matrons and Sisters and would be discussed at the quality and safety meetings. Lessons learnt are then reported back to the monthly safeguarding adult steering group.

The safeguarding adult web page is fully operational and the Associate Head Nurse for Adult Safeguarding is responsible for ensuring the site is up to date. Staff have access to various resources and information such as; audit results, newsletters, training, procedures for reporting, mental capacity assessment forms, links to NMC, equality and diversity. To date there has been a total of 90,000 hits to the safeguarding adult website



The safeguarding adult scorecard links to the DOH 6 principles of safeguarding these are: Empowerment, Protection, Proportionality, Partnerships, Accountability and Assurance. The scorecard is reviewed quarterly at the safeguarding adult steering group. Copies are distributed to all Head Nurses, Matrons and sisters for them to share with junior members of their teams and also uploaded onto the safeguarding adult website.

Ensuring that learning from SCR's/DHR's/safeguarding incidents are learned across the organisation this is a real challenge given the complexity and size of the organisation. Action plans are monitored via the Adult Safeguarding steering group & Domestic Abuse group meetings.

### 3.5.2 Adult Safeguarding Incident Data community setting:

During this last year the AHN for adult safeguarding has been working closely with the Head Nurse for Division 4 and the Community Senior Nurse to develop an adult safeguarding scorecard for the community teams. In Q3 our first scorecard was launched and we recognise that this will evolve and improve as did our one for the acute services. Main themes reported care and support, skin integrity/pressure ulcers.

Quarter	2016 - 2017
Q1	23
Q2	27
Q3	29
Q4	19
<b>Total</b>	<b>98</b>

### 3.6 Governance and Assurance

A detailed organisational safeguarding scorecard/activity report is provided for our commissioners and LSAB's which shows a breakdown of safeguarding activity by the individual Divisions. The report identifies key lessons learned, emerging themes and is supported by the use of case studies, which reflect on the application of the key safeguarding principles in practice. "Hot spot" areas are monitored and reviewed to ensure that actions are taken to mitigate any risks. See table below which has a summary of reports and various assurance tools, monitoring that is currently in place

<b><u>Requirement/report</u></b>	<b><u>Frequency</u></b>	<b><u>Who to</u></b>
Compliance Report for CQC re: Outcome 7 Reg 13	Quarterly/Bi Annually	Governance & Risk - Compliance Team
Adult Safeguarding Activity - Scorecard	Quarterly	Adult Safeguarding Steering Group, Head Nurses, Clinical Leads, Matrons.
HEFTS Adult Safeguarding Annual Report	Annual	Trust Board, Local SABS
Audit programme - monitoring staff knowledge, understanding of Adult Safeguarding, MCA/DOLS and various policies associated with safeguarding such as clinical holding & Enhanced Observation (specials)	Quarterly	Adult Safeguarding Steering Group Head Nurses/Site Teams
Implementation of action plans from case reviews DHR's, SAR's, SILPS.	Quarterly or as requested by Local SABS	Adult Safeguarding Steering Group, Local SABS (as requested)
Assurance reports to LSAB's	As requested by LSAB's	LSABS & Adult Safeguarding Steering Group
Complaint Monitoring	Quarterly	Site Head Nurses & AS Team
Performance & Quality reviews	Annual programme in place	Site Quality & Safety meetings, Senior Nurse Forums, compliance team
CCG contractual requirements in relation to Adult Safeguarding	Quarterly	CCG, Adult Safeguarding Steering Group
Safe recruitment practice & HR process (DBC-CRB checks) Disciplinary procedures	Quarterly	Adult Safeguarding Steering Group, Site Head Nurses
Hearing the Voice of the patients/Service users/Carers that access HEFT Services	Quarterly	Quality & Safety Meetings Adult Safeguarding Steering group

### **3.7 Audit**

The impact of the implementation of policies and procedures and staff education programmes needs to be measured and HEFT have a robust audit programme, which has been gathering data related to adult safeguarding across HEFT during the last year.

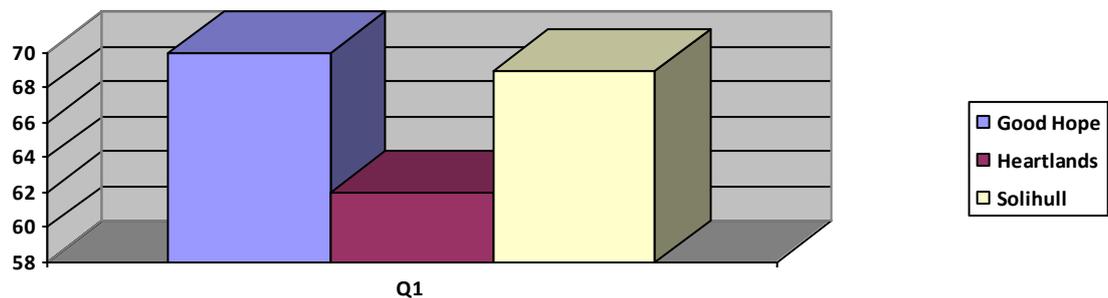
During Q1 the adult safeguarding team focused on staffs knowledge and understanding of the revised clinical holding “restraint” Policy and it’s application to practice. The team developed a structured questionnaire which had 9 questions and was scored out of 10. They randomly selected staff on all three hospital sites and interviewed staff in their clinical areas during Q1 (May & June 2016)

### Results:

A total of 60 staff were interviewed, 20 at Solihull hospital(W8,19, AMU, AMUSS, 20a & 20b), 20 at Heartlands hospital(W8,9, 21, 30, & 24) & 20 at Good Hope hospital (W9, 11, 14, 15, AMU & 24). All the staff were trained registered nurses from B5 - B8a. There were just 2 members of staff that scored 10 out of 10 (B5 W20a Sol & B7 W8 BHH)

### Overall scores:

When all the results were analysed the overall percentage of correct answers were: Good Hope hospital = 70%; Heartlands Hospital = 62%; Solihull hospital =69%.  
Overall score was 66%



### Key Findings:

Overall we were welcomed to the wards and the majority of staff were engaged and happy to be involved. A few staff however appeared quite reluctant but we felt that this may possibly be due to their confidence/lack of awareness of the subject. There were 13 staff in particular (12 B5 staff nurses & 1 B6 Sister) over the 3 sites that only scored between 3 and 5. They gave very limited answers, were unsure and needed prompting. One staff nurse became very mixed up and got the safeguarding process confused and kept referring back to the categories of abuse. There was also an EU nurse on BHH site (W9) who hadn’t been long in post however straight away she recognised her gap in knowledge/understanding and said she would read up about it. For those staff that were unsure this was a good opportunity for the safeguarding team to raise awareness, promote the training and sign post to the various resources and share practice.

The main gaps are awareness of the policy, and how restraint is used and applied in practice. Staff also unclear regarding the various forms of restraint: staff recognise the physical aspect but need to consider the use of sedation and of what equipment (position of beds/tables/lockers) are forms of restraint. Staff were more aware as to what should happen prior to restraining and what they should do during restraint but then post event we did get a mixed response and a number of staff didn't know about reporting or debrief

### Recommendations & Learning

- Discuss & share results with members of the Adult Safeguarding steering group
- Share report with Divisional Head Nurses, Champions & the Senior Nurses
- Share report with members of the MCA & DOLS steering group
- Continue to raise awareness of the policy
- Continue to promote the MCA training package as restraint is included within the new version.

### Mental Capacity Act & Deprivation of Liberty Safeguards (MCA & DOLS)

MCA & DOLS is an important feature within safeguarding and we have both a legal and CQC compliance requirement to ensure that we have robust systems and processes in place that safeguard our patients. In June 2016 we undertook an audit with the compliance manager to do a comparative report from results of Dec/Jan 2015.

The AHN for Adult Safeguarding and Compliance Manager developed an audit tool, the main focus was on Elderly Care, stroke & Trauma and Orthopaedic wards across the 3 sites. They visited 5 wards on BHH site (8, 9, 3, 21 & 30), 5 wards on GHH site (9,11,14, 15 & 24) and 3 on Sol site (8, 19 & 15). The audits took place between May & June 2016

On each of the wards a senior member of the team was identified that could assist the AHN and compliance manager with the audit and we had representation from Senior Sister/deputy/nurse in charge. The electronic handover was printed off for each ward and all the patients were reviewed to determine the following: Did the patient have capacity to make decisions about their care and treatment and if not did they meet the "acid test" whereby they were under continuous supervision and control and not free to leave ? and where appropriate had DOLS been considered/applied?

### Results

GHH site	Ward	No reviewed	No with capacity	Querys	DOLS on day	DOLS in place
	9	30	17	1	0	0
	11	31	25	0	0	0
	14	29	22	0	0	0
	15	29	23	1	0	0
	24	27	15	1	0	1

SOL site	Ward	No reviewed	No. with Capacity	Querys	DOLS on day	DOLS in place
	8	23	14	0	2	1
	19	27	19	0	1	1
	15	21	20	0	0	0

BHH site	Ward	No reviewed	No. with capacity	Querys	DOLS on day	DOLS in place
	8	34	29	2	1	0
	9	34	26	1	0	1
	3	34	30	1	1	0
	21	27	13	6*	3*	2
	30	27	10	6	1	0
<b>Totals</b>		<b>373</b>	<b>263</b>	<b>19</b>	<b>9</b>	<b>6</b>

<b>Last audit</b>	<b>totals</b>	<b>393</b>	<b>298</b>	<b>67</b>	<b>21</b>	<b>6</b>
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\* Following the audit W21 SWS & AS lead nurse reviewed the queries & DOLS and have identified that we were given inaccurate information from the sister that had been on duty and doesn't reflect a true picture.

## Summary

In total we visited 13 wards across the 3 sites - 5 on BHH, 5 on GHH and 3 on Sol, focus on Elderly care, stroke, trauma and orthopaedics. 373 patients were reviewed and out of these 263 had capacity to make decisions about their care and treatment, of the 110 that had impaired capacity we identified 19 queries, 9 DOLS on the day and 6 DOLS already in place. We felt assured that staff were able to evidence the decision making process and involving family/others. Staff were also appropriately delaying the assessments to enable infections/delirium time to resolve and had a clear plan as to what steps/action to take if this didn't change.

Overall we were welcomed to the wards and staff took time out of their busy schedule to enable the audit to be undertaken. Majority of the staff also knew the patients very well and handover was clear and precise.

## Recommendations & Next Steps

- Share report and learning Trust wide using a variety of methods such as present to SA steering group, Senior nurse forums and quality and safety groups meeting, MCA & DOLS steering group.
- Continue to raise awareness of the e-learning moodle package re MCA
- Promote the new capacity assessment forms and the staff guide
- Continue working with the Ambassador wards across all 3 sites
- Promote the B5 & B6 training package for the "hot spot" areas

## 3.8 CCG Assurance Visits

Unannounced visits to **ward 8 & 20a Solihull Hospital** and to **Wards 7, 9 and 11 Good Hope Hospital** were jointly conducted on **27<sup>th</sup> July** and **31<sup>st</sup> August & 28<sup>th</sup> October** by Joe Martin from the CCGs safeguarding team, and Lorraine Longstaff, associate head nurse adult safeguarding HEFT. These visits form part of an on-going series of low key 'snapshot' assurance visits undertaken by the CCG in partnership with the trust, aimed at capturing how effectively safeguarding principles are being applied in practice across the trust.

Key findings and overview:

All the staff we spoke to described a positive and patient centred value base. The staff we spoke to were all aware of their professional responsibilities. They gave us examples of safeguarding situations (including potential financial abuse and potential domestic abuse) which they had picked up on and reported. They could give examples of when certain situations might ring alarm bells for them. All the staff we spoke to said they would feel confident escalating concerns: 'There is always someone senior to ask'.

The staff we spoke to appeared to have been given a very clear message about adult safeguarding on their induction. Some staff were also aware of moodle packages. We heard that drop in training sessions on safeguarding and mental capacity had been delivered. On ward 7 at Good Hope the ward sister had proactively asked the safeguarding team to do this, in order to ensure that her staff were comfortable and knowledgeable about what safeguarding meant in that particular setting and environment.

Based on what staff told us, the core safeguarding responsibility of being sensitive to the possibility that vulnerable persons may sometimes be at increased risk of abuse or neglect appeared to be established. At Good Hope, the fact that some staff clearly had a good relationship with the trust's safeguarding team showed the value of safeguarding nurses having a regular presence on wards. The effect of increased resources within the adult safeguarding team therefore appears to be having a positive effect. Increased routine presence on the wards supports the raising of awareness of safeguarding responsibilities in general, but it also helps in empowering and supporting ward staff to make defensible decisions about the situations they encounter. It helps to make safeguarding everybody's business and it also helps the safeguarding team obtain a clearer picture of the challenges that staff across the trust are encountering.

### **3.9 Equality and Diversity**

The highlights for patients and staff in 2016/2017 included:

- We have become active partners of the Local Health Economy Group, working in collaboration to share equality data and promote and challenge inequalities.

Membership includes:

- West Midlands NHS Regional Equalities Network
- NHS Acute Liaison Learning Disabilities Network
- Birmingham & Black Country Chaplaincy Collaborative
- Pan Birmingham Faith Advocacy Group

- The Trust established Inclusion Steering Group and the Rainbow Friends Network (Staff LGBT Forum) to effectively engage patients and staff to address issues that differentially affect people from one or more of the protected characteristic group and to promote non-discriminatory culture within the organisation.
- The Black History Month was celebrated to honour the achievements and contribution of the Black and Minority Ethnic communities made to the society and especially to NHS. A free conference in collaboration with the University Hospitals Birmingham NHS Foundation was held on 20th October 2016 at Heartlands Hospital and 25 October 2016, at the Queen Elizabeth Hospital. To mark this occasion, a display of life stories taken from the Trust's Black and Ethnic Minority (BME) staff telling their stories of working in the NHS was held at the Good Hope, Solihull, Heartlands and Queen Elizabeth hospital sites. The staff stories display and the conferences were well received and attended by the staff from the two Trusts and colleagues from the local health economy.
- Acute Liaison Learning Disability Health Facilitation Service continued to see more patients
- 10391 face to face and telephone interpreting sessions in 50 languages including BSL (British Sign Language) were provided to patients during the year
- End March 2017, Equality & Diversity/ Human Rights training percentage achieved 93.58%

Mainstreaming equality is central to the work undertaken by the Equality & Diversity leads within the Trust in patient care and workforce areas. The principles of fairness, equality, respect and dignity for patients and staff is widely promoted through training and Equality & Diversity services and events to ensure patients and staff are not discriminated against.

**The Trust's equality objectives for 2016 - 2020 are :**

- We will work together with the local LGBT Community to improve and expand the quality of the information, knowledge and understanding we have about our LGBT service users. We will ensure their experience of our services is improved by being more responsive to their needs.
- We will ensure that our patients are communicated with in a manner that is appropriate to their specific need or requirement within the Trust. We will identify how patients prefer us to communicate with them from the earliest point of contact. Our objective will be to ensure that every time we communicate with them, that we use their preferred method.
- Work to reduce inequalities experienced by existing staff, as well as, those applying for jobs within the Trust from a LGBT background so as to improve the engagement and experiences of LGBT staff within the workplace.
- We will introduce Unconscious Bias and Inclusion training into the mandatory E&D training for all staff and offer an Inclusive Leadership Course for managers to gain the

knowledge in order to ensure all staff are managed fairly and equally and to embrace difference

### 3.10 Priorities for adult safeguarding 2017 - 2018:

Implementation of the revised strategic plan these are now linked to the 6 principles the key aims are detailed below

<b><u>Priority 1 Empowerment</u></b>	<b>Proposed Action</b>	<b>By Whom/Lead</b>	<b>Timeline</b>
<b>Strategic Ambition:</b> That Adult Safeguarding arrangements within HEFT are fully reflective of the needs and priorities of the patients and carers that access our services	<ul style="list-style-type: none"> <li>Seek regular feedback from patient and carers who have been engaged in safeguarding situations</li> </ul>	Adult Safeguarding Team	On-going
	<ul style="list-style-type: none"> <li>Ensure findings of above are reviewed at steering group and used to inform development of practice</li> </ul>	Adult Safeguarding Team	On-going
	<ul style="list-style-type: none"> <li>Explore how information about safeguarding can be presented to public in different formats; how friends, families and carers can be involved to help the individual understand the choices they face: "no decision about me without me"</li> </ul>	Adult Safeguarding Team & Comms	On-going
	<ul style="list-style-type: none"> <li>Family &amp; Friends Test results - share good practice</li> </ul>	Division Head Nurses	
	<ul style="list-style-type: none"> <li>Work in partnership with the LSAB's to embed making safeguarding personal (MSP)</li> </ul>	Adult Safeguarding Team	

<b><u>Priority 2 &amp; 3: Protection &amp; Prevention</u></b>	<b>Proposed Action</b>	<b>By Whom/Lead</b>	<b>Timeline</b>
<b>Strategic Ambition:</b> That HEFT has effective preventative practice in place, to minimise the risk of abuse or neglect occurring and that staff know how to respond to suspected abuse so that patient protected from further harm.	<ul style="list-style-type: none"> <li>Identify ambassador wards to promote best practice in dementia care, and for patients with LD or mental health problems</li> </ul>	Division Head Nurses	
	<ul style="list-style-type: none"> <li>Use patient and public feedback to identify early indicators of potential concern</li> </ul>	Division Head Nurses	On-going
	<ul style="list-style-type: none"> <li>Use quality and incident reports to identify early indicators of potential safeguarding concerns</li> </ul>	Division Head Nurses & Adult	On-going

	<ul style="list-style-type: none"> <li>• Work in partnership with community safeguarding leads to monitor trends across sectors</li> <li>• Develop a safeguarding learning hub. Ensure organisational training packages stress 'early help' interventions and defensible decision making</li> <li>• Map out alternative pathways (non- section 42) for addressing quality and clinical concerns robustly and proportionately</li> <li>• Implement learning from serious cases SAR's, DHR's, SILPS. Devise action plans to embed learning and cascade via AS steering group, NMB. Share with Head Nurses, clinical leads</li> <li>• Domestic Abuse - Work in partnership with Women's Aid to raise awareness Organise Conference Revise the policy &amp; process Develop the Domestic abuse steering group</li> <li>• Continue to raise awareness of Prevent. Revise the HEALTHWRAP training. Monitor &amp; implement actions from the self-assessment document</li> <li>• Continue to raise awareness of categories of abuse &amp; how to respond</li> <li>• Develop the role of the Adult Safeguarding Champions</li> <li>• AS policy and procedures in place that are robust and clear to staff</li> </ul>	<p>Safeguarding Team Adult Safeguarding Team Safeguarding Trainer &amp; AS Team AHN Adult Safeguarding with Adult Safeguarding LA Leads Division Head Nurses Adult Safeguarding Team Prevent Lead &amp; Adult Safeguarding Team Adult safeguarding team Adult safeguarding team Adult safeguarding team</p>	<p>On-going &amp; case by case</p>
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<b><u>Priority 4 - Proportionality</u></b>	<b><u>Proposed Action</u></b>	<b><u>By Whom/Lead</u></b>	<b><u>Timeline</u></b>
<p><b><u>Strategic Ambition</u></b> Ensure that HEFT is compliant with the application of MCA, DOLS and use of restraint within practice</p>	<ul style="list-style-type: none"> <li>• Continue to promote the Moodle MCA package for all clinical staff</li> <li>• Monitor the work plan via the AS steering group</li> </ul>	<p>Division Head Nurses, matrons</p>	<p>On-going Quarterly</p>

	<ul style="list-style-type: none"> <li>• Re-audit compliance during Q2 &amp; Q4</li> <li>• Target training to the “hot spot” areas</li> <li>• Develop case studies</li> <li>• Work in partnership with the CCG project team for MCA &amp; DOLS</li> <li>• Share practices from other Local trusts &amp; network</li> <li>• Develop the Adult safeguarding champions</li> </ul>		<p>completed</p> <p>On-going</p> <p>completed</p> <p>On-going</p> <p>Launch held Feb 2017</p>
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<b><u>Priority 5: Partnership working</u></b>	<b>Proposed Action</b>	<b>By Whom/Lead</b>	<b>Timeline</b>
<p><b>Strategic Ambition</b> That HEFT works collaboratively with the Local SAB's, other services, teams and agencies to ensure that all patients experience a personalised and individual response when safeguarding concerns are raised</p>	<ul style="list-style-type: none"> <li>• Explore representation from external groups on AS steering group</li> </ul>	AHN Adult Safeguarding	Completed
	<ul style="list-style-type: none"> <li>• Cascade newsletters, bulletins, and resources from external links</li> </ul>	Adult Safeguarding Team	On-going
	<ul style="list-style-type: none"> <li>• Continue to develop working relations with hospital based social work teams</li> </ul>	Adult Safeguarding Team	On-going
	<ul style="list-style-type: none"> <li>• Establish local agreement on HEFT's contribution to sec42 enquiries</li> </ul>		
	<ul style="list-style-type: none"> <li>• Develop improved systems for picking up and communicating issues on admission, discharge with nursing homes</li> </ul>	Division Head Nurses	
	<ul style="list-style-type: none"> <li>• Update the messages on Trust Intranet safeguarding page to reflect the MSP agenda</li> </ul>	Adult Safeguarding Team	
	<ul style="list-style-type: none"> <li>• AHN Adult Safeguarding &amp; Lead for Social Care to present to Senior Nursing staff key messages (package developed in partnership with BSAB)</li> </ul>	AHN Adult Safeguarding	Completed
<ul style="list-style-type: none"> <li>• Training to be revised to link in with the Care Act &amp; MSP Level 3 for Senior Srs, Matrons to be developed</li> </ul>	AHN Adult Safeguarding	Completed	

<b>Priority 6: Accountability - Assurance &amp; Governance</b>	<b>Proposed Action</b>	<b>By Whom/Lead</b>	<b>Timeline</b>
<p><b>Strategic Ambition</b> That HEFT is compliant with CQC regulations, the Care Act, and local &amp; national guidance around adult safeguarding.</p> <p>Implement the Quality Assurance Framework to ensure HEFT has an effective system in place for Adult Safeguarding</p>	<ul style="list-style-type: none"> <li>Review membership of the Steering group &amp; TOR</li> <li>Maintain an accurate dashboard picture of safeguarding activity across organisation</li> <li>Ensure key safeguarding challenges and risks are identified and escalated appropriately within organisation</li> <li>Ensure there is suitable organisational representation in local Safeguarding Board structures; ensure key practice issues and local challenges /developments are fed back to steering group</li> <li>Review and update policy and procedure as required</li> <li>Publish an Annual safeguarding report which includes a review of organisational compliance</li> <li>Develop the quality assurance framework</li> <li>Review audit programme. Involve SA lead from CCG &amp; compliance manager</li> <li>Explore options for external peer review/audit</li> <li>Work in partnership with PALS manager to capture feedback from patients and their carers</li> <li>Produce training needs analysis and training data.</li> <li>Report on patient outcomes</li> <li>Report on training activity</li> <li>Report on MCA activity</li> <li>Report on DOLS activity</li> </ul>	<p>AHN Adult Safeguarding</p> <p>AHN Adult Safeguarding</p> <p>Division Head Nurses &amp; Adult Safeguarding Team</p> <p>Division Head Nurses &amp; AHN Adult Safeguarding</p> <p>AHN Adult Safeguarding</p> <p>AHN Adult Safeguarding</p> <p>AHN Adult Safeguarding</p> <p>AHN Adult Safeguarding</p> <p>Adult Safeguarding Team</p> <p>Adult Safeguarding Team</p> <p>Adult Safeguarding Team</p>	<p>Completed</p> <p>Quarterly</p> <p>On-going</p> <p>On-going</p> <p>December 2018</p> <p>completed</p> <p>completed</p> <p>On-going</p> <p>Review annually</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p>

**Section 4 Domestic Abuse**

**4.1 Domestic Abuse**

**4.2 Definition**

Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional
- controlling and coercive behaviour

### 4.3 Infrastructure

The Trust has a Domestic Abuse Steering Group that reports to the Safeguarding Child and Adult Committees.

The Steering Group carries out benchmarking activity in relation to Domestic Abuse Standards and oversees training activity and improvement plans including service improvement and the implementation of recommendations from Domestic Homicide Reviews.

The Trust has a Safeguarding Adult Lead Nurse for Domestic Abuse and a Specialist Midwife for Domestic Abuse. Their roles including the establishment of education and development programmes to assist frontline staff with identification and management of domestic abuse, to provide advice and support in relation to individual cases and establishment of systems to support best practice.

### 4.4 Rates of Domestic Abuse Identified

#### 4.4.1 Domestic Abuse and Children

The Trust identifies adult domestic abuse as an issue in relation to child safeguarding both in maternity and other settings.

The table below illustrates the total number of **child safeguarding referrals that cite concerns regarding parental domestic abuse** as one of the reasons that is causing concern for the safety of the children.

Quarter	Qtr 1	Qtr 2	Qtr 3	Qtr 4
No. of Child referrals citing DA	156	122	135	154

In many instances the concern regarding domestic abuse co-exists with other concerns regarding parents including mental health issues or substance misuse problems. Audits in maternity suggest that this is the case in approximately 55%-60% of all cases where domestic abuse is identified.

#### 4.4.2 Adults identified as victims of domestic abuse

For financial year April 2016- March 2017 there were **362** adults identified as victims of domestic abuse within the Trust. This information comes from a variety of sources:

- Referrals to social Care completed on the children of victims (primary source of data in relation to domestic abuse currently)
- Referrals to Adult Social Care where this is indicated (also reported via the Trust Incident Reporting Mechanism)
- Requests for advice to the safeguarding team

Quarter:	Q1	Q2	Q3	Q4	Percentage of total cases
Area where domestic abuse identified	Number	Number	Number	Number	
Emergency areas (incl. ED, MIU etc.)	61	34	49	50	54%
Children & Families (incl. maternity, paediatrics etc.)	36	27	31	34	35%
Wards (incl. general wards)	4	9	4	5	6%
Other areas	2	8	4	4	5%
<b>Totals</b>	<b>103</b>	<b>78</b>	<b>88</b>	<b>93</b>	<b>100%</b>

In quarter 4 2016-17 collation of the response to the domestic abuse was collated for the first time. This demonstrated that 28% of cases identified pertained to households with no children. This equated to 26 of the 93 reports that quarter. These were notified to the Adult Safeguarding Team following referral of the adult victim indicating that these were likely to be adults perceived to have care and support needs and to have compromised ability to keep themselves safe.

From quarter 1 2017-18 the data will also highlight the number of adult victims that have care and support needs.

Data will also reflect numbers of staff employed by the Trust who are victims of domestic abuse.

**4.4.3 Maternity services** operate standardised routine inquiry in pregnancy. Through this mechanism and through the social assessment completed in the antenatal period they identify the majority of cases notified to the specialist midwife for domestic abuse. This is recommended good practice as pregnancy is known to be a time when domestic abuse starts or escalates.

The majority of domestic abuse cases are identified in early pregnancy (61% identified before 26 weeks) allowing sufficient time for risk assessment; sign posting; early help or another appropriate intervention or statutory intervention aimed at ensuring planning for the safety of the victim, the unborn infant and other family members.

Notifications to the Specialist Midwife come mainly from midwives (58% of all notifications) using routine inquiry and social assessment or from the police who share information in relation to domestic abuse call outs to households with children or pregnant mothers (23%). The Specialist Midwife will attend MARAC (Multi-Agency Risk Assessment Conferences) in relation to any very high risk pregnant women to ensure that maternity services are fully cited on the safety plans for victims.

Maternity Services report that Erdington and Chelmsley Wood are consistently the locations associated with pregnant women identified as being subject to domestic abuse. It is thought that the location of some refuges may influence this.

The average age of the women identified as subject to domestic abuse in maternity services is 27 years with the youngest being aged 16 years old.

## 4.5 Policy and Procedures

- The Trust updated the Domestic Abuse Policy in 2016-17.
- This now includes the new legislation in relation to coercive control.
- The policy includes how to support staff who are victims of domestic abuse and how to support male victims of domestic abuse.

#### **4.6 Partnership**

- The Trust has a strong partnership with Women's Aid and they have provided a service on site for HEFT patients in Maternity and in the Emergency Department. This service will not be available in 2017-18 due to funding cuts.
- The Trust works closely with the Community Safety Partnership teams who have identified DA leads within the Local Authority.
- The Trust works closely with partners in social care and police on a case by case basis to ensure the safety of victims and their children.
- The Trust ensures there is appropriate representation at MARAC and participation in the Domestic Homicide review Process

#### **4.7 Training**

- All clinical staff receive basic information in relation to domestic abuse including the importance of safety considerations and, where necessary, use of interpreting services when making inquiries. This is included in level 2 safeguarding training,
- All of the Level 3 safeguarding children workforce (this includes all ED clinical staff) receive training in relation to domestic abuse and the impact on children.
- The Trust delivers further specialist training in relation to domestic abuse in the maternity setting; the community setting and during 2016-18 introduced training in how to inquire safety regarding domestic abuse in the Emergency Department.
- During 2016-17 the Trust completed a robust training needs analysis for community service staff and there are plans for training that will include risk assessment processes for community staff in 2017-18.
- Human Resource Managers will also receive some bespoke training to help them support staff where domestic abuse has been disclosed or identified.
- Trust has bought in bespoke domestic abuse training sessions for staff in targeted areas. The first round of training will be delivered to 32 senior staff from specific work areas, with the option of further sessions at a later date.
- In 2016 HEFT ran a series of successful safeguarding conferences across its hospital sites. The subjects that were taught included:
  - I. the nature and prevalence of domestic abuse
  - II. domestic abuse in pregnancy and police responses and referrals
  - III. domestic abuse in the LGBT+ community
  - IV. responding to disclosures of rape and sexual violence in a trauma-informed way
  - V. managing disclosures of trauma from people with learning disabilities
  - VI. human trafficking

The conferences were attended by 300 staff members from a diverse range of disciplines and evaluated very well.

#### **4.8 Learning from Domestic Homicide Reviews**

- Learning highlights the need to consider the domestic abuse with patients present repeatedly with multiple vulnerabilities in relation to mental health, substance misuse, self-neglect.
- To consider the needs of children and ensure referral for children in relation to male patients with substance misuse and mental health issues.

#### **4.9 Key Developments for Domestic Abuse for 2017-18**

- The lead nurse for domestic abuse is undertaking a project with a consultant in

emergency medicine to formulate a process for identifying repeat attenders to emergency (particular those presenting with the trio of risks) in order to detect and safely respond to domestic abuse. This has occurred following learning from a domestic homicide review.

- The lead nurse has put together a business plan to employ IDVAs in each of its maternity and emergency departments and immediate plans are to pursue the business plan and roll out the service upon an effective bid. If successful, it will make HEFT the foremost acute service in responding to domestic abuse and will become the field leader.
- HEFT has been accepted onto a pilot project to train a Trusted Professional. The aim of this role is to ensure that opportunities to help survivors of domestic abuse are not missed, and that enquiries about the survivor's experience are conducted in a safe and trauma-informed way. The Trusted Professional scheme aims to identify survivors with vulnerabilities that are often overlooked, such as older women or those with a disability.
- There are a further set of Safeguarding Adult conferences planned for 2017 and there will once again be a strong focus on domestic abuse.

## Section 5 Conclusion

The Trust has developed a strong infrastructure in relation to safeguarding governance. There is a critical mass of specialist staff who are able to ensure that the Trust has capacity and capability to meet all statutory and regulatory requirements in relation to adult and child safeguarding.

The Trust has highlighted above, key achievements and improvements for safeguarding adults, children and in the work that Trust staff do in relation to identification and response to domestic abuse.

In the next 12 months the Trust will be aiming to improve safeguarding practice in the following ways:

- Enhancing the ability of a large cohort of key staff to articulate the implications of the mental capacity act to their practice
- Ensuring that restraint and clinical holding processes are fully understood and followed
- Defining and delivery of an early help offer to families in receipt of maternity and community services.
- Increasing scrutiny of attendances of high risk groups including frequent attenders and 16 -18 year olds.
- Exploring the safeguarding implications of transfer of services/ organisational changes.
- Maintaining the focus on safeguarding audit to test the effectiveness of safeguarding arrangements and practice

**HEART OF ENGLAND NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS**

**MONDAY 23<sup>RD</sup> OCTOBER 2017**

<b>Title:</b> 2016-17 Annual Nursing and Midwifery Revalidation Board Report							
<b>From:</b> Julie Tunney (Interim Chief Nurse) and Andrea Field (Associate Head Nurse, Workforce)						<b>To:</b> Board of Directors	
<b>The Report is being provided for:</b>							
Decision	<b>N</b>	Discussion	<b>Y</b>	Assurance	<b>Y</b>	Endorsement	<b>N</b>
<b>Purpose:</b>							
<p>The purpose of this report is to provide assurance to the Board that nursing and midwifery revalidation systems and processes are robust and functioning effectively.</p>							
<b>Key points/Summary:</b>							
<p>This is the annual assurance report to the Board of Directors on the revalidation of nurses and midwives across the Trust. Revalidation is the process that nurses and midwives in the UK have to follow to maintain their registration with the Nursing and Midwifery Council (NMC). Revalidation came into effect from April 2016 with each registrant having to revalidate to the NMC every third year to demonstrate that they are practicing safely and effectively. Failure to revalidate results in the registrant being suspended from the NMC register until proof of safe and effective practice is provided to the regulator.</p> <p>This report covers the period from September 2016 to September 2017. During this period 1,661 nurses/midwives completed their revalidation. There have been no incidents of failure to revalidate across this period. Whilst revalidation is encouraged via individual line management and the appraisal process there is no statutory requirement from the NMC for this to happen. Registrants can have their revalidation evidence confirmed by any NMC registrant prior to submission.</p> <p>Each nurse/ midwife is responsible for maintaining their own registration status and providing proof of valid registration with the NMC to their line managers. However the Trust has a responsibility in terms of patient safety and governance to ensure that all nurses and midwives maintain their registration. To assist with this each manager is provided with notification from Employee Services / E-rostering team as to when their staff are due to revalidate and it is the line manager's responsibility to ensure that all of their registrants maintain live registration with the NMC. Registered nurses that work only via the clinical bank have their revalidation and registration monitored by the Clinical Lead for temporary staffing.</p> <p>The Corporate Nursing team provide advice and support to registrants and those responsible for confirming revalidation evidence. Training continues bi-monthly as well as access to Moodle e-learning materials. One to one support is also provided to individual registrants as requested.</p>							
<b>Recommendation(s):</b>							
<p>The Board is asked to consider the information set out above.</p>							

<b>Assurance Implications:</b>			
Board Assurance Framework	Y	BAF Risk Reference No.	N/A
Performance KPIs year to date	Y	Resource/Assurance Implications (e.g. Financial/HR)	Y
Information Exempt from Disclosure	N	If yes, reason why.	
Identify any Equality & Diversity issues			
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>			
Operational Workforce Committee			

# HEART OF ENGLAND NHS FOUNDATION TRUST

## BOARD OF DIRECTORS

**MONDAY 23 OCTOBER 2017**

<b>Title:</b> Finance Report to 30 September 2017							
<b>From:</b> Interim Director of Finance				<b>To:</b> Board of Directors (23 October 2017)			
<b>The Report is being provided for:</b>							
Decision	N	Discussion	Y	Assurance	Y	Endorsement	N
<b>Purpose:</b>							
Provide an update on the Trust's financial position for the period ending 30 September 2017 (Month 6 2017/18).							
<b>Key points/Summary:</b>							
<ul style="list-style-type: none"> <li>• The Trust agreed a planned deficit of (£28.8m) pre Sustainability and Transformation Funding (STF) for the 2017/18 financial year.</li> <li>• The full STF allocation for the Trust is £21.3m subject to financial performance. Of this, 30% (£6.4m) is also tied to A&amp;E performance.</li> <li>• Including full STF, the Trust has a planned deficit of (£7.5m) for the year in line with the control total required by NHSI.</li> <li>• The in-month position is a deficit of (£5.8m) against a planned deficit pre STF of (£2.4m), an adverse variance of (£3.4m).</li> <li>• The year to date position at month 6 is a deficit of (£28.6m) against a planned deficit pre STF of (£14.5m), an adverse variance of (£14.1m).</li> <li>• The reported position excludes the allocation of STF for the year to date due to the adverse financial position against the plan.</li> <li>• A revised year-end forecast has been submitted to NHS Improvement indicating a likely deficit of circa (£48.4m) compared to a pre-STF planned deficit of (£28.8m) i.e. an adverse variance of (£19.6m). This is predicated on NHS clinical income returning to plan.</li> <li>• The cash balance is £16.4m at 30 September 2017, including (£9.8m) of interim revenue support (working capital loan).</li> <li>• The Use of Resources Metric (UoR) is a 3.</li> </ul>							
<b>Recommendation(s):</b>							
The Board of Directors is requested to:							
<ul style="list-style-type: none"> <li>• Receive the contents of this report</li> </ul>							
<b>Assurance Implications:</b>							
Board Assurance Framework	Y	BAF Risk Reference No.					
Performance KPIs year to date	Y	Resource/Assurance Implications (e.g. Financial/HR)				Y	
Information Exempt from Disclosure	N	If yes, reason why. Financial					
Identify any Equality & Diversity issues		N/A					
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							
None							

# HEART OF ENGLAND NHS FOUNDATION TRUST

## BOARD OF DIRECTORS

MONDAY 23 OCTOBER 2017

### FINANCE REPORT FOR THE PERIOD ENDING 30 SEPTEMBER 2017

#### PRESENTED BY THE INTERIM DIRECTOR OF FINANCE

##### 1. Introduction

This report covers the first six months of the 2017/18 financial year, for April to September 2017. The report summarises the Trust's financial performance and includes information on healthcare activity, expenditure variances and Cost Improvement Programme (CIP) delivery.

The Financial Plan agreed by the Board of Directors on 23 January 2017 included a pre Sustainability and Transformation Fund (STF) deficit of (£28.8m) for 2017/18. The Trust's STF allocation is £21.3m which if received in full would reduce the Trust's plan deficit to (£7.5m) in line with the control total mandated by NHS Improvement (NHSI).

The Trust has reported an actual deficit of (£5.8m) for September 2017 (month 6) compared to a pre STF planned deficit of (£2.4m), an adverse variance of (£3.4m). This moves the year to date deficit to (£28.6m) against a planned deficit pre STF of (£14.5m), an adverse variance of (£14.1m).

The key variances against the plan year to date include:

- Under-performance against clinical income targets (£4.4m);
- Under-delivery against CIP targets (£2.6m) – of which (£0.7m) is a gap in the programme, (£1.3m) relates to phasing and (£0.6m) relates to slippage against planned delivery; and
- Under-delivery against FRP/stretch savings target (£4.7m) – of which (£3.1m) is a gap in the programme, (£0.6m) relates to phasing and (£1.0m) relates to slippage.
- Non-identification of recurrent savings to replace 2016/17 non-recurrent benefits of (£3.8m).

As a result of the adverse financial performance, the allocation of STF year to date (£3.3m in quarter 1, £4.2m quarter 2) totalling £7.4m, has not been recognised and this forms part of the (£28.6m) year to date deficit.

A revised year end forecast has been submitted to NHSI indicating a likely deficit of circa (£48.4m) by the end of the year, compared to the original pre-STF deficit of (£28.8m), an adverse variance of (£19.6m). Further details are set out in section 2.7.

The cash balance at the end of September is £16.4m against the plan of £3.0m at this point, a favourable movement of £13.4m. However, this includes a £9.8m working capital loan.

## 2. Income & Expenditure

### 2.1 Summary Position

The Trust's income and expenditure position as at the end of September is a (£28.6m) deficit against the planned deficit pre STF of (£14.5m).

Table 1 below details the actual income and expenditure deficit compared to the planned trajectory submitted to NHS Improvement both pre and post STF allocation.

**Table 1: I&E – Actual vs Plan**

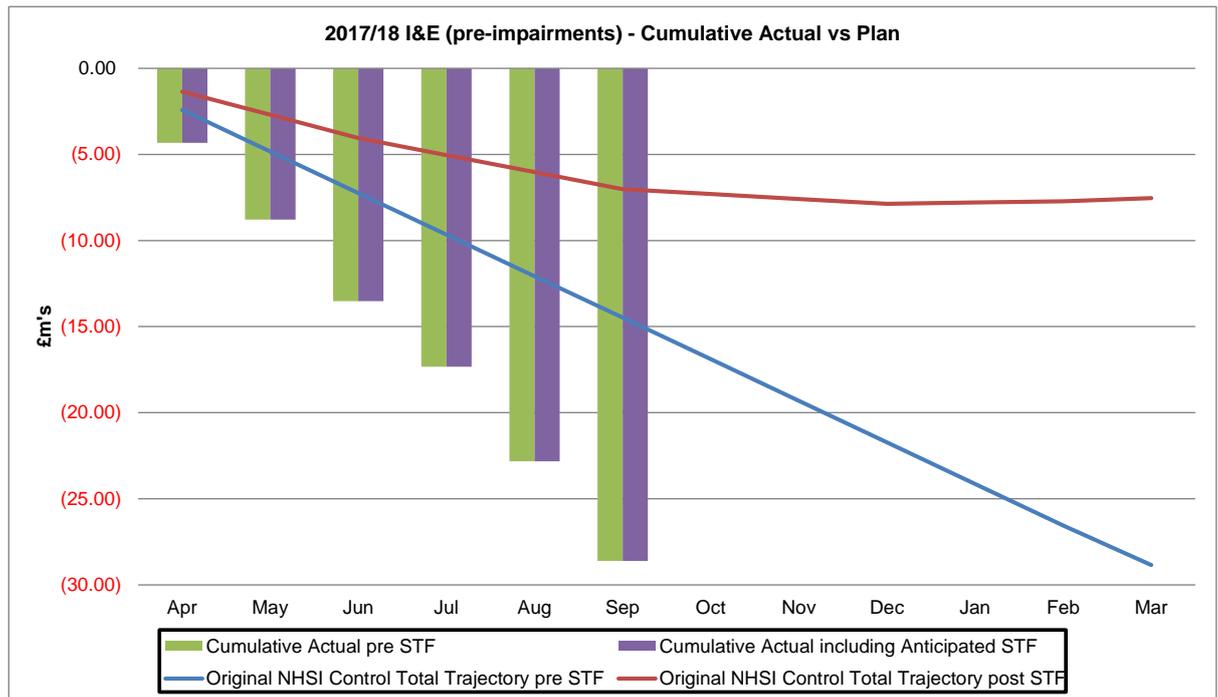


Table 2 below summarises the Trust's income and expenditure position at the end of September with analysis of expenditure from section 2.2 and operating revenue from section 2.6 below.

**Table 2: Income and Expenditure Plan vs Actual**

	In Month Plan	In Month Actual	In Month Variance	YTD Plan September	YTD Actual September	Variance
	£m	£m	£m	£m	£m	£m
<b>Control Total Items</b>						
Operating Revenue (excluding STF)	58.5	56.4	(2.1)	350.8	343.0	(7.8)
Operating Expenses	(58.9)	(61.2)	(2.2)	(353.7)	(361.3)	(7.6)
<b>EBITDA</b>	<b>(0.5)</b>	<b>(4.8)</b>	<b>(4.3)</b>	<b>(2.9)</b>	<b>(18.2)</b>	<b>(15.3)</b>
Depreciation	(1.3)	(1.0)	0.3	(8.0)	(7.7)	0.3
Interest Receivable	0.0	0.0	0.0	0.0	0.0	0.0
Interest Payable	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
PDC Dividend	(0.5)	0.1	0.6	(3.2)	(2.6)	0.6
Other Finance Costs	(0.1)	(0.0)	0.0	(0.3)	(0.0)	0.3
<b>Control Total Surplus/(Deficit) (pre STF)</b>	<b>(2.4)</b>	<b>(5.7)</b>	<b>(3.3)</b>	<b>(14.5)</b>	<b>(28.5)</b>	<b>(14.0)</b>
STF Income	1.4	0.0	(1.4)	7.5	0.0	(7.5)
<b>Control Total Surplus/(Deficit) (post STF)</b>	<b>(1.0)</b>	<b>(5.7)</b>	<b>(4.7)</b>	<b>(7.0)</b>	<b>(28.5)</b>	<b>(21.5)</b>
Gain/(Loss) on Asset Disposal	0.0	(0.1)	(0.1)	0.0	(0.1)	(0.1)
Donations and Grants Received	0.0	0.0	0.0	0.0	0.0	0.0
Depreciation on Donated Assets	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total Surplus/(Deficit) Before Impairments</b>	<b>(1.0)</b>	<b>(5.8)</b>	<b>(4.8)</b>	<b>(7.0)</b>	<b>(28.6)</b>	<b>(21.6)</b>
Impairment (Losses) / Reversals	0.0	0.0	0.0	0.0	0.0	0.0
<b>Surplus / (Deficit) After Impairments</b>	<b>(1.0)</b>	<b>(5.8)</b>	<b>(4.8)</b>	<b>(7.0)</b>	<b>(28.6)</b>	<b>(21.6)</b>

## 2.2 Operating Expenditure Analysis

The adverse operating expenditure variance of (£2.2m) in month and (£7.6m) year to date can be broken down as detailed in table 3 below.

**Table 3: Breakdown of Variance against Plan**

	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance
	£m	£m	£m	£m	£m	£m
<b>PAY</b>						
Medical Staff	10.7	11.4	(0.7)	63.1	66.7	(3.6)
Nursing	14.6	15.3	(0.7)	88.3	92.5	(4.2)
Other	12.2	11.5	0.6	73.3	69.8	3.5
<b>Total Pay</b>	<b>37.5</b>	<b>38.2</b>	<b>(0.8)</b>	<b>224.7</b>	<b>229.1</b>	<b>(4.3)</b>
<b>NON PAY</b>						
Drugs	6.2	6.2	0.0	37.3	37.5	(0.3)
Clinical Supplies & Services	6.0	6.3	(0.3)	36.0	36.4	(0.4)
Other	9.3	10.4	(1.1)	55.7	58.3	(2.6)
<b>Total Non Pay</b>	<b>21.5</b>	<b>23.0</b>	<b>(1.5)</b>	<b>129.0</b>	<b>132.2</b>	<b>(3.2)</b>
<b>GRAND TOTAL</b>	<b>58.9</b>	<b>61.2</b>	<b>(2.2)</b>	<b>353.7</b>	<b>361.3</b>	<b>(7.6)</b>

The main areas of pay and non-pay variance are explored further in sections 2.3 and 2.4 below.

## 2.3 Pay Analysis

Table 4 below details the average monthly pay expenditure each quarter through 2016/17 (adjusted for 2017/18 pay inflation) in comparison to the quarters 1 and 2 averages in 2017/18.

**Table 4: Quarterly Average Monthly Pay Expenditure**

	2016/17				2017/18		
	Qtr 1 Avg	Qtr 2 Avg	Qtr 3 Avg	Qtr 4 Avg	Qtr 1 Avg	Qtr 2 Avg	Mth 6
MEDICAL & DENTAL	10.5	10.5	11.0	11.0	10.9	11.3	11.4
NURSING & MIDWIFERY	15.3	14.9	15.1	15.5	15.5	15.4	15.3
OTHER SUPPORT STAFF	4.8	5.0	4.8	4.8	4.8	4.8	4.8
PAMS	2.2	2.2	2.2	2.2	2.2	2.3	2.3
PROFESSIONAL & TECHNICAL (PTB)	2.3	2.2	2.3	2.3	2.4	2.3	2.3
SCIENTIFIC & PROFESSIONAL	0.6	0.7	0.6	0.6	0.6	0.6	0.6
TRUST BOARD	1.8	1.7	1.6	1.5	1.6	1.6	1.6
<b>Pay Total</b>	<b>37.4</b>	<b>37.3</b>	<b>37.7</b>	<b>37.9</b>	<b>38.0</b>	<b>38.3</b>	<b>38.2</b>

Overall the monthly average pay costs have increased by a further (£0.3m) in quarter 2 compared to quarter 1, predominantly within medical staffing. The main areas of increase compared to quarter 2 of 2016/17 (after inflation adjustment) relate to Medical staffing (increase of £0.8m) and Nurse staffing (increase of £0.5m).

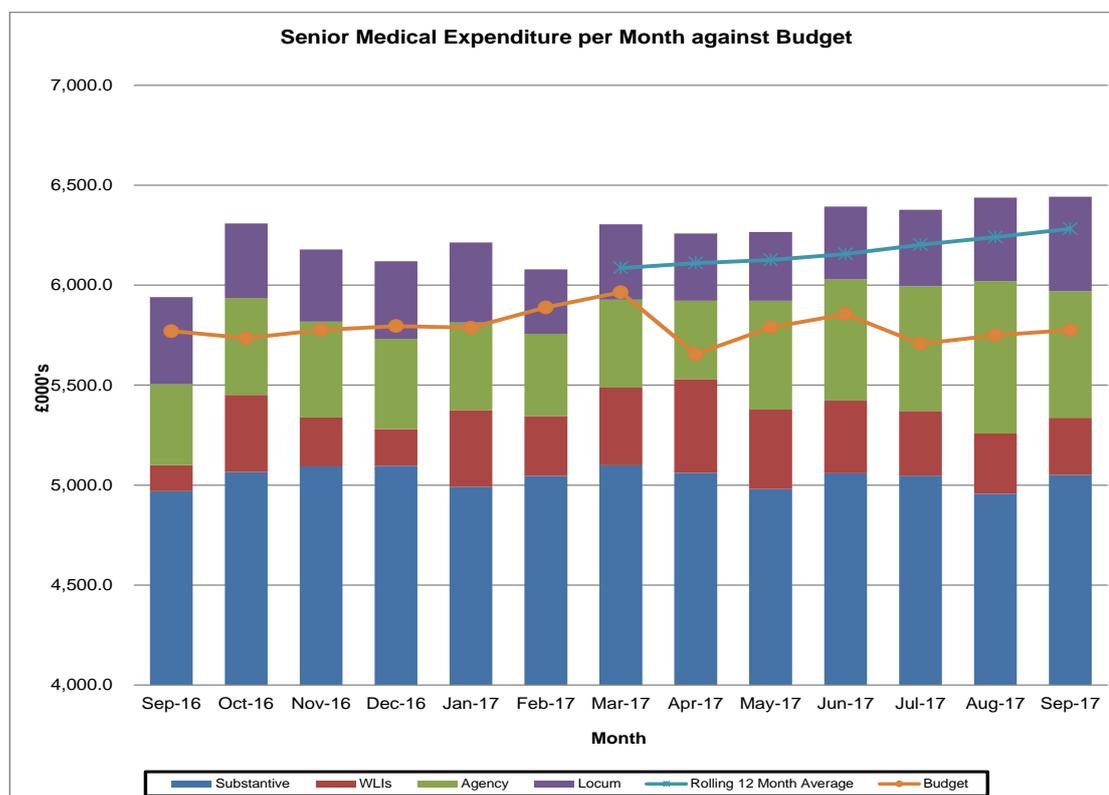
### 2.3.1 Medical Staffing

Tables 5.1 and 5.2 below detail the monthly expenditure for medical staff split between consultant and non-consultant posts respectively.

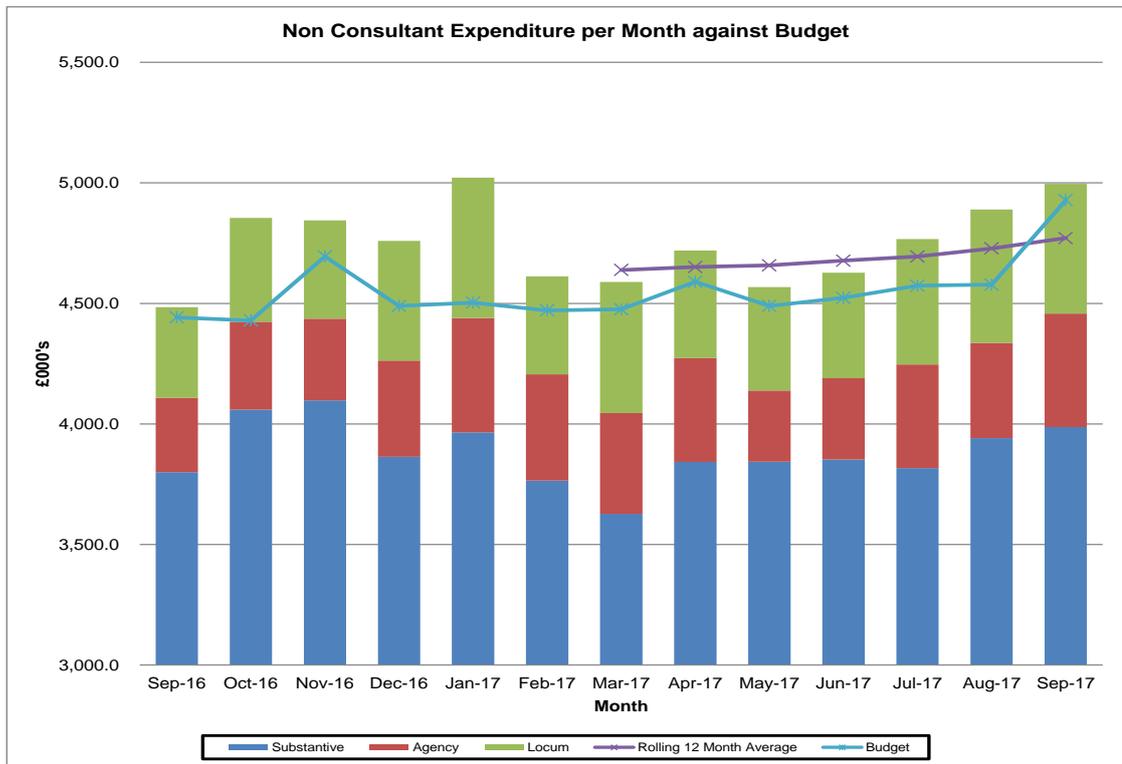
Total medical expenditure was £11.4m in September, which is (£0.1m) higher than the expenditure in August and is (£0.5m) higher than the rolling twelve month average (adjusted for pay inflation) overall.

The September expenditure on consultant medical staff was £6.4m which is broadly in line with August. September expenditure on non-consultant staff was £5.0m which is a further (£0.1m) higher than in August.

**Table 5.1: Senior Medical Expenditure per Month**



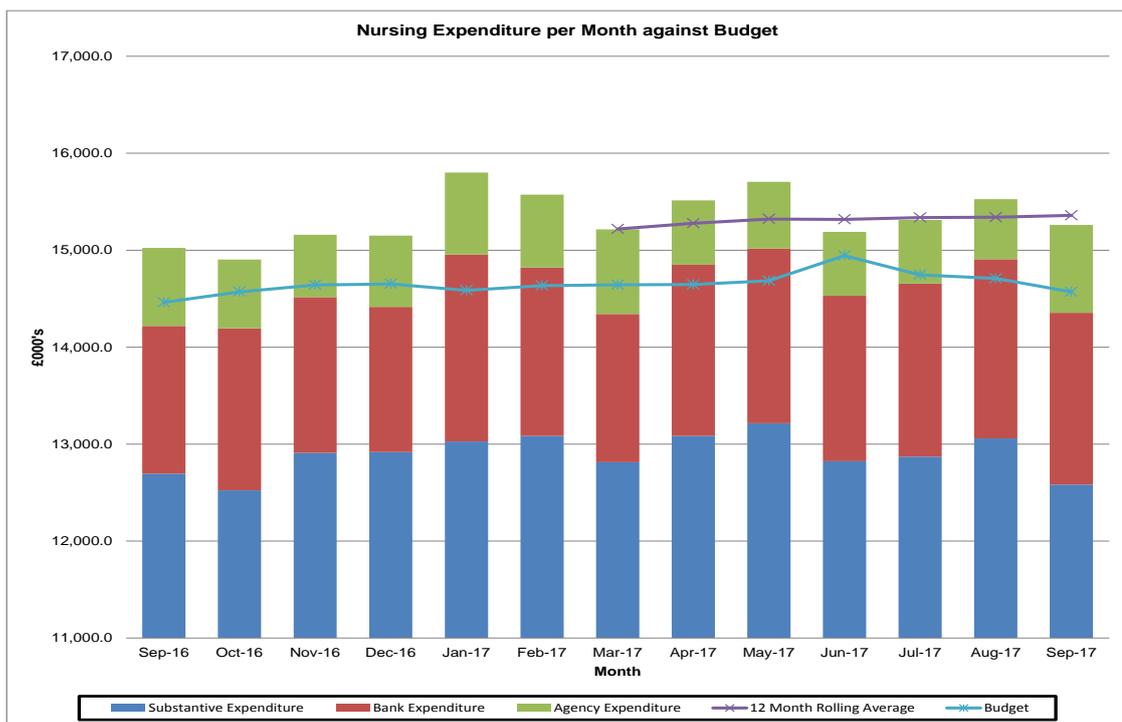
**Table 5.2: Non-Consultant Medical Expenditure per Month**



**2.3.2 Nursing**

Table 6 below details the monthly expenditure on nursing compared to the previous twelve months (adjusted for pay inflation).

**Table 6: Monthly Nursing Expenditure**



Total nursing expenditure in September was £15.3m which is £0.2m lower than the expenditure in August and is £0.1m lower than the rolling 12 month average (adjusted for pay inflation).

## 2.4 Non Pay Expenditure

Table 7 below details the average monthly non pay spend each quarter by expenditure group through 2016/17 in comparison to the quarters 1 and 2 averages in 2017/18.

**Table 7: Non Pay Spend by Expenditure Group**

	2016/17				2017/18		
	Qtr 1 Avg	Qtr 2 Avg	Qtr 3 Avg	Qtr 4 Avg	Qtr 1 Avg	Qtr 2 Avg	Mth 6
Clinical Supplies	5.8	5.7	5.9	6.2	6.0	6.1	6.3
Drugs	5.8	6.1	6.0	6.3	6.2	6.3	6.2
Less: Pass Through Items	(5.9)	(6.5)	(6.5)	(6.6)	(6.2)	(6.5)	(6.7)
<b>Clinical Supplies and Drugs Subtotal</b>	<b>5.6</b>	<b>5.4</b>	<b>5.5</b>	<b>5.8</b>	<b>6.0</b>	<b>6.0</b>	<b>5.9</b>
Non-Clinical Supplies	1.6	1.6	1.6	1.7	1.6	1.6	1.6
Premises	2.5	2.5	2.6	2.8	2.6	2.8	2.8
Purchase of Healthcare Services NHS	0.7	0.7	0.6	0.5	0.6	0.7	0.7
Purchase of Healthcare Services Non NHS	0.6	0.6	0.4	0.4	0.6	0.6	0.6
Other	5.2	3.7	3.1	3.4	4.2	4.3	4.8
<b>Grand Total</b>	<b>16.2</b>	<b>14.5</b>	<b>13.8</b>	<b>14.7</b>	<b>15.5</b>	<b>15.8</b>	<b>16.3</b>

### 2.4.1 Drugs and Clinical Supplies and Services

The expenditure on drugs and clinical supplies increased to £12.6m in September, an increase of (£0.6m), but was largely offset by an increase in cost per case drugs and devices of £0.5m for which additional healthcare income will be received. The quarterly averages in table 7 above show that the costs of clinical supplies and drugs which are within tariff, have remained broadly consistent through quarters 1 and 2, but remain (£0.6m) higher than the quarter 2 average in 2016/17.

### 2.4.2 Other Non-Pay

The increase in the other non-pay expenditure reflects the costs associated with a permanent injury charge claim recognised in the month.

## 2.5 Divisional Performance

Table 8 below details the budgetary variance by Division split by expense type. The "Income" expense type refers to Category C income such as SLA income from other organisations; it does not refer to NHS Clinical Income, which is detailed in section 2.6 below.

**Table 8: Variance Breakdown by Division**

Division	ExpenseGroupDesc	In Month Budget - £000's	In Month Actual - £000's	In Month Variance - £000's	YTD Budget - £000's	YTD Actual - £000's	YTD Variance - £000's
D1	INCOME	(461.3)	(459.6)	(1.7)	(2,697.4)	(2,658.9)	(38.4)
	NON PAY EXPENDITURE	2,588.7	3,242.2	(653.5)	14,719.6	17,046.6	(2,327.0)
	PAY EXPENDITURE	7,974.1	8,024.2	(50.1)	47,359.8	48,201.9	(842.1)
<b>D1 Total</b>		<b>10,101.5</b>	<b>10,806.9</b>	<b>(705.4)</b>	<b>59,382.0</b>	<b>62,589.5</b>	<b>(3,207.5)</b>
D2	INCOME	(431.0)	(371.4)	(59.6)	(2,611.8)	(2,461.3)	(150.5)
	NON PAY EXPENDITURE	1,038.8	1,214.5	(175.7)	6,246.4	7,200.8	(954.5)
	PAY EXPENDITURE	4,641.3	4,654.0	(12.7)	28,871.3	28,821.1	50.2
<b>D2 Total</b>		<b>5,249.1</b>	<b>5,497.1</b>	<b>(247.9)</b>	<b>32,505.9</b>	<b>33,560.7</b>	<b>(1,054.8)</b>
D3	INCOME	(344.2)	(313.1)	(31.1)	(1,920.3)	(1,822.0)	(98.3)
	NON PAY EXPENDITURE	2,530.5	2,794.9	(264.4)	15,039.1	16,558.7	(1,519.6)
	PAY EXPENDITURE	7,579.0	8,134.3	(555.3)	44,866.0	47,925.3	(3,059.4)
<b>D3 Total</b>		<b>9,765.3</b>	<b>10,616.1</b>	<b>(850.8)</b>	<b>57,984.9</b>	<b>62,662.1</b>	<b>(4,677.2)</b>
D4	INCOME	(194.0)	(187.4)	(6.6)	(1,146.6)	(1,287.1)	140.5
	NON PAY EXPENDITURE	4,237.3	4,410.2	(172.9)	25,294.5	27,595.3	(2,300.9)
	PAY EXPENDITURE	6,459.2	6,706.4	(247.3)	38,587.4	40,064.5	(1,477.1)
<b>D4 Total</b>		<b>10,502.5</b>	<b>10,929.3</b>	<b>(426.8)</b>	<b>62,735.3</b>	<b>66,372.8</b>	<b>(3,637.5)</b>
D5	INCOME	(139.1)	(147.3)	8.3	(834.7)	(899.1)	64.4
	NON PAY EXPENDITURE	3,747.7	3,527.8	219.9	21,877.1	21,279.4	597.7
	PAY EXPENDITURE	5,446.0	6,009.6	(563.7)	32,573.2	35,611.3	(3,038.1)
<b>D5 Total</b>		<b>9,054.6</b>	<b>9,390.2</b>	<b>(335.5)</b>	<b>53,615.7</b>	<b>55,991.6</b>	<b>(2,376.0)</b>
<b>Grand Total</b>		<b>44,673.1</b>	<b>47,239.5</b>	<b>(2,566.4)</b>	<b>266,223.7</b>	<b>281,176.7</b>	<b>(14,953.0)</b>

The main areas of variance in month for each Division are as follows:

- Division 1 (CSS) - Radiology (£253k) non pay predominantly on clinical supplies and outsourcing of reporting, (£180k) pay primarily on Radiographer bank and agency premium rate cover. Theatres pay of (£23k) on nursing and professional and technical staffing.
- Division 2 (W&C) - Obstetrics (£104k) non pay and Paediatrics (£53k) non pay primarily due to unmet CIP targets. Income under-performance of (£60k) predominantly due to reduced Maternity PbR income from other organisations.
- Division 3 (Emergency) - Nursing overspends of (£449k) across the division with (£235k) in Accident and Emergency, (£108k) in Acute Medicine and (£37k) in Respiratory. Medics overspend of (£149k) across the division with Accident and Emergency presenting the biggest pressure at (£182k). Unmet CIP targets across the division in non-pay with Acute Medicine and Respiratory being the biggest pressure points in this area.
- Division 4 (Medicine) - Unmet CIP targets in non-pay across the division with Elderly Care and Therapies presenting the biggest pressures in this area. Drug overspends of (£222k) driven by Clinical Haematology and Oncology (£175k). Nursing overspends of (£78k) driven by Elderly Care (£78k). Medic overspends of (£101k) with the biggest pressure in Elderly Care (£68k).
- Division 5 (Surgery) - Medical overspends of (£517k) with the biggest pressures in Trauma and Orthopaedics (£235k) and Gastroenterology (£166k).

## 2.6 Income Analysis

### 2.6.1 Total Operating Income

Total operating income (excluding STF) is (£2.1m) below plan in September taking the year to date under-performance to (£7.8m) as shown in table 9 below.

**Table 9 – Income against Plan**

	In Mth Plan September £m	In Mth Actual September £m	Variance £m	YTD Plan September £m	YTD Actual September £m	Variance £m
Clinical - NHS	(52.7)	(51.6)	(1.2)	(316.3)	(313.5)	(2.8)
Clinical - Non NHS	(0.9)	(0.7)	(0.2)	(4.6)	(4.4)	(0.1)
Other	(4.8)	(4.1)	(0.7)	(29.9)	(25.1)	(4.8)
<b>TOTAL</b>	<b>(58.5)</b>	<b>(56.4)</b>	<b>(2.1)</b>	<b>(350.8)</b>	<b>(343.0)</b>	<b>(7.8)</b>

NHS Clinical Income is a further (£1.2m) below plan in September moving the year to date under-performance to (£2.8m). Within this, excluded drugs and devices were £0.6m above plan in September with over-performance of £1.9m for the year to date.

The remaining variance of (£1.8m) under-performance in September against the seasonal healthcare income target related to activity moves the year to date under-performance to (£4.7m).

The main areas of variance during September and year to date are detailed in table 10 below:

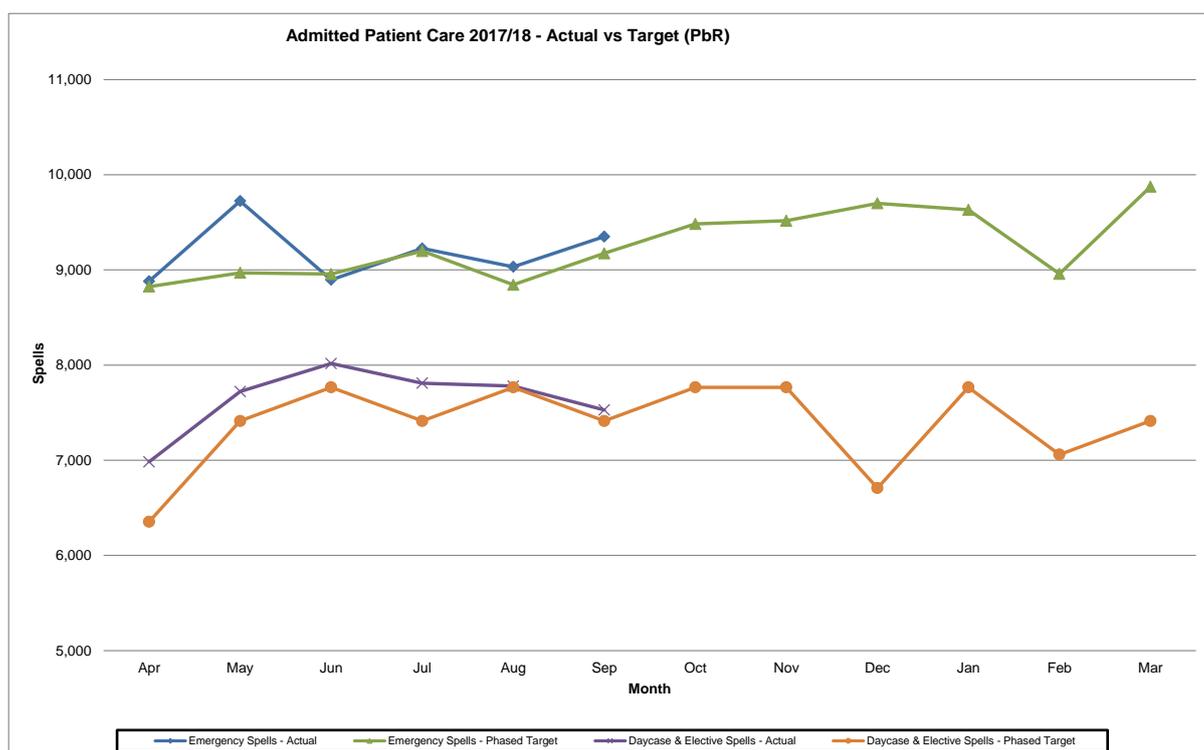
**Table 10 – Healthcare Income Variances by Point of Delivery**

	In Month Variance	YTD Variance
Maternity Spells/Pathways	(0.5)	(1.3)
Emergency Activity	(0.1)	0.2
Accident and Emergency	0.1	0.5
Elective/Daycase Spells	(0.6)	(1.3)
Outpatients	(0.3)	(1.6)
Other	(0.4)	(1.2)
<b>Grand Total</b>	<b>(1.8)</b>	<b>(4.7)</b>

### 2.6.2 NHS Clinical Income/Activity - Inpatients

Table 11.1 below details the monthly admitted patient care (APC) spells against the seasonally phased targets in September.

**Table 11.1: Trust Inpatient Activity**



The September in-month activity position reflects a 1.9% over-performance in emergency pathways (175 spells) against the seasonally phased plan, resulting in year to date over-performance against the seasonal plan of 2.1% (1,142 spells). Emergency ambulatory work continues to over-perform by 240 spells in the month whilst emergency inpatient admissions have this month under-performed by (58) spells.

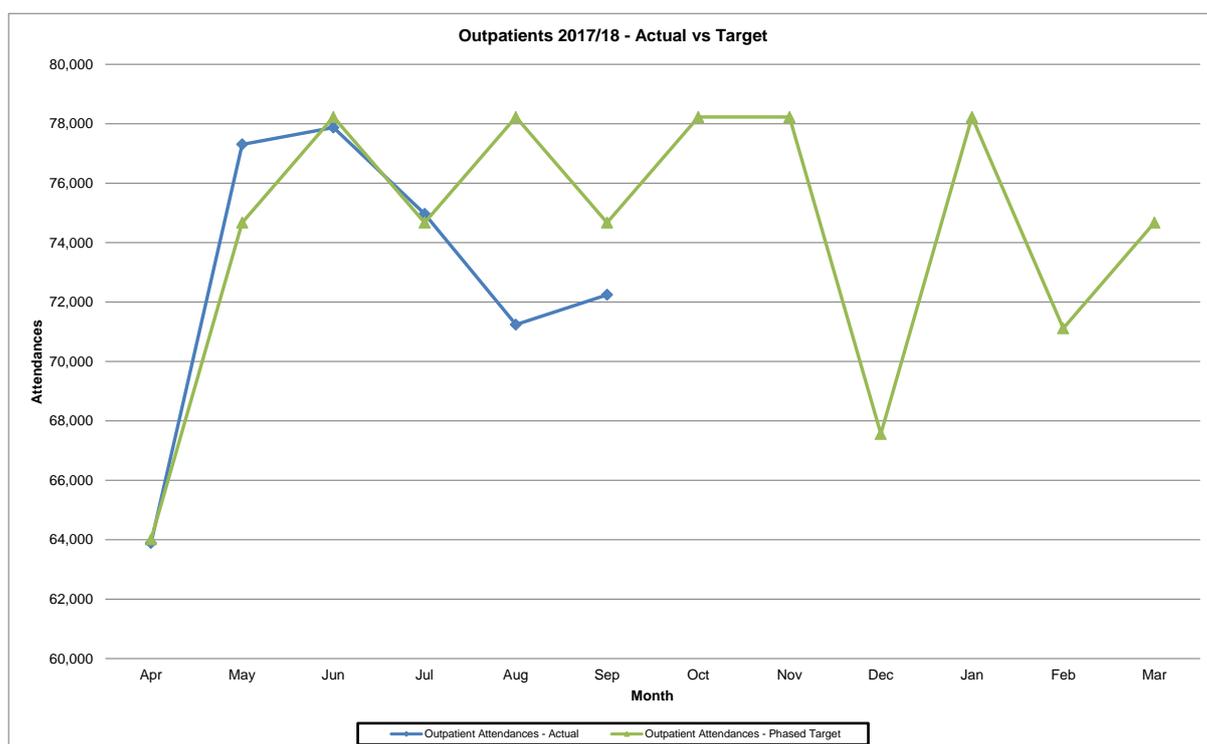
A&E activity has shown a (0.6%) under-performance in September (131 attendances) increasing the year to date under-performance to (0.4%), (482 attendances).

The elective and daycase activity was 1.6% above plan in September (116 cases) taking the year to date over-performance to 3.9% (1,713 cases).

### 2.6.3 NHS Clinical Income/Activity – Outpatients

Table 11.2 below details the monthly outpatient attendances compared to the seasonally phased targets in September.

**Table 11.2: Trust Outpatient Activity**



Outpatient activity in month has under-performed by (3.3%) in September (2,430 attendances) taking the year to date position to under-performance of (1.6%) (6,969 attendances). The main areas of over-performance in the month are within Cardiology (571 attendances, 11.5%) and Ophthalmology (471 attendances, 6.8%). Largest areas of under-performance in the month relate to Therapies (1,518 attendances, 18.3%), Diabetes (668 attendances, 15.9%) and ENT (392 attendances, 10.6%).

#### 2.6.4 Divisional Performance

Table 12 below details the variance against the year to date seasonally phased plan, split by Division and point of delivery but excluding performance on Excluded Drugs and Devices.

**Table 12: Healthcare Income Variance vs Seasonally Phased Plan**

Division	Point of Delivery			Total - £000's
	IP - £000's	OP - £000's	Other - £000's	
1 - CSS	607	(75)	(1,032)	(499)
2 - W&C	(230)	(398)	(1,991)	(2,620)
3 - Emergency	386	635	(656)	365
4 - Medicine	(1,994)	(1,474)	(569)	(4,038)
5 - Surgery	(308)	(362)	(624)	(1,294)
Central Risks	0	0	3,311	3,311
<b>Total</b>	<b>(1,540)</b>	<b>(1,673)</b>	<b>(1,562)</b>	<b>(4,775)</b>

### 2.6.5 Other Miscellaneous Operating Revenue

The adverse variance of (£0.7m) against the planned other operating revenue in September is broadly in line with previous months and is predominantly driven by slippage on income cost improvement schemes of (£0.5m) built into the plan.

### 2.7 Year End Forecast

The Trust has submitted a revised forecast within the month 6 return to NHS Improvement indicating a likely year end deficit of (£48.4m). This was calculated based on the following assumptions:

- Healthcare income (excluding cost per case) recovers back in line with plan
- CIP planned phasing delivers as anticipated
- Recovery schemes deliver in line with divisional projections
- International fellows and ACP programme deliver anticipated savings
- Costs increase for winter in line with previous years trends
- Vacancy and sickness rates do not materially change

As a result of the adverse movement to the Trust's forecast, NHS Improvement attended the Trust on 11 October 2017 for an assurance visit. They challenged the assumptions made in the forecasting process, assessed the expenditure controls and interviewed operational divisions about the robustness of the Trust's governance processes associated with the identification and delivery of efficiency savings. Verbal feedback received following this visit has been reasonably positive with regard to the controls in place and there was an acknowledgement of the scale of the challenge facing the Trust, however it is not yet clear whether the revised forecast will be accepted.

It should be noted that the further adverse movement in month 6 within Healthcare Income, is contrary to the assumption that this will recover back in line with plan and therefore this presents a significant downside risk attached to the forecast.

## 3. Efficiency Savings

The financial plan for 2017/18 relies on delivering a total efficiency of £33.2m (4.7% of income). Forecast delivery overall currently stands at £15.3m or 2.2% of total income.

### 3.1 Cost Improvement Programme

The 2017/18 identified schemes by Division, together with delivery against them both in September and year to date, is detailed in table 13 below.

**Table 13: CIP Delivery by Division**

Division	In Month 12ths Target	In Month Delivery	In Month Variance	YTD 12ths Target	YTD Delivery	YTD Variance	Annual Target	Forecast Delivery
CORPORATE	130.8	238.9	108.1	784.8	845.1	60.3	1,569.6	1,476.7
FACILITIES	146.4	137.1	(9.3)	878.4	648.4	(230.0)	1,756.7	1,260.6
TRUSTWIDE EDUCATION SERVICES	33.6	106.4	72.8	201.8	106.4	(95.3)	403.5	911.5
RESEARCH & INNOVATION	8.1	0.0	(8.1)	48.5	0.0	(48.5)	96.9	0.0
CSS	209.7	130.0	(79.7)	1,258.4	730.0	(528.4)	2,516.7	2,111.4
WOMENS & CHILDRENS	106.3	38.0	(68.3)	637.7	232.0	(405.7)	1,275.3	511.0
EMERGENCY CARE	185.3	162.3	(23.0)	1,111.7	573.0	(538.7)	2,223.3	2,166.1
MEDICINE	202.9	503.2	300.3	1,217.4	956.2	(261.2)	2,434.8	2,139.2
SURGERY	171.5	87.0	(84.5)	1,029.0	451.0	(578.0)	2,058.0	2,358.3
<b>TOTAL</b>	<b>1,194.6</b>	<b>1,403.0</b>	<b>208.4</b>	<b>7,167.4</b>	<b>4,542.1</b>	<b>(2,625.3)</b>	<b>14,334.8</b>	<b>12,934.8</b>

The variance against the year to date target of (£2.6m) reflects a combination of slippage on schemes initially identified to deliver year to date (£0.6m), planned phasing adjustments (£1.3m) and target with schemes unidentified (£0.7m).

### 3.2 Financial Recovery Plan

Year 2 of the Trust's Financial Recovery Plan for 2017/18 included agreed cross cutting schemes with saving opportunities of £4.7m, the delivery against which is detailed in table 14 below.

**Table 14: Year 2 Cross Cutting Schemes**

Workstream / Project	Scheme Start	Month 6		YTD Target	YTD Actual	Full Year Target	Full Year Forecast
		In Mth Target	In Mth Actual				
Length of Stay	Jun-17	104	0	417	0	1,042	0
Theatre Productivity	Apr-17	44	44	258	258	524	524
Diagnostics	Apr-17	8	8	50	8	100	58
Procurement: National & Local Standardisation	Apr-17	2	2	29	29	41	41
Procurement: UHB Alignment	Aug-17	68	50	136	80	544	600
Procurement: Direct Source Pricing	Aug-17	17		33	0	133	0
Procurement: GHX Renewal	Oct-17	0		0	0	114	0
Procurement: Review 111 Other Contracts	Oct-17	0		0	0	114	0
Procurement: Mobile Phones	Apr-17	2	2	11	11	22	22
Medical: International Fellows	Apr-17	0		0	0	0	0
Medical: Business Case Pipeline	Jun-17	23	0	136	0	272	0
Medical: E-rostering & Compliance with Policies	Jul-17	0		0	0	0	0
Nursing: Matron Review	Apr-17	9	9	55	55	111	111
Nursing: E-rostering & Compliance with Policies	Jun-17	83	0	255	0	755	125
Nursing: ACP	Sep-17	57	19	82	44	426	194
Corporate: Updated Communications	Apr-17	2	2	12	13	25	25
A&C: Balance to full year effect of restructures	Apr-17	65	65	350	350	698	698
<b>Grand Total</b>		<b>485</b>	<b>202</b>	<b>1,824</b>	<b>847</b>	<b>4,921</b>	<b>2,398</b>
Balance to find from original FRP following validation				658	0	1,315	
Balance to find from stretch targets				2,450	0	4,900	
<b>Total FRP/Stretch Target</b>				<b>4,932</b>	<b>847</b>	<b>11,136</b>	

As with the CIP targets the total FRP/stretch savings target has been posted in the ledger in 12ths. Overall there is circa (£1.0m) slippage on the planned delivery to date and (£0.6m) of under-delivery in the position which relates to the planned phasing of the schemes. A further (£3.1m) relates to the unidentified balance of the FRP and the additional stretch savings target.

The current year end forecast delivery is £2.4m against the overall additional savings target of £11.1m, slippage of circa (£8.7m). Work continues to try to identify further programmes to close this gap.

### 3.3 2016/17 Non Recurrent Benefits

Within the reported position for 2016/17, circa £7.7m was delivered non-recurrently either through one off savings or through release of balance sheet flexibility. Therefore in order to achieve the plan as set for 2017/18, additional savings are required in order to recurrently achieve this cost reduction.

To date, this is contributing an adverse variance of (£3.9m) in comparison to the Trust's planned position.

## **4. Statement of Financial Position**

The Statement of Financial Position (Balance Sheet) shows the value of the Trust's assets and liabilities. The upper part of the statement shows the net assets after deducting short and long term liabilities with the lower part identifying sources of finance. Table 15 below summarises the Trust's Statement of Financial Position as at 30 September 2017.

**Table 15: Statement of Financial Position**

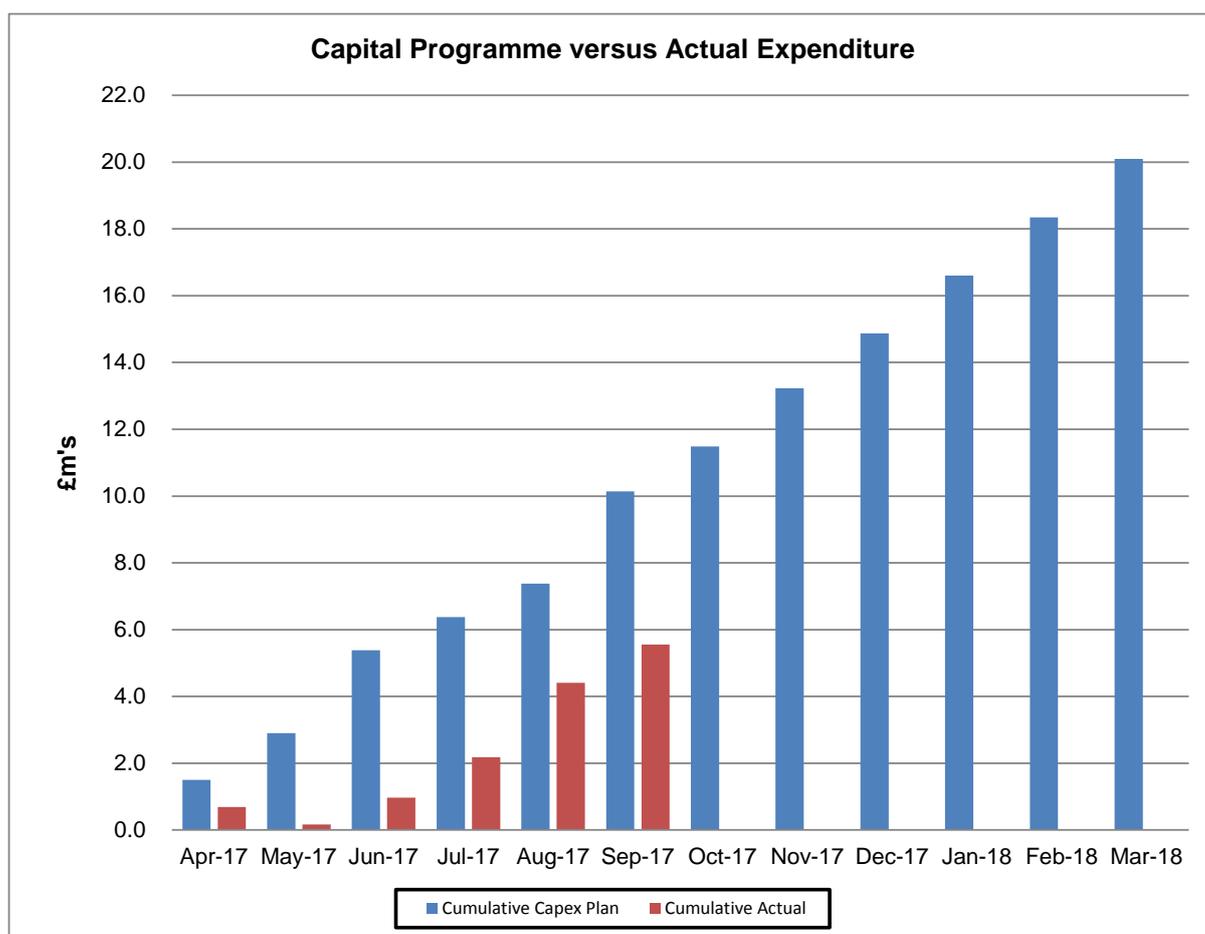
		Actual Mar-17 £m	Actual Sep-17 £m	Plan Sep-17 £m	Annual Plan Mar-18 £m
<b>Non Current Assets:</b>					
	Property, Plant and Equipment	248.1	246.0	257.4	259.8
	Intangible Assets	2.0	1.9	9.4	9.1
	Trade and Other Receivables	1.0	1.3	1.6	1.6
	Other Assets	3.8	3.7	3.7	3.6
	<b>Total Non Current Assets</b>	<b>254.8</b>	<b>253.0</b>	<b>272.1</b>	<b>274.0</b>
<b>Current Assets:</b>					
	Inventories	10.7	11.0	11.0	10.0
	Trade and Other Receivables	32.2	93.1	46.1	43.8
	Cash	19.2	16.4	3.0	3.0
	<b>Total Current Assets</b>	<b>62.2</b>	<b>120.4</b>	<b>60.1</b>	<b>56.8</b>
<b>Current Liabilities:</b>					
	Trade and Other Payables	(102.4)	(116.9)	(101.6)	(98.8)
	Borrowings	(0.5)	(0.5)	(0.5)	(0.5)
	Working Capital Loan	0.0	(9.8)	(1.0)	(3.5)
	Provisions	(3.2)	(3.7)	(2.9)	(2.4)
	Tax Payable	0.0	0.0	0.0	0.0
	Other Liabilities	(6.3)	(58.0)	(6.5)	(6.5)
	<b>Total Current Liabilities</b>	<b>(112.4)</b>	<b>(188.8)</b>	<b>(112.4)</b>	<b>(111.6)</b>
<b>Non Current Liabilities:</b>					
	Borrowings	(3.3)	(3.1)	(3.1)	(6.0)
	Provisions	(6.2)	(6.2)	(5.8)	(5.8)
	Other Liabilities	0.0	(0.4)	(3.0)	0.0
	<b>Total Non Current Liabilities</b>	<b>(9.5)</b>	<b>(9.6)</b>	<b>(11.9)</b>	<b>(11.8)</b>
<b>TOTAL ASSETS EMPLOYED</b>		<b>195.1</b>	<b>174.9</b>	<b>207.8</b>	<b>207.3</b>
<b>Financed by:</b>					
	Public Dividend Capital	196.7	196.7	196.7	196.7
	Income and Expenditure Reserve	(45.9)	(74.0)	(42.8)	(42.7)
	Donated Asset Reserve	(0.2)	(0.2)	(0.2)	(0.2)
	Revaluation Reserve	52.9	52.4	54.1	53.5
	Merger Reserve	0.0	0.0	0.0	0.0
<b>TOTAL TAXPAYERS EQUITY</b>		<b>203.5</b>	<b>174.9</b>	<b>207.8</b>	<b>207.3</b>

## 5. Capital Expenditure (Non-Current Assets)

The initial capital programme for 2017/18 totalled £18.1m, this included £16.0m of internally funded schemes and £2.1m of costs associated with the enabling works for ACAD for which a DH loan has been approved. This programme was subsequently uplifted to £20.1m as a result of anticipated slippage of £1.0m on 2016/17 schemes and £1.0m slippage on the costs of ACAD. This is the value at which the final plan was submitted to NHSI.

Table 16 below details the planned trajectory of the £20.1m together with the actual spend from April to September. Expenditure to date is £5.6m against a plan at this point of £10.1m, slippage of (£4.5m) against the plan. The most notable items of slippage relate to medical equipment replacement (£4.9m) and enabling works costs associated with ACAD of (£1.1m) offset by ahead of plan expenditure within ICT of £1.4m.

**Table 16: Capital Programme Trajectory vs Actuals**



## 6. Current Assets

The Trust's total current assets (excluding cash and inventories) amount to £93.1m at 30 September 2017 an increase of (£4.0m) during September and (£46.9m) higher than plan. The balance is broken down as detailed in table 17 below.

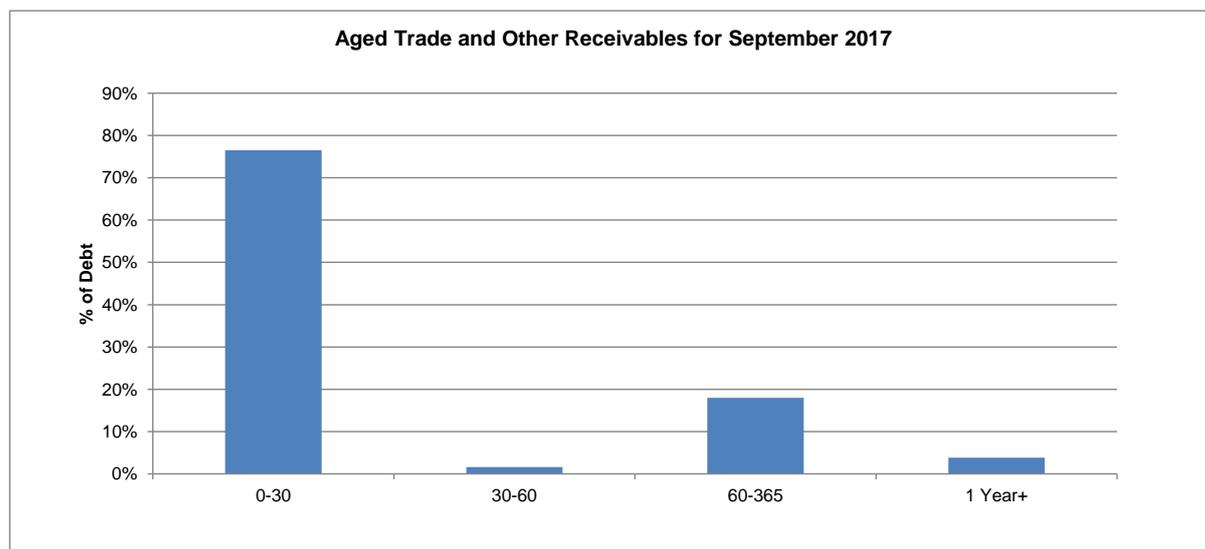
**Table 17: Analysis of Current Assets (excluding Inventories and Cash)**

	YTD Actual September 2017 £m	YTD Plan September 2017 £m
Trade Receivables	85.3	42.1
Bad Debt Provision	(11.9)	(9.3)
Other Receivables	2.2	2.3
<b>Trade and Other Receivables</b>	<b>75.7</b>	<b>35.1</b>
Accrued Income	3.0	3.5
<b>Other Financial Assets</b>	<b>3.0</b>	<b>3.5</b>
Prepayments	14.4	7.5
<b>Other Current Assets</b>	<b>14.4</b>	<b>7.5</b>
<b>TOTAL</b>	<b>93.1</b>	<b>46.1</b>

The main movement against the plan is as a result of billing commissioners earlier for the mandate payment, in order to ensure the cash is received into the Trust in a timely manner. This results in increased trade receivables at the end of each month offset by increased deferred income (within Other Liabilities).

Analysis of the age profile of Trade Receivables (unpaid invoices issued by the Trust) is summarised in table 18 below.

**Table 18: Aged Debt Analysis**



Overdue debt now stands at £17.1m of which £9.5m relates to CCG/NHS England healthcare income contracts within the top 10 balances. This represents an overall increase of (£0.1m) on the position at the end of August 2017. The top balances (outside of CCG/NHS England Healthcare Income contracts) are:

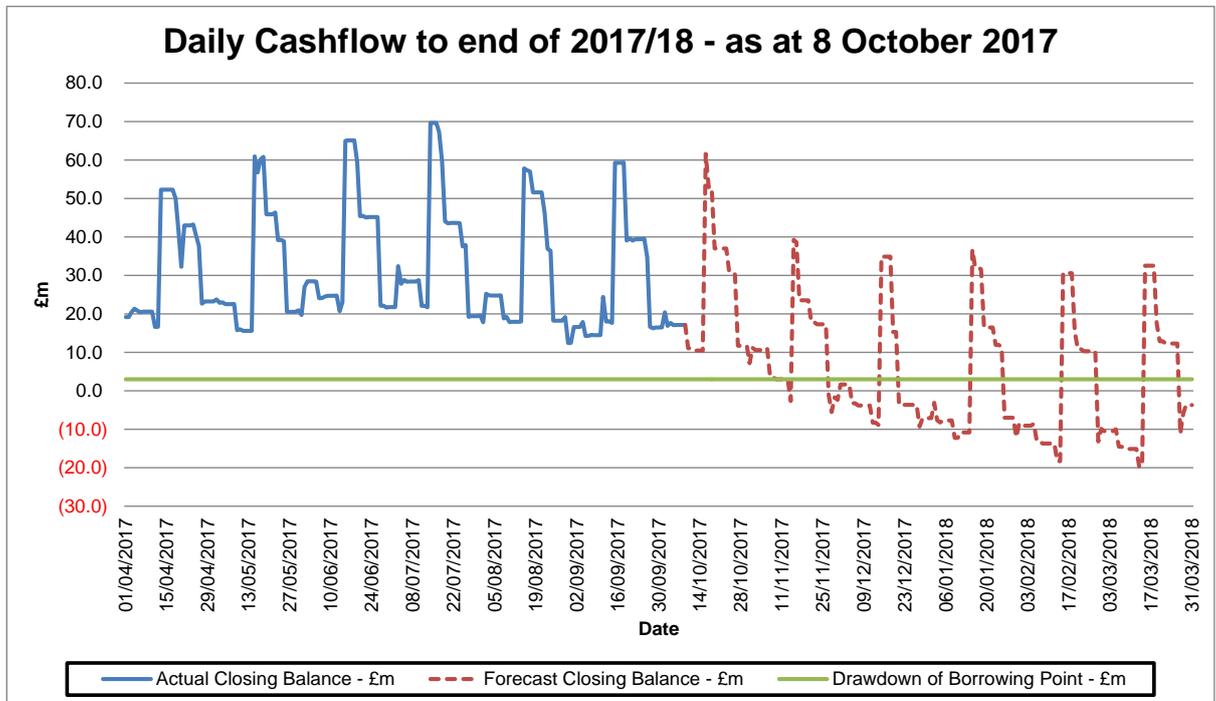
- Burton Hospitals Foundation Trust (£0.9m > 30 days, £1.1m total) – this is a reduction of £0.2m on both the greater than 30 days and the total debt from the position at the end of August 2017. Debt associated with maternity pathways for 15/16 and 16/17 accounts for (£0.4m), with a further (£0.5m) relating to current year maternity pathway queries. The remainder relates to ad hoc recharges which are currently being validated. The queries around the 2016/17 contract remain under discussion.
- Sandwell and West Birmingham Trust (SWBH) (£0.6m > 30 days, £0.9m total) – this is an increase of (£0.1m) on both the overdue debt and the total debt compared to August 2017. The majority of the overdue debt relates to prior year surgical SLA provision.

## 7. Cash Flow

The cash balance at the end of September 2017 was £16.4m, an increase of £4.0m during September and a positive variance of £13.4m against the planned balance of £3.0m. However during September, the Trust made its first drawdown against its working capital facility and therefore the above balance includes £9.8m of loan funding.

Table 19 below details the anticipated cash balances to the end of the 2017/18 financial year, including the working capital draws in September and October but without any future draws. This demonstrates that the Trust is likely to need further borrowing each month in order to remain above the minimum cash balance of £3.0m at all times.

**Table 19: Daily Cashflow Forecasting as at 8 October**



## 8. NHS Improvement Finance and Use of Resources Metric

### 8.1 Finance and Use of Resource Metrics

The Finance and Use of Resource (UoR) metric has replaced the previous Financial Sustainability Risk rating (FSRR). Each metric is scored between 1 (best) and 4 (worst) and then an average is calculated to derive the overall UoR score for the provider. Where providers have an overall score of 3 or 4 for finance and use of resources, this will identify a potential support need under this theme, as will providers scoring a 4 against any of the individual metrics. Providers in financial special measures will default to an overall score of 4 on this theme.

The individual metrics scored against are detailed in table 20 below.

**Table 20: Scoring Mechanism for Finance and Use of Resources Metric**

Area	Metric	Weight	Definition	Use of Resource Metrics			
				1	2	3	4
Financial Sustainability	Capital Service Capacity	20%	Degree to which the provider's generated income cover its financial obligations	>2.5x	1.75-2.5	1.25-1.75	<1.25
	Liquidity (days)	20%	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial Efficiency	I&E Margin	20%	I&E surplus or deficit / total revenue	>1%	1%-0%	0%-(1%)	<(1%)
Financial Controls	Distance from Finance Plan	20%	Year-to-date actual I&E surplus/deficit in comparison to year-to-date plan I&E surplus/deficit	≥0%	(1%)-0%	(2%)-(1%)	≤(2%)
	Agency Spend	20%	Distance from provider's cap	≤0%	0%-25%	25%-50%	≥50%

## 8.2 Trust Performance

The Trust has been put into segment 3 as was anticipated. This means mandated support must be complied with to address specific issues and help move the Trust into segment 2.

With regards the Finance and Use of Resource Metric, the September year to date metric scoring is detailed in table 21 below.

**Table 21: Trust Scoring Year to Date**

Area	Metric	Weight	Use of Resource Metrics	
			Actual	Score
Financial Sustainability	Capital Service Capacity	20%	(6.42)	4
	Liquidity (days)	20%	(40.21)	4
Financial Efficiency	I&E Margin	20%	(8.30%)	4
Financial Controls	Distance from Finance Plan	20%	(6.34%)	4
	Agency Spend	20%	(4.17%)	1

This rating is anticipated to continue throughout the financial year but is only being maintained through the Trust's delivery against the agency ceiling.

## 9. Conclusion

The Trust has recorded an overall deficit of (£5.8m) during month 6 of the 2017/18 financial year, an adverse variance of (£3.4m) against the planned deficit of (£2.4m) for the month pre STF. This moves the year to date deficit to (£28.6m) an adverse variance of (£14.1m) against the planned deficit pre STF of (£14.5m). As a result of under-delivering against the financial plan, the year to date allocation of £7.4m of STF has not been assumed.

A revised year end forecast has been submitted to NHS Improvement as part of the month 6 return indicating a likely full year deficit of (£48.4m) against a pre-STF planned deficit of (£28.8m), an adverse variance of (£19.6m). Given the further unexpected shortfall in Healthcare Income in month 6, this forecast includes significant downside risk.

The Trust's cash balance as at 30 September 2017 was £16.4m, a favourable variance of £13.4m against the planned balance at this point. However, this includes cash of £9.8m received from a working capital loan facility.

## **10. Recommendations**

The Board of Directors is requested to:

- Receive the contents of this report.

Julian Miller  
Interim Director of Finance  
17 October 2017

<b>Title:</b> <b>BOARD ASSURANCE FRAMEWORK Q2</b>			
<b>From:</b> David Burbridge		<b>To:</b> Board of Directors	
<b>The report is being provided for:</b>			
Decision: N	Discussion: Y	Assurance: Y	Endorsement: Y
<b>The Board is being asked to:</b>			
Review the updated BAF and identify any gaps in controls and assurances or any further changes required to update the BAF			
<b>Key points / summary:</b>			
<ul style="list-style-type: none"> <li>• The Board Assurance Framework is an important document for providing assurance that the Board is aware of the risks to its key objectives and has a robust system of internal control</li> <li>• The 2017/18 Assurance Framework is included at <b>Appendix 1</b></li> <li>• There are currently <b>12</b> risks on the register of which <b>8</b> are scored as Red and <b>3</b> as Amber and <b>1</b> as Yellow</li> <li>• The proposed changes included in this report for Q2 are based on discussions with Executive Directors</li> </ul>			
<b>Recommendations:</b>			
Review the revised BAF and identify any gaps in controls and assurance.			
<b>Identify any Equality and diversity issues:</b>			
None			
<b>Outline how any equality and diversity risks are to be managed:</b>			
Not applicable			
<b>Which committees has this paper been to?</b>			
None			

## 1. Introduction

- 1.1. The purpose of the Board Assurance Framework is to:
  - 1.1.1. Identify the Trust's key strategic risks, linked to its key objectives:
  - 1.1.2. Identify the current level of risk
  - 1.1.3. Identify the mitigations to address the risk (controls and assurances)
  - 1.1.4. Identify any further action required to reduce the likelihood or the consequence of the risk occurring
- 1.2. The Trust has identified its key objectives for 2017/18 as:
  - 1.2.1. Clinical Quality
  - 1.2.2. Workforce
  - 1.2.3. Integration
  - 1.2.4. Affordability
- 1.3. The Board Assurance Framework is supported by the operational clinical risk registers which are managed and escalated from the clinical directorates and divisions as well as the Executive (corporate) risk registers (see structure chart at Fig 1 below). These risks identify the more detailed risks associated with the day to day delivery of Trust services.

Operational risk registers are reviewed at quarterly update meeting with the Director of Operations and, with effect from June 2017, are now discussed at the quarterly executive performance meetings.
- 1.4. The updated Board Assurance Framework is attached in **Appendix 1**. It has been updated since Q1 following discussions with Executive Directors and the changes are highlighted in the body of this report.

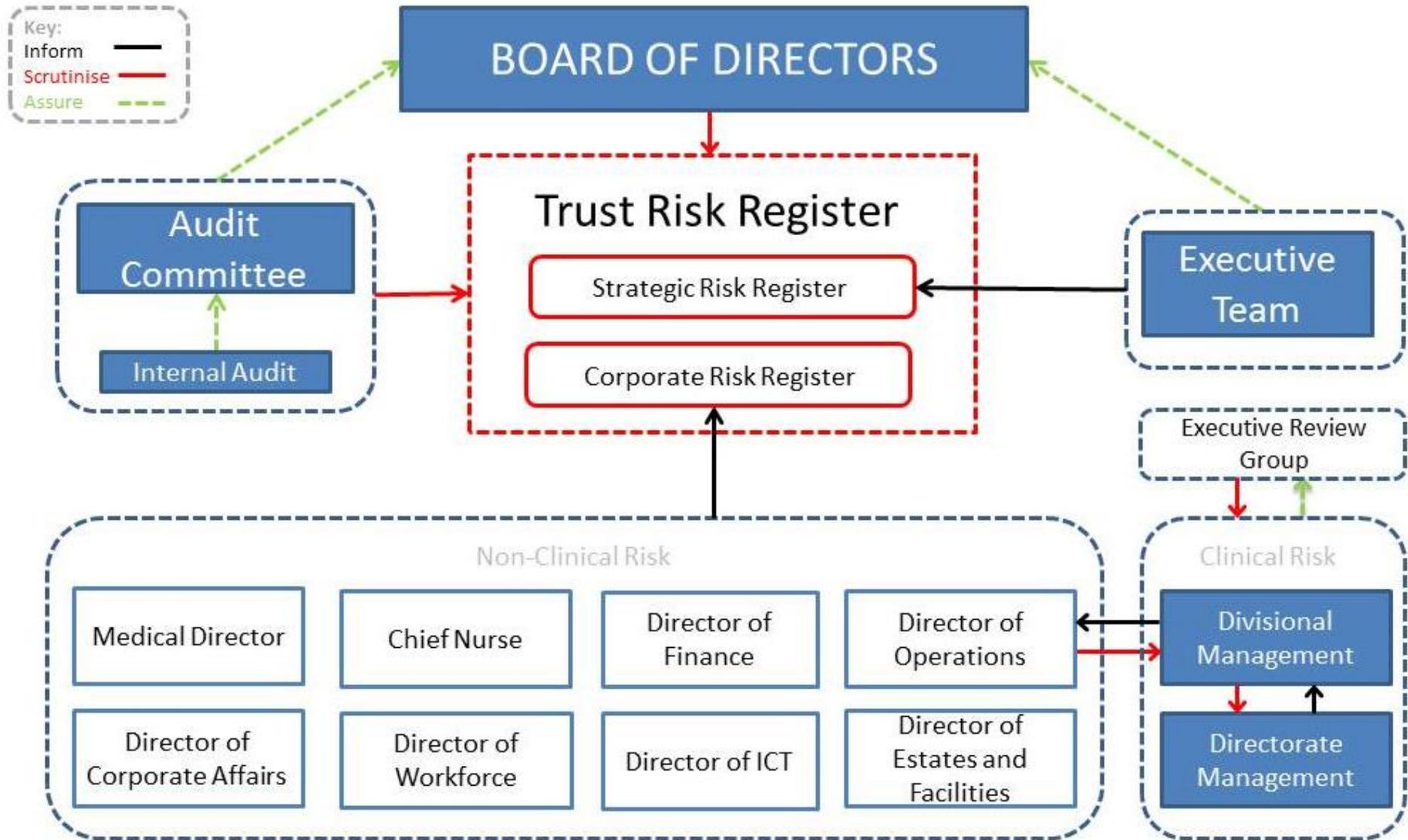
## 2. Trust risk matrix

- 2.1. The Table below identifies the profile of the Trust's risks for each of its key objectives.

Table 1. Key Risks and Objectives

Ref	Risk title	Owner	Proposed	Initial Score (LxC)	Score Last Quarter	Current Score (LxC)	Target Score (LxC)	HEFT Objective	Single Oversight Framework
SRR 1/15	Delivery of clinical operational standards	JB	Nov-15	16 (4x4)	12 (3x4)	16 (4x4)	9 (3x3)	Quality	Operational Performance
SRR 2/15	Leadership skills and capacity	CEO/Chair	Nov-15	12 (3x4)	20 (5x4)	20 (5x4)	8 (2x4)	Workforce	Leadership / Improvement
SRR 3/15	IT Infrastructure	SC	Mar-16	12 (3x4)	16 (4x4)	16 (4x4)	6 (2x3)	Quality	Finance and Resource
SRR 1/16	Sustainable medical workforce model	DR	Oct-16	12 (3x4)	12 (3x4)	12 (3x4)	6 (2x3)	Workforce	Quality
SRR 2/16	Sustainable nursing workforce model	SF	Oct-16	12 (3x4)	12 (3x4)	12 (3x4)	6 (2x3)	Workforce	Quality
SRR 3/16	Physical estate	KB	Oct-16	16 (4x4)	16 (4x4)	16 (4x4)	8 (2x4)	Quality	Finance and Resource
SRR 5/16	Sustainability and Transformation Plan	CEO	Oct-16	CLOSED (proposed see section 3)				Quality	Strategic Change
SRR 6/16	BREXIT	CEO	Jan-17	20 (5x4)	16 (4x4)	16 (4x4)	12 (3x4)	Workforce	Quality
SRR 7/16	Case for change	DB	Jan-17	16 (4x4)	12 (3x4)	12 (3x4)	8 (2x4)	Integration	Strategic Change
SRR 8/16	Increasing delays in transfer of care (DTCOC)	JB	Jan-17	16 (4x4)	12 (4x3)	15 (5x3)	9 (3x3)	Integration	Quality
SRR 1/17	Financial plan 2017/18	JM	Apr-17	20 (5x4)	20 (5x4)	20 (5x4)	8 (2x4)	Affordability	Finance and Resource
SRR 2/17	Cash position	JM	Apr-17	20 (5x4)	20 (5x4)	20 (5x4)	8 (2x4)	Affordability	Finance and Resource
SRR 3/17	Regulatory action	DB	Apr-17	16 (4x4)	12 (3x4)	8 (2x4)	4 (1x4)	Quality	Quality
SRR 4/17	High profile cases	KB	Jul-17	CLOSED (proposed see section 3)				Quality	Quality

Figure 1. Risk Management and Board Assurance



### 3. Proposed changes since the last report

Following discussions with Executive Directors, the proposed changes to the existing risks on the BAF are included in **Appendix 1** as follows:

- Risk SRR 1/15 – Delivery of clinical operational standards – score to increase from 12 (3x4) to 16 (4x4)
- Risk SRR 5/16 – Sustainability and Transformation Plan – risk to be closed
- Risk SRR 8/16 – DTOC – score to increase from 12 (4x3) to 15 (5x3)
- Risk SRR 3/17 – Regulatory action – score to decrease from 12 (3x4) to 8 (2x4)
- Risk SRR 4/17 – High profile cases – risk to be closed

### 4. New Risks

There are no new risks identified in Q2

### 5. Recommendation

5.1. The Board of Directors is asked to discuss the risks identified in the Board Assurance Framework and:

- 5.1.1. Discuss / approve the proposed changes (section 3) and identify additional existing controls and/or actions;
- 5.1.2. Consider additional controls and assurances that may need to be implemented; and
- 5.1.3. Consider whether the Audit Committee should be asked to seek additional assurance regarding any of the risks identified.

**David Burbridge**  
**Interim Director of Corporate Affairs**  
**October 2017**

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 1/15	<p>Failure to deliver clinical operational standards (primarily A&amp;E, RTT and 62 days) owing to increase in demand for services, delayed TOC, rising ED attendances and gaps in community provision and decommissioning of services by CCG</p> <p>This situation is likely to be exacerbated by winter pressures, which have the potential to affect the ability to consistently meet various standards</p>	Clinical Quality	Director of Ops	<p>Improvement plans for urgent care, length of stay, cancer services and scheduled care</p> <p>Implementation of governance structures relating to improvement plan delivery</p> <p>Revised divisional structure and associated accountability</p>	<p>Monthly report to trust Board re operational performance</p> <p>Monthly report to Chief Executives group re operational performance</p> <p>Monthly updates on progress of work streams</p> <p>Bi-monthly divisional performance meetings</p>	16 (4x4)	<p>Workforce gaps (particularly with medical grades)</p> <p>External capacity in the wider health economy</p>	<p>On-going delivery of improvement plans</p> <p>See also action plans for SRR 1/16 and 2/16 regarding workforce and SRR 8/16 DTOC</p>	Jan 2018

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 2/15	Failure to have appropriate leadership skills and capacity at all levels to deliver new ways of working and appropriate ways of leading	All	CEO/Chair	Managed through the new executive team meetings and Trust Board Structures including accountability currently being worked on and will be implemented early 2016. Good Governance Institute commenced work with the Board	Minutes of and reports to the Board Appraisals of Execs and NEDs	20 (5x4)	New senior leadership structure now in place, but on interim basis only.	Review progress against GGI report  Case for Change being developed	Dec 2016  Late 2016/2017

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 3/15	The current IT infrastructure (including the fixed network, wireless network and telephony) is not fit for purpose. This creates potential safety, reputational and financial risk due to lack of capacity in the systems and the data centre and a lack of robust business continuity arrangements and security controls. In addition there is no health informatics / business intelligence team within the Trust leading to an increased risk of poor data quality and completeness of reporting	Clinical Quality and Affordability	Director of ICT	Baseline of issues and risks completed. Action plan in place to ensure:	Monthly updates to joint UHB / HEFT Digital Healthcare Group  Bi-monthly updates to IG group Monthly updates to Board of Directors via Medical Director Monthly updates to Emergency Planning Group (for BCP)	16 (4x4)			On going to be completed Q4 17/18  Paper Q3 17/18  Q2 17/18  Q3 17/18
				Network is modernised and fit for purpose and supported 24/7/365					
				Wireless network is fit for clinical purposes				Network, wireless and telephone capital milestones achieved	
				Telephone system replacement solution				17/18 Work programme continues and is on plan	
				Data Centre is fit for purpose and has sufficient capacity			Slippage on UHB plans for secondary data centre (essential for HEFT disaster recovery and BCP)		
				Disaster Recovery and business continuity plans are in place for all key clinical systems			Lack of IT capability and readiness aligned to key systems, BCPs to be reviewed	IT to undertake gap analysis and develop necessary remediation plan including potential investment via business case. Information asset owners to provide assurance with respect to BCPs	
				Security Controls and data loss protection measures are robust and in place			Security controls policy review and development with IG	IT align technical controls to meet policy	

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
				A Health Informatics / Business Intelligence function is established				Informatics scoping work to be undertaken to develop appropriate investment case Analysis of information flows commenced	<b>Q3 17/18</b>

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 1/16	Risk of failure to deliver a sustainable medical workforce model due to age profile of existing consultant workforce, availability of staff in specific specialties, on call arrangements, reduction in HEE trainees and inability to retain staff	Clinical Quality, Workforce & Affordability	Medical Director	Developing the future Medical Workforce work stream including: <ul style="list-style-type: none"> <li>- Physician associates</li> <li>- ACPs</li> <li>- Improve training experience for HEE trainees</li> <li>- Explore recruitment of non UK doctors</li> <li>- New career structure for SAS doctors</li> <li>- ED recruitment plan</li> <li>- Review of medical on call middle grade provision</li> <li>- Paper for the proposal to recruit non HEE doctors</li> <li>- Participation in International Fellows Programme (15 fellows start Sept 17 and more to start in March 2018)</li> <li>- Medical workforce group chaired by Deputy CEO</li> <li>- Non consultant vacancies to be invested in a group chaired by DME</li> </ul>	Regular updates to strategic workforce group  Monthly updates to Board of Directors via Medical Director  Updates to Medical workforce group	12 (3x4)	Vacancy matrix  Corporate oversight of recruitment with exec support to make it happen as likely push-back from division and directorates who have their own agendas/plans  Meetings with CDs and DDs to better define medical workforce.	Develop and maintain a vacancy matrix  Paper to Executives to gain support for corporate oversight of recruitment in the future  Meetings with CDs and DD to develop a more robust medical workforce plan	Q2 17/18

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 2/16	There is a potential patient safety risk if nursing and midwifery staffing levels and skill mix are unable to be matched to demand and capacity. Potential risk areas include hard to recruit to specialties such as Children's and Maternity, the Emergency Dept, Elderly Care Theatres and Critical Care. The current national shortage in hard to recruit areas has the potential to increase this risk. Risk is mitigated currently by use of agency staff which triggers a further risk regarding potential breach of control limits for agency spend	Clinical Quality, Workforce & Affordability	Interim Chief Nurse	<ul style="list-style-type: none"> <li>- On-going recruitment programme to recruit to agreed staffing levels</li> <li>- Fast follower status – 41 Nursing associates recruited</li> <li>- Use of bank and agency staff</li> <li>- Focussed recruitment in 'difficult to recruit to' staff groups</li> <li>- e-rostering KPIs</li> <li>- Daily and weekly review of staffing levels and skill mix</li> <li>- Use of bank and agency with robust monitoring system.</li> <li>- Healthcare scientists in IPC</li> <li>- Closer dialogue with HEIs to consider implications of spending review</li> <li>- Launch of retention strategy October 2017</li> <li>- Opportunities post merger for more rotational posts pan Birmingham</li> </ul>	<p>Monthly updates to Trust Board</p> <ul style="list-style-type: none"> <li>- Monthly updates to Chief Executives Group</li> <li>- Monthly monitoring on Care Quality dashboard</li> <li>- Care Quality professional committee</li> </ul>	12 (3x4)	Piece or work, commenced October 2017 to determine an appropriate level of spend for 'specials'. At present this is a cost pressure and needs to be included in baseline budgets	<p>Nursing and midwifery retention plan (already commenced)</p> <p>Retention Strategy</p> <p>Workforce plan by Directorate and Division</p>	<p><b>Q3 17/18</b></p> <p><b>Oct 17</b></p> <p><b>Apr 18</b></p>

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 3/16	The physical estate / equipment is insufficient to facilitate the safe and effective delivery of clinical services	Clinical Quality	Deputy Chief Executive, Improvement	<p>Proactive risk management system to continuously measure and monitor risk and prioritise investment and allocation of resource.</p> <p>Comprehensive Planned Preventative Maintenance Programme that ensures the Estate, Plant, Infrastructure and Equipment is safe, compliant and utilised to its maximum capacity and full lifecycle.</p> <p>Priority risk based annual Capital Bids to improve the Estate and upgrade Plant, Infrastructure Equipment etc.</p> <p>Reactive Maintenance SLA to ensure the Estates, Plant, Infrastructure &amp; Equipment are returned to use in a timely manner.</p> <p>Estates strategy</p> <p>Workforce monitoring</p>	<p>Estates Department Performance &amp; Assurance Framework</p> <p>Monthly Directorate Statutory Compliance Group Assurance Meeting</p> <p>Internal Audit Programmes</p> <p>External Accreditation to ISO9001 &amp; ISO14001 standards</p> <p>Six Facet Property Condition Survey</p> <p>Funding agreed to develop ACAD building and associated utility infrastructure.</p> <p>Annual IA review</p> <p>Customer satisfaction survey</p>	16 (4x4)	<p>Functional Suitability of the Estate restricts the delivery of Clinical Services, the attainment of current standards and does not allow for expansion and technical development.</p> <p>Harmonisation of Clinical Requirements / Needs and Estate Development.</p> <p>Current infrastructure at maximum capacity, has limited resilience and in need of modernisation. There is no scope for future expansion.</p> <p>Increase in clinical activity and demand has outgrown many of the current facilities and caused overcrowding.</p> <p>Appropriate Investment in the Trusts Estates, Infrastructure, Plant &amp; Equipment.</p>	<p>Clarification of Clinical Strategy / Clinical Needs.</p> <p>Determine which clinical services are to be provided from which site to balance use of the existing Estate</p> <p>Estate Strategy to be aligned with Clinical Strategy / Clinical Needs</p> <p>Significant investment in Estate Development to meet Clinical Needs and proposed development</p>	On going

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 5/16	Sustainability and Transformation Plan (STP) will face challenges re delivery of objectives/divert Trust resources and management time, impacting on the Trust's ability to provide high quality care and improve patient experience and longer term health outcomes	Clinical Quality, Workforce, Integration & Affordability	CEO	Chair/CEO involvement in STP	Chair & CEO reports to BoD	12			Close

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 6/16	<p><b>BREXIT</b></p> <p>Article 50 was invoked on 29 March to begin the 2 year process of withdrawal from the EU. The main areas of uncertainty that may impact on the NHS relate to workforce, regulation, budget, access to treatment and cross border cooperation.</p> <p><b>Context:</b></p> <p>Staffing – what will happen to existing EU staff and the ability to recruit new staff from EU</p> <p>Regulation (EWTD, Medicines, procurement, med devices, information sharing)</p> <p>Impact on UK economy and therefore funding for NHS</p> <p>How will EU citizens access UK services in future and vice versa</p> <p>Cross border threats and information sharing / scientific research funding</p>	Quality	CEO	For staffing see risk 1 and 2		16 (4x4)			

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 7/16	<b>Case for Change</b> There is a risk that the business case to merge HEFT with UHB will not be approved or there will be additional delay to the process	Integration and Affordability	Director of Corporate Affairs	On going dialogue with NHSI and CMA  Consultation with staff and other stakeholders	Regular updates to Trust Board	12 (3x4)			



No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 1/17	Failure to achieve the Financial Plan for 2017/18 resulting in the NHSI control total being exceeded, a loss of Sustainability and Transformation Funding, cash shortages (see risk 7 below) and further regulatory action.	Affordability	Director of Finance	<p>Controls reviewed and updated.</p> <p>Financial Recovery Plan developed with EY and submitted to NHSI in May 2016.</p> <p>Monthly review of progress against trajectory and KPI's.</p> <p>Revised governance structure introduced.</p> <p>New financial reporting Framework introduced</p> <p>New divisional structures introduced to increase accountability.</p> <p>Key senior appointments made to finance team including Head of Financial Recovery and Head of Operational Finance</p> <p>New CIP policy and monitoring arrangements (online CIP tracker)</p> <p>Exec efficiency group established to review high profile cases</p>	<p>Monthly financial reporting.</p> <p>Financial Recovery Programme Board</p> <p>Divisional Review Meetings</p> <p>CIP Steering Group</p> <p>Bi-monthly exec performance reviews</p> <p>Monthly finance report to the Board of Directors</p> <p>Monthly performance report to NHSI</p> <p>Monthly call / PRM with NHSI</p> <p>Internal audit reports on key financial controls</p> <p>Head of Internal Audit opinion</p> <p>External audit / going concern assessment</p>	20 (5x4)	<p>Unidentified savings within stretch component of 2017/18 efficiency programme.</p> <p>Risk to some cross cutting schemes within FRP</p> <p>Impact of workforce issues on finances – recruitment difficulties etc</p>	<p>On going identification of CIP's and additional recovery schemes through FRPB and other forums.</p> <p>Continued focus on improving efficiency across all aspects of the organisation.</p> <p>Medical efficiency programme (focus on locums &amp; job planning)</p> <p>Workforce redesign</p> <p>Roll out of SLR and Patient Level Cost Benchmarking (Albatross) to identify further efficiency opportunities.</p>	On going

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score	Gaps in Controls and Assurances <i>(Where are we failing to put controls / systems in place or failing to make them effective)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 2/17	Deterioration of Trust's cash position as a consequence of running a deficit for a sustained period results in an inability to pay staff and suppliers	Affordability	Director of Finance	<p>Cash controls reviewed and updated.</p> <p>Weekly cash flow monitoring.</p> <p>Cash management measures in place e.g. restricting supplier payments, constraining capital expenditure.</p> <p>Discussions commenced with NHSI about need for interim revenue support and process to access.</p> <p>Financial Recovery Plan continues to reduce deficit which will reduce cash outflows.</p> <p>Ability to access interim revenue support</p> <p>Interim revenue support application approved by Board 2017/18.</p>	<p>Monthly financial reporting.</p> <p>Financial Recovery Programme Board</p> <p>Monthly finance report to the Board of Directors</p> <p>Weekly cash report to NHSI</p> <p>Monthly performance report to NHSI</p> <p>Monthly call / PRM with NHSI</p> <p>Internal Audit reports including cash management</p> <p>External audit of annual accounts</p>	20 (5x4)	Ability to secure STF funding for 2017/18 through achievement of control total and delivery of ED 4 hour target	<p>Finalise proposals for establishing interim revenue support in 2017/18.</p> <p>Gain necessary Board approvals for the facility.</p> <p>Continued action to deliver 2017/18 Financial Plan (see 6 above).</p>	On going

No.	Risk Description <i>(Describe the risk that threatens the objective)</i>	Trust objective	Owner	Controls <i>(What existing controls and processes are in place to manage the risk)</i>	Assurance <i>(Where can we gain evidence that the controls and systems in place are effective)</i>	Current Score (LxC)	Gaps in control or assurance <i>(Are there any gaps in controls or assurance?)</i>	Action Plan <i>(What further action (if any) is necessary to address the gap?)</i>	Time frame
SRR 3/17	<p><b>Breach of Regulatory Requirements.</b></p> <p>Regulators include CQC, NHSI (Monitor), HSE, GMC,NMC, may intervene to reduce independence of board and restrict service</p> <p><b>Context:</b> Monitor may intervene in relation to concerns with any of the themes listed in the Single Oversight Framework. The Trust is currently assessed as level 3 segment, meaning that we receive mandated support.</p> <p>CQC may intervene where there is evidence of failure to meet the fundamental standards in the 5 domains. The Trust was last inspected in October 2016 where a provisional grading of “requires improvement” was given</p> <p>HSE may intervene on the basis of any concern regarding and may issue improvement or prohibition notices and may prosecute.</p>	Quality	Director of Corporate Affairs	<p>Performance monitoring arrangements</p> <p>Quarterly divisional performance meetings</p> <p>On going dialogue with main regulators including CQC and NHSI</p> <p>Contract review meetings</p> <p>NHSI and CQC action plans</p> <p>Internal Audit</p>	<p>Board performance reports</p> <p>Quarterly performance packs</p> <p>Internal Audit reports</p> <p>CQMG reports</p>	8 (2x4)			On going

**HEART OF ENGLAND NHS FOUNDATION TRUST**

**Board of Directors**

**23<sup>rd</sup> October 2017**

<b>Title:</b>	<b>QUARTER 2 COMPLIANCE AND ASSURANCE REPORT</b>
<b>Responsible Director:</b>	David Burbridge, Interim Director of Corporate Affairs
<b>Contact:</b>	Ann Keogh, Head of Clinical Safety and Governance

<b>Purpose:</b>	To present an update to the Board of Directors of the internal and external assurance processes around compliance with NICE and local guidelines, national and local clinical audits, NCEPOD and Novel Techniques.	
<b>Confidentiality Level &amp; Reason:</b>	None	
<b>Annual Plan Ref:</b>	Affects all strategic aims	
<b>Key Issues Summary:</b>	<p>Final CQC report received and response prepared to the requirement notices</p> <p>Summary of external visits undertaken since Q2 2016/17</p> <p>Increasing numbers of NICE guidance awaiting response from Directorates</p> <p>Update on review of Clinical Guidelines : 45% of clinical guidelines are out of date</p>	
<b>Recommendations:</b>	The Board of Directors is asked to receive the report.	
<b>Approved by:</b>	David Burbridge	Date: October 2017

# HEART OF ENGLAND NHS FOUNDATION TRUST

## Board of Directors

23<sup>rd</sup> October 2017

### COMPLIANCE AND ASSURANCE REPORT

#### PRESENTED BY THE INTERIM DIRECTOR OF CORPORATE AFFAIRS

## 1 Purpose

The purpose of this paper is to provide the Board of Directors with information regarding internal and external compliance.

## 2 Trust Compliance with Regulatory Requirements - Care Quality Commission (CQC)

2.1 A Care Quality Commission (CQC) inspection was carried out within Heart of England NHS Foundation Trust (HEFT) in quarter 3 2016/2017. The inspection commenced with an unannounced visit on 6<sup>th</sup> September 2016 and a further visit 18<sup>th</sup> to 21<sup>st</sup> October 2016.

2.2 HEFT received the draft report from the CQC for factual accuracy in June 2017 and the final report was published on 2nd August 2017.

2.3 CQC did not rate the trust overall for this inspection as they did not inspect the exact same services and domains as in December 2014. However they did give the "Well-led" section a rating as they felt they had sufficient information to do so at an overall level.

2.4 The overall rating for the Trust on the CQC website remains: requires improvement which is the same as the 2014 inspection despite the improvements noted during the 2016 inspection:

2.4.1 Safe: requires improvement

2.4.2 Effective: good

2.4.3 Caring: requires improvement

2.4.4 Responsive: requires improvement

2.4.5 Well-led: good

2.5 The current report describes the ratings each core service achieved and how that compared to the previous inspection.

### 2.5.1 ED overall rating:

a) BHH: requires improvement (inadequate in 2014)

b) SH: good (requires improvement in 2014).

c) GHH was requires improvement (same as 2014)

### 2.5.2 Medical Care overall rating:

a) GHH and SH: good (improvement on the previous inspection).

b) BHH remained the same with a rating of requires improvement.

### 2.5.3 OPD DI:

a) BHH and GHH increasing their ratings to good from requires improvement.

b) SH remained the same with a good rating.

- 2.5.4 **Surgery** was rated as requires improvement at BHH and GHH, with good at SH. Not rated in 2014
- 2.5.5 **Critical Care** achieved a good rating at this inspection at BHH.
- 2.5.6 The Chest Clinic, Runcorn Road Dialysis, Castle Vale Renal Unit and Community adult services were all rated good for all domains, with the exception of Runcorn Road Dialysis well-led domain which achieved an outstanding rating.
- 2.5.7 The CQC ratings are for the services inspected are set out in **Appendix 1**.

## 2.6 Requirement Notices

The following "Requirement Notices" were identified within the final CQC report, where it was considered that HEFT did not meet the CQC fundamental standards:

### 2.6.1 Safe Care and Treatment - Regulation 12 2 (d), (g), (h)

- a) Medical and nursing staff at both Birmingham Heartlands Hospital and Good Hope Hospital in outpatients, theatres and the ED did not follow good IPC practices.
- b) The Trust did not collect data to determine rates of surgical site infection at Solihull Hospital.
- c) The three side rooms in intensive care at Birmingham Heartlands Hospital did not have negative pressure to contain any bacteria within the room to reduce the risk of cross infection to other patients.
- d) The environment in ED at Birmingham Heartlands Hospital did not meet the needs of patients waiting. Having patients waiting in the corridor compromised their safety, resulted in ambulance waits and prolonged handover waits.
- e) In the surgical department at Birmingham Heartlands Hospital expired controlled medicines for patients were not disposed of correctly. Staff did not record fridge temperatures accurately and temperatures exceeded recommended limits. Staff supplied and administered medicines under Patient Group Directions (PGD) when they were not trained to do so.

### 2.6.2 Premises and Equipment – Regulation 15 1(b), 1(c)

All premises and equipment used by the service provider must be secure and suitable for the purpose for which they are being used

- a) The premises in ED were not suitable for the service provided, including the layout and size to accommodate the potential number of people using the service at any one time.
- b) Security and access to the critical care unit was not sufficiently robust.
- c) Security and auditing of clinical waste storage did not meet required standards.

### 2.6.3 Regulation 18: Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.

- a) Solihull Hospital Medical Care - ensure staffing numbers are sufficient to meet the needs of patients. We saw that staffing levels were not sufficient to meet the needs of patients.

## 2.7 Summary of the recommendations

- 2.7.1 The recommendations in the report are a combination of area specific and Trust wide recommendations, and are split into “must do” (18) and “should do” (44) recommendations:
- 2.7.2 The majority of the “should and must do” recommendations have been completed or form part of “business as usual”. A report outlining outstanding/on-going actions will be sent to the Directorate Quality and Safety Meetings with exception reporting to the Divisional Quality and Safety Meetings.
- 2.7.3 The Trust has prepared a response to 17 of the 18 breaches of regulations (the “must do” recommendations, set out in **Appendix 2**)
- 2.7.4 Further information regarding the CQC’s comments under regulation 15 (Premises and Equipment 1b), specifically relating to security and access to the critical care unit has been requested to assist the Trust in its response to this point.

## 3 Trust Compliance with Regulatory Requirements - NICE guidance

### 3.1 Overall Position (Data Extracted 06/10/17)

- 3.1.1 The Clinical Audit team have undertaken a baseline assessment of NICE guidance to date and the current status. They are working with the Divisions and Directorates to update the status where they have not been fully implemented or implemented where applicable.
- 3.1.2 1,148 unique NICE guidelines applicable to the Trust have been published to date.

Guidance Fully Implemented	414 (36.1%)
Guidance Fully Implemented (Where Applicable)	80 (7.0%)
Guidance Not Applicable	390 (34.0%)
Guidance Not Implemented	72 (6.3%)
Guidance Partially Implemented (Action Required)	17 (1.5%)
Guidance for information only	16 (1.4%)
Guidance awaiting a response from directorates	159 (13.9%)

- 3.1.3 The figures above include 29 guidance published on the last working day of September 2017. This guidance was distributed to divisions on 4th October within agreed timescales for the distribution of newly published or updated guidance. Divisions are requested to provide a response within 30 working days of publication, at the time of the report the deadline had not been reached.
- 3.1.4 It should be noted that there has been a steady rise over the last year in the number of guidance items awaiting response from directorates. The Clinical Audit and Governance Facilitation Teams are actively working with Directorates and Divisions to clarify the position and gain updates.

### 3.2 Quarter 2 Guidance

3.2.1 The table below summarises all unique guidance published in Q2. Divisional and directorate level information is provided via Divisional Quarterly Governance Reports.

3.2.2 Please note that at the time of the report the September 2017 guidance had been distributed to divisions; however the 30 day period for response from directorates had not been reached. This guidance is included within the data below within the awaiting response category.

	For information only	I	NA	NI	PI (FIWA)	Awaiting directorate response	Grand Total
TA (Technology appraisal guidance)	3	7				22	32
CG (Clinical guidelines)						9	9
NG (NICE Guidelines)						7	7
QS (Quality Standards)						7	7
IPG (Interventional procedures guidance)			3	1		6	10
MIB (Medtech innovation briefing)	5		3		1	6	15
PH (Public Health guidance)						2	2
DG (Diagnostics guidance)	1					1	2
HST (Highly specialised technologies guidance)						1	1
MTG (Medical technologies guidance)						1	1
ES (Evidence summary)	1						1
<b>Grand Total</b>	<b>10</b>	<b>7</b>	<b>6</b>	<b>1</b>	<b>1</b>	<b>62</b>	<b>87</b>

Guidance: Fully Implemented I; Not Applicable NA; Not Implemented NI; Partially Implemented (Action Required) PI (AR); Fully Implemented (Where Applicable) PI(FIWA)

### 3.3 Good Practice Guidance on Patient Group Directions

3.3.1 Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. This guideline (MPG2) covers good practice for developing, authorising, using and updating patient group directions.

3.3.2 In March 2017, changes were made to update the format of this guideline in response to the changes, the Pharmacy Directorate have completed a NICE baseline assessment against the updated guidance which shows that the Trust meets all 65 recommendations (100%).

### 3.4 NICE Public Board Meeting

- 3.4.1 NICE held their public board meeting at Birmingham Heartlands Hospital on 20 September 2017. An area of note from the meeting is NICE's intention to increase capacity within their technology appraisal (TA) programme.
- 3.4.2 Prior to 2014/15 NICE produced on average 30 TAs per year. The 2017/18 target is 55 TAs. It is anticipated that this may rise to 75 TAs each year.
- 3.4.3 Technology appraisals assess the clinical and cost effectiveness of health technologies - such as new pharmaceutical and biopharmaceutical products - but also include procedures, devices and diagnostic agents. This ensures that all NHS patients have equitable access to the most clinically and cost-effective treatments that are available.
- 3.4.4 Regulations require Clinical Commissioning Groups, NHS England and Local Authorities to comply with recommendations in a technology appraisal within 3 months of its date of publication.

## 4 Trust Compliance with External Visits/Peer Reviews

- 4.1 An updated External Agency Policy was approved at the Chief Executives Group on the 24<sup>th</sup> July 2017, which sets out the process for ensuring the appropriate coordination and evaluation of external recommendations arising from external agency visits, inspections, accreditations and peer review/assessment.
- 4.2 Since Q2, 2016/17 there were **2** external visits during Q3, 16/17, **2** external visits during Q4, 16/17, **4** during Q1, 17/18 and **3** during Q2, 17/18.
- 4.3 The current status of the external visits (**Appendix 3**) using the definitions within the policy are as follows:
  - 4.3.1 **Positive assurance:** No concerns or risks were identified or all actions have been completed and evidenced: **2 visits**
  - 4.3.2 **Neutral assurance:** Concerns/risks were found and an action plan has been received by the Safety and Governance Directorate to address all shortfalls: **8 visits**
  - 4.3.3 **Negative assurance:** Major concerns/risks were identified during the visit or identified actions are overdue: **1 visit** see below:

Public Health England (PHE) Screening Quality Assurance Visit

The QA team identified 6 high priority findings:

    1. Lack of administrative support for the hospital based programme co-ordinator (HBPC)
    2. Backlog of data collection for national invasive cervical cancer audit due to lack of administrative support for the HBPC
    3. Difficulties producing and reviewing cervical screening performance data & circulating to staff
    4. Cervical histological specimen turnaround times are not meeting national standards
    5. Waiting times for colposcopy appointments are not meeting national standards

6. Attendance of colposcopists at colposcopy MDT meetings does not meet the national standard

There were 16 actions within the 3 month time frame and 5 within 6 months. An update was sent to SQAS 04/10/17 detailing progress

**3 month actions:** 1 action is incomplete as outlined below:

- Update the Hospital Based Programme Co-ordination (HBPC) job description to include indicative time and details of administrative support. The JD has been updated and is currently with HR for sign off

**6 month actions:** 2 are complete, 3 are overdue and outlined below:

- Data collection for the national invasive cervical cancer audit is up to date
- Cervical histology specimen turnaround times meet national standards
- Audit adherence to the national human papilloma virus (HPV) triage and test of cure protocol

## 5 Clinical Audits

### 5.1 Forward Audit Programme

5.1.1 The 2017/18 Forward Audit Programme (FAP) was approved by Audit Committee on 24 July 2017 and included all level 1 (national must do audits) and level 2 (internal must do audits). Directorates were requested to populate the level 3 (department priority) and level 4 (clinician interest) audits. The FAP is owned at divisional level and is aligned to the Trust's strategic and corporate objectives. Both national and local audits are included within the FAP.

5.1.2 In July 2017 there was a 38.5% FAP return rate which had increased to 62.7% by 20 September 2017. The Clinical Audit Team is actively chasing the outstanding FAPs.

5.1.3 The current number of divisional audits and their priority levels, as indicated on the FAPs, are shown below.

Division	Level 1: External 'Must Do' Audit	Level 2: Internal 'Must Do' Audit	Level 3: Specialty/Clinical Department Priority	Level 4: Clinician Interest	Total
Div 1 (CSS)	12	24	14	24	74
Div 2 (W&C)	15	9	22	11	57
Div 3 (Em Care)	23	6	7	5	41
Div 4 (Med)	38	4	15	18	75
Div 5 (Surg)	29	12	7	9	57
<b>Grand Total</b>	<b>117</b>	<b>55</b>	<b>65</b>	<b>67</b>	<b>304</b>

5.1.4 To enable effective monitoring of audit status and to evidence assurance of implementation the directorates must ensure that all FAP audits are registered on the Clinical Audit Database. At 20 September 2017, 205 of the 304 FAP audits, so far identified by

directorates, had not been registered on the Clinical Audit Database.

- 5.1.5 A member of the Clinical Audit is meeting with 2-3 Directorate Audits Leads per week to support completion of the FAP and ongoing updating of the Audit database. This will also be followed up and monitored by the Safety and Governance Teams via divisional and directorate governance meetings and will form part of the Quarterly Quality Governance Reports distributed to Divisions and Directorates.

## 5.2 National Audits

- 5.2.1 There are 117 level 1 external “must do” audits that are identified on the Forward Audit Programme. The table below shows the status of these level 1 audits as at 6<sup>th</sup> October 2017. At present there are 55 national audits that are applicable to the Trust and reportable in the Quality Account (This will change over the year as amendments are made to the National Clinical Audit Directory by HQIP)

Division	Approved by Directorate Audit Lead	Completed - Data collection, analysis and audit report complete. Action plan developed.	Signed off - All identified actions implemented. Evidence saved to Clinical Audit Database.	Submitted on Clinical Audit Database by Clinical Lead	To be Added to Trust Audit Database by directorate audit lead	Grand Total
Div 1 (CSS)				1	11	12
Div 2 (W&C)	1			6	8	15
Div 3 (Em Care)	3			5	15	23
Div 4 (Med)					38	38
Div 5 (Surg)	2	2	1		24	29
<b>Grand Total</b>	<b>6</b>	<b>2</b>	<b>1</b>	<b>12</b>	<b>96</b>	<b>117</b>

## 6 National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

### 6.1 Studies in progress

#### 6.1.1 Cancer in Children, Teens and Young Adults

This study was not applicable to the Trust.

#### 6.1.2 Acute Heart Failure

Case note submission is on-going during September and October 2017.

#### 6.1.3 Peri-operative Diabetes Management

Peri-operative diabetes patient identifier spreadsheet was submitted to NCEPOD in June 2017.

#### 6.1.4 Young People Mental Health Study

Case notes have been submitted to NCEPOD. One set of case notes is outstanding; this has been followed up with the clinician in September 2017.

#### 6.2 Published reports

- 6.2.1 A key role of NCEPOD is to make recommendations based on the findings of the reports undertaken. Recommendations are based on themes that emerge during analysis of the data collected.
- 6.2.2 Status of current NCEPOD Reports as at 20 September 2017. The Clinical Audit Team will gain updates on the historical reports and provide an update in Q3.

<b>NCEPOD Report</b>	<b>Specialty Lead</b>	<b>Published</b>	<b>Current Status</b>	<b>Recs. fully met</b>
Acute Non Invasive Ventilation	TBC	July 2017	Leads to be invited to initial working group.	TBC
Mental Health Care in General Hospitals	Trust wide	January 2017	Ongoing action plan.	8/21
Acute Pancreatitis	Surgery	July 2016	Ongoing action plan.	6/18
Sepsis	Infectious Diseases	November 2015	Ongoing action plan	14/21
Gastrointestinal Haemorrhage	Gastroenterology	July 2015	Action plan developed areas of non-compliance risk assessed and included on the Directorate risk register.	19/21
Tracheostomy Care	Anaesthetic	June 2014	Ongoing action plan	13/25
Alcohol Related liver disease	Acute Medicine	June 2013	Ongoing action plan	19/28
Cardiac Arrest procedures	Resuscitation	June 2012	Ongoing action plan.	16/21
Peri-operative care	Surgery	December 2011	Ongoing action plan	8/11
Surgery in Children	Surgery	October 2011	Ongoing action plan	14/17
Elective and Emergency Surgery in the Elderly	Surgery	November 2010	Ongoing action plan	12/24

## Novel Techniques and Interventional Procedures (NTIPs)

### 7.1 Proposals Approved

7.1.1 Since 2004 the NTIP Group has received 63 proposals and approved 57 proposals. Of the six proposals that did not received approval, three were not approved by the Group and three were disbanded by the proposer. Of the 57 proposals approved, seven of these procedures are no longer performed in the trust.

7.1.2 For 2017/2018 five new proposals have been approved by the NTIP Group (table 1). There are currently no proposals being reviewed by the NTIP Group.

Table 1: 2017/2018 NTIP approved proposals

NTIP no	Title	Date Approved	Proposer	Directorate
59	UroLift Laser	Apr-17	Vivek Wadhwa	Urology
60	Hilotherm Bandage	May-17	Mark Dunbar	Trauma & Orthopaedics
61	Insertion of arm portacaths	October-17	Matthew Fowler	Oncology and Haematology
62	Introduction of Trans-anal TME (TaTME) procedure to treat patients with rectal cancer	October-17	David McArthur	Surgery
63	Intravesical Hyperthermic Mitomycin	October-17	Laura Johnson	Urology

### 7.2 Audit position

7.2.1 In accordance with the Clinical Audit Policy and Procedure and the Policy for the Introduction and Development of New Techniques and Interventional Procedures, all implemented NICE and Non-NICE Interventional Procedures should be audited. Audits should be completed following completion of 25 cases or six months after the approval of the procedure, for procedures that are more rarely performed the audit period may be extended to 12 months, if required.

7.2.2 Audits have been completed for 30 of the 50 approved NTIP proposals which are still used in the Trust.

7.2.3 For the remaining 20 audits, these are either ongoing, overdue, have not yet commenced or the Clinical Audit team are awaiting confirmation of current status/completion from the proposer.

7.2.4 The Clinical Audit team has requested updates from NTIP proposers in September 2017 where the audit status is not confirmed complete and although some responses have been received, a number are outstanding and will be followed up in October 2017.

## Clinical Guideline Compliance

8.1 A review of the current guidelines status has shown that there are currently 274 documents housed centrally on the Trust's Guidelines SharePoint site

across all 5 Divisions, however not all of the documents are clinical guidelines. A number of the documents are flow charts, checklists and referral forms, not clinical guidelines. When these documents are removed from the total count the number of clinical guidelines remaining is 246. The documents, that are not clinical guidelines, are owned by Division 2 (18) and Division 4 (10). These are being reviewed with a plan to include them in the relevant existing guidelines as appendices.

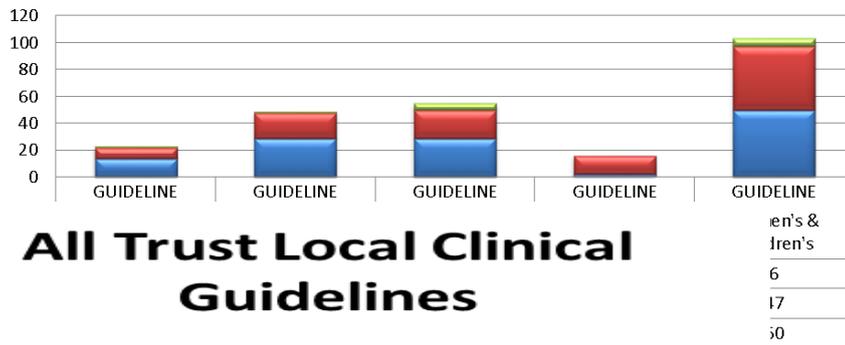
8.2 In addition there were seven links within the guideline site which were being counted as clinical guidelines. These links are to internal HEFT sites where guidelines are housed. These have been removed from the guidelines list and now sit in a 'Useful Links' section on the Clinical Guidelines Site (see table below):

Useful Link	Department	Division
<a href="#">Stroke Guidelines and Pathways</a>	Emergency Department	ED
<a href="#">Nursing Guidelines</a>	N/A	N/A
Pharmacy (Antibiotic Guidelines)	Pharmacy	Clinical Support Services
<a href="#">Enteral Feeding Guidelines</a>	Nutrition	Surgery
<a href="#">Critical Care Guidelines</a>	Critical Care	Clinical Support Services
<a href="#">Dermatology Guidelines</a>	Dermatology	Medical Specialites
Haematology & Oncology SOP	Haematology & Oncology	Medical Specialites

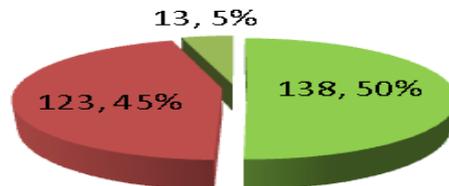
8.3 These Guidelines will need to be formally approved as Clinical Guidelines as per Trust policy and then added to the main Trust site. This will allow version control of the documents, regular review and assurance that the guideline is accessed from one location.

8.4 **Status of all 274 Local Clinical Guidelines currently housed centrally**

### All Divisions - Local Clinical Guidelines



### All Trust Local Clinical Guidelines



8.4.1 An evaluation of the guideline process and issues raised in previous reports has resulted in the following:

## 8.5 **Ratification groups**

8.5.1 All new guidelines should be overseen by the Clinical Guideline Group and uploaded onto the Trust intranet site once ratified. All working/minor updated guidelines are currently not taken to CGG for ratification, this action sits within the divisions and specialities with an expectation that they are peer reviewed (with a local terms of reference – TOR) and disseminated as appropriate.

8.5.2 It has been noted that not all guidelines are being ratified by the Clinical Guideline Group, there a number of groups within directorates that have taken on the role of ratification of clinical guidelines. This has led to a lack of a standardised process and an absence of a cohesive mechanism for ensuring that guidelines meet an adequate trust standard. The Terms of Reference for these subgroups has been reviewed and updated to ensure standardisation.

## 8.6 **Clinical guidelines tracker**

The local clinical guideline tracker has been developed allowing accurate data to be pulled quickly at divisional and directorate level and will be able to be displayed as a dashboard.

## 8.7 **Guideline documents**

The guideline team are currently liaising with directorates and divisional leads to remove documents that are not guidelines from the Trust's Guidelines SharePoint site. These are to be integrated into the appropriate guideline, to ensure easy access to referral forms etc the front page of the guideline will contain hyperlinks to all of the documents/appendices within the guideline.

## 8.8 **Guidelines held by directorates**

8.8.1 It has been identified that clinical guidelines exist within directorates that are not housed on the Trust Guidelines SharePoint site but in local sites and within departmental files. Again, there is no assurance of the ratification processes around these guidelines or evidence of update and review in line with best practice.

8.8.2 The Guidelines Team are currently liaising with the relevant directorate leads to review guidelines that are held this way. They will be providing support to ensure that these guidelines are compliant with the Trust clinical guideline process, are moved onto the formal Trust guideline site and removed from the local site.

## 8.9 **Clinical Guidelines Group (CGG) meeting**

It has been agreed that the CGG meeting will be held monthly rather than bi-monthly to increase the rate of guideline approval by the CGG and reduce the number of out of date guidelines.

## 8.10 Risk Register

- 8.10.1 Currently those guidelines which are not linked to the Trust site but are available to staff pose a risk to the organisation as there is no assurance of the ratification processes around these guidelines or evidence of update and review in line with best practice. Where possible the use of external accredited sites is recommended.
- 8.10.2 2 new risks have been identified in relation to the clinical guideline process, these are:
- a) Guidelines held on local sites that do not comply with the Trust guideline process
  - b) The integration of guidelines across HEFT and UHB following the proposed merger
- 8.10.3 Both of these risks have been assessed and included on the Safety and Governance Directorate Risk Register.
- 8.10.4 In addition, there is an existing risk on the risk register relating to the number of out of date guidelines on the Trust clinical guideline site.

## 8.11 Joint University Hospitals Birmingham (UHB) and HEFT guideline working group

- 8.11.1 A working group has been established to support the process of integration of guidelines across both organisations. The group is in the process of cross referencing the guidelines currently used at UHB and HEFT. In addition the process for management of clinical guidelines across both organisations is being reviewed with a view to establishing a single process moving forward.
- 8.11.2 As part of this process, any new guidelines or guidelines under review within each organisation will be reviewed by the relevant speciality in both trusts to ensure that they are aligned as much as possible, and where differences exist, these will highlighted within the new/updated guideline.

## 9 Recommendation

The Board of Directors is asked to accept this report.

**David Burbridge**

**Interim Director of Corporate Affairs**

**October 2017**

## Appendix 1- CQC ratings by site/service

### Birmingham Heartlands Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement				
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good

### Good Hope Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Good	Good	Good	Requires improvement	Good	Good
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good

### Solihull Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	Good	Good	Good	Requires improvement	Good

### Castle Vale Renal Dialysis Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good

### Runcorn Road Renal Dialysis Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Outstanding	Good

### Adult Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Outpatient and diagnostic imaging services – satellite sites	Good	Not rated	Good	Good	Good	Good

**Appendix 2 Response to CQC Requirement Notices**

Require-ment notices	Type and number	Site and special-ity	Exec lead	Opera-tional lead	CQC recommendation	HEFT response/comments	Dead Line	Monitoring group
Regulation 18: Staffing	MUST 01	SOL MED	Julie Tunney, Interim Chief Nurse	Andrea Field, Associate Head Nurse	The Trust must ensure staffing is in line with Safer Staffing Guidelines	<p>Executive Board Note: The recommendation within the CQC report relates to nursing workforce only at Solihull</p> <p>A quarterly staffing report is provided to commissioners to provide assurance of safe staffing levels, this includes:</p> <ol style="list-style-type: none"> <li>1. Monthly staffing compliance to agreed establishments by Division/ Speciality</li> <li>2. Mitigation where any area falls below the agreed level of compliance</li> <li>3. Evidence of compliance with NHS Standard Contract 5.2.4 relating to workforce acuity and dependency reviews.</li> </ol> <ul style="list-style-type: none"> <li>• There are circa 247 qualified vacancies across the Trust (nursing and midwifery) with a planned 196 Band 5 RN/RM new starters between August and October 2017.</li> <li>• The Trust holds monthly Saturday recruitment events throughout the year for Band 5 registered nurses</li> <li>• Discussions around safe staffing are held at the Care Quality Meetings chaired by the Chief Nurse (recent meeting dates 21st March 2017, 20th April 2017, 24th May 2017, 21st July 2017, 17th August 2017).</li> <li>• Key workforce issues including monthly safe staffing compliance are reported in the 'Ward to Board' quality reports that are presented to the Trust Board by the Chief Nurse on a monthly basis.</li> </ul>	On-going	<p>Divisional Staffing Meetings</p> <p>Care Quality Group</p> <p>Executive Board</p>

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises & Equipment 1(b), 1©	MUST 02	BHH ED	Kevin Bolger	John Sellars, Director of Asset Management	The Trust must ensure that the premises is suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time.	Site strategy shared with NHS Improvement (+E) as part of the case for changes	Complete	Executive Board
Regulation 12(2) (d)	MUST 03	BHH ED	Jonathan Brotherton, Director of Operations	Sarah Moulton, Group Manager and Deputy Head of Operations	The Trust must ensure it is doing all that is reasonably practicable to mitigate any risks in relation to patients waiting in the corridors, delays in triage and ambulance handover times.	<ul style="list-style-type: none"> <li>• All signage has been reviewed to ensure it is clear where ambulances should report to</li> <li>• Reinforced the role of the point of contact/assessment nurse for handover</li> <li>• Monthly meetings with the Ambulance Service Senior Operations Manager and Hospital Ambulance Liaison Officers (HALO's) to discuss performance, issues and service improvements</li> <li>• Designated computers for handover</li> <li>• Site based HALOs</li> <li>• Daily HALO reports</li> <li>• Escalation and deployment of corridor nurse - ED flow co-ordinator escalates any delays over 20 minutes to ED Consultant and nurse in charge</li> <li>• All over 30 min delays validated jointly between the Trust and Ambulance service to learn from any delays (SOP agreed)</li> <li>• Additional trolleys purchased to ensure timely handovers</li> <li>• Monthly data reported has shown a significant improvement in our handover delays - Trust month end sign off from performance</li> </ul>	On-going	Division 3 Quality and Safety Group

Regulation 12 (2) (h)	MUST 04	BHH ED	Julie Tunney, Interim Chief Nurse	Gill Abbot, Senior Nurse Infection Control	The Trust must ensure infection control procedures including hand washing, the use of protective clothing and cleaning procedures meet the requirements to prevent the spread of infections.	<ul style="list-style-type: none"> <li>• Wards complete a monthly hand hygiene audit and environmental audit. Any score below 90% triggers a request by the infection prevention and control team for an action plan to be developed and implemented and for the audits to be carried out weekly.</li> <li>• The infection prevention and control audit results for hand hygiene and environment are reported on the Ward to Board Dashboard and discussed at the monthly Care Quality Meeting which is chaired by the Chief Nurse and attended by Divisional Head Nurses.</li> <li>• The facilities team carry out a monthly cleaning audit with the results reported to the supervisory ward sister and the matron for the ward and also to the infection prevention and control team. Any issues or concerns are highlighted directly to the infection prevention and control team. The environmental cleaning scores are discussed at the Food and Environment Group which meets quarterly.</li> <li>• There is an annual programme of monthly hand hygiene education and compliance activities carried out throughout the Trust.</li> <li>• There are policies and procedures for hand hygiene and standard precautions and a cleaning matrix.</li> <li>• The infection prevention and control nurses carry out annual peer hand hygiene and environment audits.</li> <li>• Hand hygiene, personal protective equipment and cleaning are included in mandatory training which is completed every two years for all staff in clinical areas or with patient contact.</li> <li>• No specific concerns have been identified by the infection control team in the regular audits within ED therefore no specific actions have been instigated.</li> </ul>	On-going	Care Quality Group/TIPC
None	MUST 05	BHH ED	Julie Tunney, Interim Chief Nurse	Dawn Chaplin, Head Nurse Patient Experience	There must be effective systems to make sure that all complaints are investigated without delay.	<p><b>Current/planned actions to address the requirement</b></p> <ul style="list-style-type: none"> <li>• Revised complaints policy and leaflets provided to all ward areas.</li> <li>• Working together with divisions to resolve complaints within 30 working days as part of the policy and best practice guidelines for complaints management.</li> <li>• Better alignment between complaints staff and divisions with responsible person allocated to a specialty and division.</li> </ul> <p><b>New system in place:</b></p> <ul style="list-style-type: none"> <li>o Day 1 a complaint is launched to the Triumvirate and</li> </ul>	On-going	Performance against complaints management is monitored at Divisional Performance Review Meetings

					<p>appropriate Ward/Matron or Consultant is informed of the complaint or concern raised.</p> <ul style="list-style-type: none"> <li>o Complaint entered onto Datix and acknowledged within 3 working days.</li> <li>o Complainants are asked how they wish their complaint to be resolved i.e. with a meeting or formal response</li> <li>o All statements requested by day 10</li> <li>o Escalated to division if no response by day 15</li> <li>o Draft prepared and out to Division by day 20</li> <li>o On completion of draft a thorough QA process is instigated to provide clinical and Divisional accuracy re services and QA of complaints to make sure all questions are answered before the final sign off by the Chief Nurse.</li> </ul> <p><b>Evidence demonstrating the Trust is taking appropriate steps to address the requirement.</b></p> <ul style="list-style-type: none"> <li>• KPI reported through performance, reduction in complaints over 12 month period, escalation to triumvirate and head of complaints when complaint responses are delayed.</li> <li>• Weekly escalation document sent to heads of division and chief nurse indicating progression of every complaint by division. Monthly assurance information submitted to Board by Chief Nurse.</li> <li>• Quarterly complaint and patient experience report submitted to the CCG.</li> <li>• Progress in relation to complaints management is discussed at the Trust board via the Quality Paper which is presented by the Chief Nurse. Complaints management is also included in the Aggregated Report that is presented monthly at the Care Quality Management Group meeting.</li> <li>• A Trust-wide complaints review will commence in Quarter 3.</li> </ul>		
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Regulation 12 (2) (g)	MUST 06	BHH SURG	Dave Rosser/ Alan Jones	Tania Carruther s, Clinical Director Pharmacy	The Trust must consistently ensure medicines are stored appropriately and are suitable for use.	<p>Actions taken:</p> <ul style="list-style-type: none"> <li>• Controlled Drugs (CD) Newsletter Nov16 (for information re. returns of CDs and opiate patch administration)</li> <li>• Controlled Drugs Newsletter May17 (for information regarding returns of CDs and opiate patch administration)</li> <li>• Medicines Safety Matters Newsletter No.17 (for information regarding fridge and room temps)</li> <li>• Safe Medication Practice Group Minutes 3/11/16 (reference to verbal feedback from CQC &amp; specific issues to follow up).</li> <li>• Safe Medication Practice Group six monthly report April 2017 (reference to room temperatures in report presented to Clinical Quality Monitoring Group).</li> <li>• Safe Medication Practice Group 6-monthly report Apr16 (Reference to Safe &amp; Secure Handling audit report 2015)</li> <li>• Safe Medication Practice Group minutes May 2016 (reference to safe &amp; secure handling of medicines audit 2015 and on-going actions followed up)</li> <li>• Medicines Management Group six monthly report (April 2016) (Reference to Safe &amp; Secure Handling of Medicines Audit 2015)</li> <li>• Pharmacy Quality &amp; Safety meeting minutes November 2016 (p2) and January 2017 (on p2) (reference to on-going completion of ward storage audits and proposed use of 'respond by' documentation for ward feedback).</li> <li>• Delays in completion of audits mean that 2016 report is due for reporting to the relevant committees/groups in Sept 2017.</li> <li>• Dispensing standards amended to reflect pharmacy adding expiry dates to dispensed liquid medication Controlled Drugs</li> <li>• All CD liquids with shortened expiry upon opening must be supplied with a specific expiry date. e.g. the date 28 or 90 days after the dispensing date will be the expiry date (dependent on product information)</li> <li>• Information sent to ward managers and matrons regarding room temperature thermometers Safe Medication Practice Group June 16 (reference to actions to implement room temperature</li> <li>• Weekly top up audits undertaken</li> <li>• Quarterly medicines management audits undertaken, to increase to monthly from September 2017</li> </ul>	On- going	Safe Medication Practice Group Medicines Management Group
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Regulation 12 (2) (g)	MUST 07	BHHS URG	Dave Rosser/ Alan Jones	Tania Carruthers, Clinical Director Pharmacy	The Trust must ensure staff are trained and competent to administer medicines under PGDs.	<ul style="list-style-type: none"> <li>• NICE Guidance Patient Group Directions (GPG2) - a gap analysis was completed in November 2016. This was updated in August 2017 &amp; shared with Medicines Management Group August 2017</li> <li>• The PGD policy was reformatted into a procedure in Q4 2016/17 whilst on-going work was undertaken to complete a significant review of the procedure . The revision took account of the feedback from CQC in October 2016, the outcome of a PGD audit and the NICE Guidance.</li> <li>• The draft new procedure was discussed at Safe Medication Practice Group on 6th July 2017.</li> <li>• The new procedure was approved by the Trust Medicines Management Group on 9th August 2017</li> </ul> <p>Next steps:</p> <ol style="list-style-type: none"> <li>1. MSO will deliver training and awareness to lead pharmacists across all sites within next 2 weeks. A presentation has been developed to facilitate this and is on the medicines management website.</li> <li>2. Pharmacists will be supporting with the training and awareness in their areas once communications have been issued. MSO will help deliver training to areas not covered by them.</li> <li>3. Two weeks prior to launch w/c 2nd October 17, all wards and departmental managers will be advised of their responsibilities with implementation of the PGD procedure.</li> <li>4. w/c 2nd Oct launch the PGD procedure will be launched Trust wide via Communications and will direct registered staff to the medicines management website for the presentation.</li> <li>5. Registered staff will be expected to sign a staff signature list on the ward to say they have read the procedure supported by the presentation. This will be retained on each ward/dept.</li> <li>6. As each member of staff has read each relevant PGD for their area, they must sign a separate authorised staff list which is kept on each ward/department</li> <li>7. Mini audit will be completed at 3 months by pharmacy governance to check paperwork completed correctly</li> <li>8. A biannual audit will be included on the pharmacy Forward Audit Plan for 18-24 months' time.</li> </ol>	Nov-17	Care Quality Group Safe Medication Practice Group Medicines Management Group
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						A PGD Moodle is being developed which will streamline the process going forward e.g. will accommodate centralised for PGDs and PGDs in operation on each ward/dept. This will support PGD awareness training for new starters. This should be completed by the end of December 17.		
Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	MUST 08	CASTLE VALE RENAL UNIT	Jonathan Brotherton, Director of Operations	John Sellars, Director of Asset Management	The Trust must review and improve security and access arrangements at the unit.	<p>A full security audit has been arranged involving the Trust's LSMS to identify any shortfalls in local procedures and physical access restriction required. Once the audit has been completed a bid for funding will be made to rectify all high risks.</p> <p>This audit will also be extended to our other renal unit located in Balsall Heath (Runcorn Road)</p>	Feb-18	Safety Group
Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	MUST 09	CASTLE VALE RENAL UNIT	John Sellars, Director of Asset Management	Sharon Rogers, Group Manager, Division 4	The Trust must review its clinical waste storage at the unit.	<ul style="list-style-type: none"> <li>The issue with regards to working bin locks has been taken up several times with the current contractor and there is a programme of visits arranged by the facilities team to inspect the site to assess the storage area and look at workable solutions to secure it.</li> <li>There is a plan to review the unit to assess the feasibility of creating an outside secure unit for clinical waste, this will be discussed at the waste management group meeting</li> </ul>	Dec-17	Waste Management Group

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	MUST 10	CASTLE VALE RENAL UNIT	John Sellars, Director of Asset Management	Sharon Rogers, Group Manager, Division 4	The Trust must ensure only clinical waste skips with working locks are accepted and used at the unit.	<ul style="list-style-type: none"> <li>• The issue with regards to working bin locks has been taken up several times with the current contractor and there is a programme of visits arranged by the facilities team to inspect the site to assess the storage area and look at workable solutions to secure it.</li> <li>• The issue of faulty locks on clinical waste bins has been brought to the attention of the Trust's clinical waste contractor.</li> <li>• The department manager will develop a checklist for completion each week when the waste bins are delivered, this will include: Broken locks, damaged lids, dirty bins, faulty wheels.</li> <li>• Any waste bins found to be unsatisfactory will not be accepted</li> </ul>	Sep-17	Waste Management Group
Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©	MUST 11	CASTLE VALE RENAL UNIT	John Sellars, Director of Asset Management	Sharon Rogers, Group Manager, Division 4	The Trust must review its waste audit process to ensure audits are carried out properly and are effective.	<ul style="list-style-type: none"> <li>• The Trust has a Waste Management Policy</li> <li>• Waste audits are undertaken quarterly by the Estates Department</li> <li>• Any areas of non-compliance are reported to the ward manager/department manager</li> <li>• A monthly facilities meeting is held and audit results are reviewed at this meeting</li> <li>• A quarterly multi-professional waste management group meeting takes place</li> <li>• New processes implemented in response recommendations</li> <li>• In addition to the above processes in place within Estates, the department manager undertakes a monthly waste audit, the Matron will check the audit process and findings bi-monthly to ensure that it is robust</li> <li>• The department manager will develop a checklist for completion each week when the waste bins are delivered, this will include: Broken locks, damaged lids, dirty bins, faulty wheels.</li> <li>• Any waste bins found to be unsatisfactory will not be accepted</li> </ul>	Feb-18	Waste Management Group

Regulation 12 (2) (g)	MUST 12	GHH ED	Dave Rosser/ Alan Jones	Tania Carruther s, Clinical Director Pharmacy	The ED at Good Hope Hospital must ensure they follow policies and procedures about managing medications; including storage, checking medications are in date, and safe disposal of medications.	<p>Actions taken:</p> <ul style="list-style-type: none"> <li>• Controlled Drugs (CD) Newsletter Nov16 (for information re. returns of CDs and opiate patch administration)</li> <li>• Controlled Drugs Newsletter May17 (for information regarding returns of CDs and opiate patch administration)</li> <li>• Medicines Safety Matters Newsletter No.17 (for information regarding fridge and room temps)</li> <li>• Safe Medication Practice Group Minutes 3/11/16 (reference to verbal feedback from CQC &amp; specific issues to follow up).</li> <li>• Safe Medication Practice Group six monthly report April 2017 (reference to room temperatures in report presented to Clinical Quality Monitoring Group).</li> <li>• Safe Medication Practice Group 6-monthly report Apr16 (Reference to Safe &amp; Secure Handling audit report 2015)</li> <li>• Safe Medication Practice Group minutes May 2016 (reference to safe &amp; secure handling of medicines audit 2015 and on-going actions followed up)</li> <li>• Medicines Management Group six monthly report (April 2016) (Reference to Safe &amp; Secure Handling of Medicines Audit 2015)</li> <li>• Pharmacy Quality &amp; Safety meeting minutes November 2016 (p2) and January 2017 (on p2) (reference to on-going completion of ward storage audits and proposed use of 'respond by' documentation for ward feedback).</li> <li>• Delays in completion of audits mean that 2016 report is due for reporting to the relevant committees/groups in Sept 2017.</li> <li>• Dispensing standards - p11 - amended to reflect pharmacy adding expiry dates to dispensed liquid medication (attachment)Controlled Drugs</li> <li>• All CD liquids with shortened expiry upon opening must be supplied with a specific expiry date. e.g. the date 28 or 90 days after the dispensing date will be the expiry date ( dependent on product information)</li> <li>• Information sent to ward managers and matrons regarding room temperature thermometers</li> <li>• Safe Medication Practice Group June 16 (reference to actions to implement room temperature</li> <li>• Topping up audit is completed weekly</li> <li>• Quarterly medicines management audit has been undertaken, this will be increased to monthly from Sep17</li> </ul>	On- going	Safe Medication Practice Group Medicines Management Group
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Regulation 12 (2) (h)	MUST 13	GHH ED	Julie Tunney, Interim Chief Nurse	Gill Abbot, Senior Nurse Infection Control	The ED must ensure that cleanliness standards are maintained throughout the department in order to ensure compliance with infection prevention and control requirements. (The Emergency department at Good Hope Hospital had blood on the floor from a previous patient which was not cleaned before the cubicle was used for the next patient).	<ul style="list-style-type: none"> <li>• Emergency departments are cleaned by domestic staff in line with the national specification for cleaning and a quarterly audit of cleanliness is carried out by the facilities team.</li> <li>• The department completes a monthly environmental audit and a peer audit is carried out by the infection prevention and control team annually and then as required.</li> <li>• The infection prevention and control team advise that cubicles, couches and equipment in clinical areas are decontaminated between patient use using disinfectant wipes or hypochlorite solution.</li> <li>• The department have introduced a laminated checklist in each cubicle which is completed and signed as evidence that the cubicle has been cleaned and checked between patients.</li> <li>• The staff in the department use the green indicator tape to identify that equipment has been cleaned between patients.</li> </ul>	On-going	Care Quality Group Trust Infection Prevention & Control Group
Regulation 12 (2) (g)	MUST 14	GHHS URG	Dave Rosser/ Alan Jones	Tania Carruthers, Clinical Director Pharmacy	The Trust must consistently maintain medicines within their correct storage conditions to ensure medicines are suitable for use.	<p>Actions taken:</p> <ul style="list-style-type: none"> <li>• Controlled Drugs (CD) Newsletter Nov16 (for information re. returns of CDs and opiate patch administration)</li> <li>• Controlled Drugs Newsletter May17 (for information regarding returns of CDs and opiate patch administration)</li> <li>• Medicines Safety Matters Newsletter No.17 (for information regarding fridge and room temps)</li> <li>• Safe Medication Practice Group Minutes 3/11/16 (reference to verbal feedback from CQC &amp; specific issues to follow up).</li> <li>• Safe Medication Practice Group six monthly report April 2017 (reference to room temperatures in report presented to Clinical Quality Monitoring Group).</li> <li>• Safe Medication Practice Group 6-monthly report Apr16 (Reference to Safe &amp; Secure Handling audit report 2015)</li> <li>• Safe Medication Practice Group minutes May 2016 (reference to safe &amp; secure handling of medicines audit 2015 and on-going actions followed up)</li> <li>• Medicines Management Group six monthly report (April 2016) (Reference to Safe &amp; Secure Handling of Medicines Audit 2015)</li> <li>• Pharmacy Quality &amp; Safety meeting minutes November</li> </ul>	On-going	Safe Medication Practice Group Medicines Management Group

						<p>2016 (p2) and January 2017 (on p2) (reference to on-going completion of ward storage audits and proposed use of 'respond by' documentation for ward feedback).</p> <ul style="list-style-type: none"> <li>• Delays in completion of audits mean that 2016 report is due for reporting to the relevant committees/groups in Sept 2017.</li> <li>• Dispensing standards - p11 - amended to reflect pharmacy adding expiry dates to dispensed liquid medication (attachment)</li> </ul> <p>Controlled Drugs</p> <ul style="list-style-type: none"> <li>• All CD liquids with shortened expiry upon opening must be supplied with a specific expiry date. e.g. the date 28 or 90 days after the dispensing date will be the expiry date ( dependent on product information)</li> <li>• Information sent to ward managers and matrons regarding room temperature thermometers Safe Medication Practice Group June 16 (reference to actions to implement room temperature</li> <li>• Weekly top up audits undertaken</li> <li>• Quarterly medicines management audits undertaken, this will be increased to monthly from September 2017</li> </ul>		
Regulation 12 (2) (h)	MUST 15	GHHS URG	Julie Tunney, Interim Chief Nurse	Divisional Head Nurses and Divisional Directors	The Trust must ensure that theatre staff wear appropriate clothing outside of theatres to reduce the risk of spread of infection.	<ul style="list-style-type: none"> <li>• A revised uniform policy was launched throughout the Trust in July 2017, supported by a communications campaign and a programme of check and challenge by the senior nurses</li> <li>• The uniform policy was discussed at the following meetings: <ul style="list-style-type: none"> <li>o Monthly Care Quality meeting</li> <li>o Quarterly Trust Infection Prevention Committee</li> <li>o Surgery Quality &amp; Safety Meeting</li> </ul> </li> </ul>	On-going	Divisional Quality Safety Meetings

Regulation 12 (2) (h)	MUST 16	SOL SURG	Julie Tunney, Interim Chief Nurse	Martin Richardson	The hospital did not collect data to determine rates of surgical site infection at Solihull Hospital.	<ul style="list-style-type: none"> <li>• The Trust has contributed to the mandatory requirement for audit of surgical site infection in one type of orthopaedic operation for one quarter a year. This was carried out in 15/16 at Heartlands Hospital for fractured neck of femur. This is not performed at Solihull. Heartlands Hospital is also contributing voluntarily to large bowel surgery SSI which is not carried out at Solihull.</li> <li>• The surgical division 5 will review and develop a programme of collection of surgical site infection data, including post discharge, to ensure we maintain the mandatory T&amp;O reporting and continue to contribute and increase our participation in the voluntary surveillance.</li> <li>• Further work will be undertaken to develop an on-going monitoring process for surgical site infection as captured within the Copeland Risk Adjusted Barometer tool.</li> <li>• The infection prevention and control team are currently collecting data relating to rates of surgical site infection in Solihull community services within podiatric surgery.</li> </ul>	Dec-17	<p>Division 5 Quality and Safety Group</p> <p>Trust Infection Prevention &amp; Control Group</p>
Regulation 12 (2) (h)	Regulation	BHH critical care	Kevin Bolger	John Sellars, Director of Asset Management	<p>The three side rooms in intensive care at Birmingham Heartlands Hospital did not have negative pressure to contain any bacteria within the room to reduce the risk of cross infection to other patients.</p>	<p>No active plans in place to replace . This has been reviewed but the cost is prohibitive and will go into the site strategy.</p> <p>We attempt to mitigate against the risks of infecting HCWs through a detailed process of infection control supervision of the cases and training of staff. We also have to consider other infections that require respiratory precautions like influenza, and of course the neutropaenic septic patients that require positive pressure rooms.</p> <p>There have been no recorded events of nosocomial cross transmission of tuberculosis in the critical care unit. The management of patients with tuberculosis involves close supervision by infection control through the maintenance of closed ventilation circuits as well as adequate respiratory precautions. Whilst these measures have been effective so far, they are not a substitute for isolation rooms that have negative pressure capability. The longer term solutions will involve refurbishment of the current facilities or the commissioning of new isolation rooms with negative pressure capability."</p>	On-going	Executive Board

<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and Equipment 1(b), 1©</p>	<p>Regulation</p>	<p>BHH critical care</p>			<p>Security and access to the critical care unit was not sufficiently robust.</p>	<p>Comment in CQC report Staff also showed us the ITU waiting room, which was located within another department. Staff told us that as the waiting area was so small that frequently relatives were in the corridor. The other department provided emergency treatment and access may be difficult if staff needed to get the patient on a trolley in an emergency.</p>		<p>The Trust has asked CQC for more information on this breach to assist with our response.</p>
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### Appendix 3 : External visits

Date of Visit	Inspecting Organisation	Division and Area Inspected	Outcome of Visit	Assurance Level	Assurance/Outstanding Actions
18 -21 Oct 16	CQC Inspection		See separate report	Neutral Assurance	
18 -19 Oct16	External Maternity Review	Division 2 Maternity Services	One of the members of the review team had previously assisted in the 2014 HEFT CQC inspection and the report identified that there has been significant progress since the CQC inspection in 2014. There was evidence of improved inter-departmental working especially notable on the GHH site.	Neutral Assurance	An action plan has been developed and approved at the CQMG meeting in July 2017; there are 19 actions in total.  The Governance Facilitation Team are supporting division 2 are working closely with the directorate to monitor progress with the action plan.
24/01/17	Public Health England (PHE) Screening Quality Assurance Visit	Division 1 Pathology Division 2 Gynaecology	The QA team identified 6 high priority findings: 1. Lack of administrative support for the hospital based programme co-ordinator (HBPC) 2. Backlog of data collection for national invasive cervical cancer audit due to lack of administrative support for the HBPC 3. Difficulties producing and reviewing cervical screening performance data & circulating to staff 4. Cervical histological specimen turnaround times are not meeting national standards 5. Waiting times for colposcopy appointments are not meeting national standards 6. Attendance of colposcopists at colposcopy MDT meetings does not meet the national standard	Negative Assurance	The actions are broken down into 3 month, 6 month and 12 month timeframes. There were 16 actions within the 3 month time frame and 5 within 6 months. An update was sent to SQAS 04/10/17 detailing progress  <b>3 month actions:</b> 1 action is incomplete as outlined below: <ul style="list-style-type: none"><li>• Update the Hospital Based Programme Co-ordination (HBPC) job description to include indicative time and details of administrative support. The JD has been updated and is currently with HR for sign off</li></ul> <b>6 month actions:</b> 2 are complete, 3 are overdue and outlined below: <ul style="list-style-type: none"><li>• Data collection for the national invasive cervical cancer audit is up to date</li><li>• Cervical histology specimen turnaround times meet national standards</li><li>• Audit adherence to the national human papilloma virus (HPV) triage and test of cure protocol</li></ul>

07/02/17	Unannounced visit from Birmingham Cross City CCG	Division 5 Ward 4, BHH Thoracic Surgery	The visit to conducted in response 3 MRSA outbreaks and 2 MRSA bacteraemia cases during the period of October 2016 to January 2017. The outbreaks affected wards 3, 4 and 30. Wards 3 and 4 were visited during this inspection.	Neutral Assurance	7 actions were developed and 6 of these have been completed.  The final action is in relation undertaking a deep clean on ward 4. This was due in June 2017; however it has not been undertaken due to capacity issues.  <b>Note: An overall rating of neutral assurance has been applied as 1 action is outstanding but is beyond the control ward 4</b>
		Division 4 Ward 3, BHH Renal	See above		The Safety and Governance Directorate have received an action plan from division 4 in and all actions are now complete
21/04/17	Environment Agency: Radioactive substances Activity	Division 1 Radiology	Routine compliance assessment visit  The report was received by HEFT on the 14 <sup>th</sup> June 2017 and 2 minor recommendations were made	Neutral Assurance	The Safety and Governance Directorate have received an action plan and progress is currently within the timeframe set
13/06/17	Birmingham Cross City CCG	Division 4 Ward 12, Elderly Care, GHH	Safeguarding Assurance Visit	Positive Assurance	Overall positive feedback, 3 minor recommendations made. An action plan was developed and Safety & Governance have received confirmation that all actions are complete

13/06/17	Specialist Urology Cancer Services Review NHS England Quality Surveillance Team	Division 5 Urology	<p>2 serious concerns were identified. A serious concern is an issue that, whilst not presenting an immediate risk to patient or staff safety, is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve. The serious concerns are outlined below:</p> <ol style="list-style-type: none"> <li>1. The reviewers are not assured that all appropriate patients are being offered access to minimally invasive surgery</li> <li>2. There has been little progress in developing the recovery package. Lack of psychological support in the patients' pathway may affect the quality of the patient experience</li> </ol>	Neutral Assurance	<p>The Safety and Governance Directorate has received an action plan.</p> <p>A meeting is scheduled at UHB 11/10/17 to discuss access to robot surgery.</p> <p>An EVAS has been submitted for a band 6 nurse to provide support in oncology clinics and a band 5 nurse to provide holistic needs assessment.</p>
05/2017	Farwell Audit EL(97)52	Division 1 Pharmacy	<p><b>General Summary</b></p> <p>This was a well organised and much improved unit. While there are a few deficiencies that require attention, some important, overall this unit operates safely and the auditor was confident in the awarded rating: <b>Low Risk</b></p>	Positive Assurance	<p>An action plan has been developed. 1 important deficiency was identified during the audit and the action for this is complete. A further 11 actions have been developed based on comments or minor deficiencies and these are all progressing within the allocated timescales.</p>

19 & 20 07/17	Human Tissue Authority	Division 1	<p>The Trust met the majority of the HTA standards, three major and seven minor shortfalls were found against the following standards:</p> <ul style="list-style-type: none"> <li>• Governance and quality</li> <li>• Traceability</li> <li>• Premises/facilities and</li> <li>• Equipment standards</li> </ul> <p>1 Major shortfall action is complete and the remaining 2 are due for completion 31/10/17</p> <p>The 2 outstanding major shortfalls are outlined below:</p> <p>1. Wet tissue samples that are stored following PM examination at another licensed establishment are in pots that are not labelled with details on the type or amount of tissue they contain and therefore are not traceable.</p> <p>2. Tissue taken at PM examinations conducted at the establishment is processed into blocks and any residual wet tissue is disposed of. In the case of the tissue taken during PM examinations at the other licensed establishment, any residual wet tissue is stored. The purpose of the retention and storage of these samples is unclear, although in some cases it may be at the request of the family pending a medico-legal case.</p>	Neutral Assurance	<p>A corrective and preventative action (CAPA) plan has been developed.</p> <p>The actions for 3 of the 7 minor shortfalls are now complete and the remaining 4 are due for completion 31/10/17</p>
12/07/17	National Peer Review: Trauma Audit	Division 5	<p>1 immediate risk and 4 serious concerns were identified during the review. The immediate risk related to theatre significant challenges in accessing spinal injury care pathways at UHB</p>	Neutral Assurance	<p>Immediate Risk:</p> <p>A meeting with UHB is scheduled for late</p>

			<p>The serious concerns are outlined below:</p> <ul style="list-style-type: none"> <li>• Appropriately trained Emergency Trauma Nurse /AHP available 24/7</li> <li>• The review team were not reassured that Level 1 or Level 2 training was being delivered.</li> <li>• Administration of Tranexamic Acid (TXA) according to CRASH-2 protocol</li> <li>• Provision of trauma and rehabilitation Coordinator Service 7 days/week</li> </ul>		<p>September/early October 17</p> <p>Serious concerns:</p> <p>Actions have been developed and are due to be completed by end Nov 2017</p>
07.08.17	Cardiothoracic Surgery Review: Getting it Right First Time (GIRFT)	Division 5	<p>The following notable practice was identified:</p> <ol style="list-style-type: none"> <li>1. Busy, safe, cost effective unit</li> <li>2. Exemplary low length of stay</li> <li>3. Exemplary discharge practices, including excellent patient follow up, e.g. chest drain clinic</li> </ol>	Neutral Assurance	<p>4 actions have been identified from this review relating to:</p> <ol style="list-style-type: none"> <li>1. Cancellation rates</li> <li>2. Lung cancer resection rates</li> <li>3. Management of Empyema</li> <li>4. Coding</li> </ol>



**HEART OF ENGLAND NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS**

**23<sup>rd</sup> October 2017**

<b>Title:</b> Information Governance Annual Report and Update							
<b>From:</b> Director of Corporate Affairs				<b>To:</b> Board			
<b>The Report is being provided for:</b>							
Decision	N	<b>Discussion</b>	Y	<b>Assurance</b>	Y	Endorsement	N
<b>Purpose:</b> To provide an update on the Trusts current position in relation to Information Governance, changes in the last financial year, current compliance position and key pieces of work for the coming year.							
<b>Key points/Summary:</b>							
<ul style="list-style-type: none"> <li>• <b>2016/17 IG Toolkit submission: This was submitted as ‘not satisfactory’ and requires significant work for 2017/18.</b></li> <li>• <b>Overview of work undertaken in 2016/17, including a change in leadership for IG.</b></li> <li>• <b>Detail on the strategic direction and priority work areas required for 2017/18 to improve IG within the Trust.</b></li> <li>• <b>Current incident themes in the trust.</b></li> </ul>							
<b>Recommendation(s):</b>							
The Board is asked to review the report noting the current gaps in the organisation and the work needed to rectify them.							
<b>Assurance Implications:</b>							
Board Assurance Framework	Y/N	BAF Risk Reference No.				N/A	
Performance KPIs year to date	Y/N	Resource/Assurance Implications (e.g. Financial/HR)				Y/N	
Information Exempt from Disclosure	Y/N	If yes, reason why.					
Identify any Equality & Diversity issues							
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							
Information Governance Group (chaired by David Burbridge) 10 <sup>th</sup> April 2017							

# HEART OF ENGLAND NHS FOUNDATION TRUST

## BOARD OF DIRECTORS

23<sup>rd</sup> October 2017

### INFORMATION GOVERNANCE (IG) ANNUAL REPORT

#### 1. Introduction

- 1.1. Information Governance (IG) provides a framework to ensure all information held by the Trust (including clinical and corporate) is handled in a legal, secure, efficient and effective manner, in order to comply with the law. It also supports the delivery of organisational objectives including the provision of good quality care for our patients. IG covers all information systems and processes used to hold information whether electronic or paper based. This is the first of what will become an annual report on all activities covered under the IG agenda.
- 1.2. IG will remain at the forefront of NHS priorities in light of the release of the new General Data Protection Regulations. The Trust will be required to have a robust action plan in place (monitored by the Information Governance Group) to ensure it is compliant when the new regulations become law in mid-2018.
- 1.3. In the last financial year there have been significant changes in the leadership of this agenda within the Trust. A new Executive lead (David Burbridge) took on Board ownership for IG and in June 2016 operational responsibility was given to the Head of Risk and Compliance. At that time there was not a substantive Head of IG in post and this role was filled in October 2016. The change of leadership has resulted in significant improvements to the governance of IG but in doing so has also highlighted areas of concern regarding IG practice across the Trust which had not previously been identified which need to be addressed urgently.

#### 2. Summary

##### 2.1. 2016/17 Information Governance Toolkit Submission

A "Not Satisfactory" rating with a score of 40% has been submitted to the Health and Social Care Information Centre (HSCIC aka NHS Digital) for 16/17. A level 2 is the minimum level for passing a requirement and the Trust achieved a level 2 or above on only 13 of the 45 requirements.

Whilst in itself, this score does not create additional IG risks; it does bring potential risk to the Trust in terms of reputation, ability to work with other NHS Trusts and compliance with various regulatory requirements/expectations.

Some other implications of this submission are it places requirements on the Trust such as creating an action plan for achieving future compliance which the Trust can be monitored against and could impact on other Trusts being willing to share data with us as we are no longer a Trusted organisation.

There are a number of areas of work the Trust will need to focus on in relation to the toolkit; some of these are detailed in section 4 of this paper.

## **2.2. Freedom of Information Act Compliance (FOI)**

The Trust received 736 in 2016/17 compared to 619 requests in 2015/16, showing a significant increase. The Trust responded to 85% of requests within the legal requirement of 20 working days.

## **2.3. Serious Incidents: ICO Reporting**

The Trust reported 3 serious incidents (level 2) to the ICO in 2016/17. These included inappropriate use of system access, which has been identified as a theme over the last year; and loss of detailed handover documentation. In all three incidences the ICO determined not to take any formal action against the Trust due to the ICO audit that was being undertaken in December 2016 and the serious action taken by the Trust in relation to disciplinary and remedial action.

In 2016/17:

- A total of 194 incidents that identified IG as the compliance area, were reported on Datix.
- Of these 3 incidents were reported to the Information Commissioners Office (ICO) as they met the threshold for reporting. These related to inappropriate use of system access and loss of sensitive personal data which ended up in the public domain.
- The top incident themes were:
  - Inappropriate use of system access- this includes staff looking at records of their own, family, friends and colleagues.
  - Lack of appropriate safeguards to maintain security- this includes data left easily accessible in public areas, loss of handovers/ notes and failure to secure work areas.

## **3. Overview of key areas of work undertaken within 2016/17**

3.1. IG covers a number of areas including: Corporate Records Management; Freedom of Information and, Data Protection and Confidentiality.

3.2. The IG team provide support in a number of areas which are business as usual, including, providing expert, and sometimes 'hands on' advice to clinical and corporate teams such as tender support, new Information Sharing arrangements, provision of training, organisational change such as new services/ office moves, new contracts, projects, tailored training, incident management and investigation, as well as day to day customer and client services. This is in addition to the annual work plan that is required to support the IG Toolkit submission and general work plan for business improvement/ planning. Some specific areas are outlined below.

### **3.3. Strategic IG**

Significant work was undertaken soon after the changes to leadership outlined above to bring IG related policies up to date, to fully resource the team, to develop a clear picture of the current status of IG and develop plans for improvement. In addition, an Executive lead IG Group was re-established with a new attendee list to ensure key roles and all divisions are represented and that there was a robust governance process in place for monitoring progress with IG performance. Working to develop a culture of IG is central to this and significant awareness-raising has been undertaken in the area, as it is this which will ensure processes are adhered to and become embedded in the day to day working for all staff

### **3.4. IG Training**

The IG toolkit sets organisations a target of 95% of staff to undertake annual IG training. In October 2016 the Trust had a compliance level of around 20%; since then the IG Team have worked hard to deliver comprehensive face to face training (complimented by an e-learning package) and has managed to increase the compliance level to 75%<sup>1</sup>, which, whilst being a challenge to the team has also been a significant achievement. As part of this work, new training content was also needed in order to meet national standards.

### **3.5. Corporate Records Management**

The Trust is required to have a defined approach for corporate records (everything except individual patient records) of all types in all formats, throughout their life cycle, from planning and creation through to ultimate disposal, to ensure we have a 'corporate memory'. In 2016/17 a new policy and suite of procedures were developed and approved to support staff in this area, and as a basis for further required work in relation to implementation throughout the Trust.

### **3.6. Information Commissioners Office (ICO) Audit**

In December 2016 the ICO undertook a mandatory audit of 2 key areas- Data Protection Governance and Training and Awareness. This was as a result of a number of serious incidents reported to the ICO in 2014/15 where concerns were raised about the Trust approach to IG.

These areas were chosen due to the nature of incidents that had occurred. It is important to note that these 2 areas form a small part of the IG Assurance Framework remit.

The final report graded the Trust as Limited Assurance. The ICO report stated that: *There is a limited level of assurance that processes and procedures are in place and delivering data protection compliance. The audit has identified considerable scope for improvement in existing arrangements to reduce the risk of non-compliance with the DPA.*

As part of the report the ICO highlighted areas of good practice and made a number of recommendations, which are being used to develop an improvement plan for 2017/18. Delivery against this action plan will be reported to the Audit Committee.

### **3.7. Legacy Decisions**

During the year, as practice and process has been reviewed, it has become evident that decisions/ actions taken prior to the current team being in place have, in some cases, been incorrect. This this not only presents a potential risk to the Trust but has also impacted upon the resources within the IG Team as practices have been challenged and unpicked. Examples of this include:

- Previously submitting a 'satisfactory' (level 2) IG Toolkit with a high percentage score which was not accurate;
- Providing a leaflet to all staff attached to pay slips and marking this as compliant formal annual training.
- Approval to send text messages to any patients that present through ED in the Trust, to seek feedback, without seeking consent which is required by the Information Commissioners Office.
- Failure to site exemptions on FOI responses which is a legal requirement when refusing information.

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<sup>1</sup> As at 29/03/17

### **3.8. Freedom of Information**

The Freedom of Information (FOI) Act provides a right to request recorded information held by the Trust, and we are required to respond within a statutory timeframe of 20 working days. In the last 9 months the process has been thoroughly reviewed and streamlined, with a robust escalation process to ensure that compliance with the national target is achieved. In addition face to face training has been provided to the FOI Leads to assist them in carrying out their roles

This has resulted in a marked improvement in compliance with that target and significantly reduced the backlog which had built up early in 2016.

### **3.9. Incident Management**

A thorough review and update has been taken in relation to how IG incidents are scored, managed and investigated by the IG Team, to ensure that appropriate investigation and resulting actions are taken to mitigate the risk of re-occurrence. This includes review of all IG related incidents which are scored and followed up as appropriate, regular reporting to the IG Group, clear roles and responsibilities for those involved operationally (such as the requirement to inform the affected data subject) and a formal link being established with HR to ensure disciplinary action is considered and taken where appropriate.

## **4. 2017/18 Priorities**

The IG function has developed a comprehensive work plan, which is constantly being reviewed according to the needs of the organisation and is responsive to changes in legal and national requirements in order to provide the Board with assurance in relation to IG activities.

### **4.1. Strategic Direction**

An important piece of work for 2017/18 will be to consider and define a strategic direction in relation to a number of IG related work priorities and legal and national requirements including: the General Data Protection Regulations (GDPR) due for implementation by May 2018; a number of national and government papers such as The Power of Information<sup>2</sup>, which sets out a 10 year strategy, IG Toolkit requirements, and this should be used to inform decisions.

It is clear that a significant programme of work is necessary for the coming year in order to change the Trust culture and behaviours in relation to IG principles. The list below highlights just some of the priorities which will form part of the much wider programme of work:

### **4.2. General Data Protection European Directive/ Regulation (GDPR)**

The GDPR was released in May 2016 and must be implemented for May 2018. The government has confirmed the UK's decision to leave the EU will not affect the commencement of GDPR, and our compliance with these will be of importance when we are no longer in Europe to show us a trusted country to work with. The GDPR is the most significant change to Data Protection since it was released in 1998 and increases the requirements on organisations in relation to processing personal data beyond those within

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<sup>2</sup> <http://www.england.nhs.uk/2012/05/21/the-power-of-information/>

the Data Protection Act. The importance of the regulations is reflected in the new potential monetary penalty levy which has been set at a maximum of 30 million euro.

The Trust needs to undertake a comprehensive gap analysis to determine the level of work to meet the new regulations; however it is already clear that significant work will be required due us not meeting current Data Protection requirements.

#### **4.3. Information Governance Toolkit**

A number of pieces of work will link into the IG Toolkit as the overall compliance monitoring tool. A process has been developed to ensure this work is effectively planned with an aim to submit a satisfactory submission in March 2018.

#### **4.4. Information Governance Training (IGT Req. 112)**

Achieve an annual level of 95% compliance which is a national requirement through the NHS Operating Framework 2010/2011 and monitored through the IG Toolkit. The Trust needs to create new nationally compliant content for both new starters and existing staff and to ensure all relevant staff are monitored, e.g. volunteers, junior doctors and student nurses.

#### **4.5. Contracting (IGT Req. 110)**

A process developed and embedded to ensure all contracting activities (existing and new) need to be reviewed for possible IG requirements and to ensure appropriate clauses are agreed and are regularly monitored for Data Processors.

#### **4.6. Information Governance Awareness (IGT Req. 200s)**

There is a need to develop a communications plan to maintain and develop awareness on an annual basis, particularly around key risk areas, such as safe-haven (secure email) and legitimate access to system. In order to maintain and increase the cultural improvements/awareness in the Trust over the past year, communications need to be regular and is vital to achieving this.

#### **4.7. Information Sharing**

Clear processes and approval arrangements providing assurance, need to be developed and implemented throughout the Trust so that all sharing of personal data is clearly identified, mapped and risk assessed (data flow mapping). This is a significant exercise and the results will create a further subset of work in relation to any compliance failings identified, reviewing arrangements for how data is transferred securely and developing and approving appropriate data sharing agreements with third party organisations we share with.

#### **4.8. Information Asset Ownership (IAO) (IGT 300s)**

With cyber security at the forefront of government agenda IAO is an important area to develop. The Trust needs to develop a phased work plan based on priorities for the continuation and improvement of the current IAO framework. This work will further progress made to date, with a focus on looking to define a long term, workable, framework for the Trust. This is a key area for the Trust and one which needs to be effectively embedded with the right people, in the right roles.

To be successful this work requires support from staff across the organisation, especially the Trust SIRO, and recognition of the importance of the IAO role.

#### **4.9. Corporate Records Management**

A plan needs to be developed for implementation of a corporate records programme throughout the Trust, including an audit programme, to comply with the policy and procedures already agreed. This plan would impact upon all areas of the Trust and is a fundamental shift in the way staff manage their information.

#### **4.10. ICO Audit Actions**

The ICO audit report identified a number of required actions for the Trust which we will be monitored against over the coming year. Failure to achieve these could result in further and greater action by the ICO.

### **5. Conclusion**

- 5.1. The Trust is in a more positive position at year end. There is now a clear and honest picture of the current gaps in the implementation of a robust IG framework, awareness of the associated risks and these are recorded, and the work needed to rectify this identified. The work identified is a significant task for the Trust and will require input from all divisions.
- 5.2. IG will remain at the forefront of NHS priorities in light of the Caldicott 3 review, National Data Guardian Security Standards and release of the General Data Protection European Directive<sup>3</sup> (GDPR) and is integral to the overall future strategic direction of the Trust.
- 5.3. The IG function requests that the Board recognise and accept the strategic direction and priority areas detailed above, to support a successful IG Toolkit submission, minimise current risks, improve the culture of IG awareness in the Trust and prepare for GDPR implementation.

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<sup>3</sup> It has been confirmed the UK will still be required to comply with directive.

# HEART OF ENGLAND NHS FOUNDATION TRUST

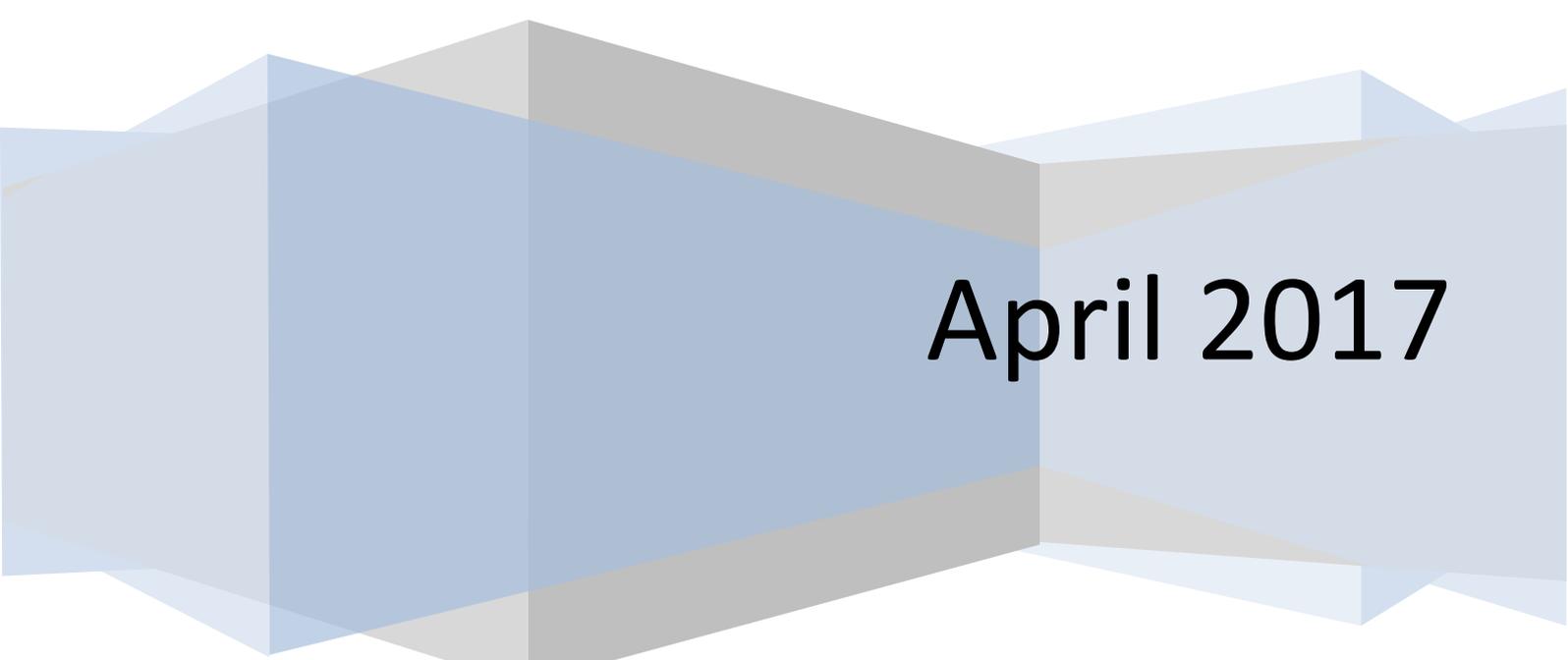
## BOARD OF DIRECTORS

**23<sup>rd</sup> October 2017**

<b>Title:</b> Emergency Planning Compliance Report							
<b>From:</b> Kellie Jervis/Jonathan Brotherton				<b>To:</b> Trust Board			
<b>The Report is being provided for:</b>							
Decision	N	Discussion	Y	Assurance	Y	Endorsement	Y
<b>Purpose:</b> Approval of annual report Agreement of HEFT compliance level against 2017 national core standards							
<b>Key points/Summary:</b>							
<u>EP annual report highlights</u>							
<ul style="list-style-type: none"> <li>• All core and supporting plans reviewed in 2016/17</li> <li>• 111 training sessions to 968 staff</li> <li>• All Civil Contingency Act exercising obligations met</li> <li>• 7 incidents/activations of plans responded to</li> <li>• Business Continuity review challenging due to changes in structures.</li> <li>• Emergency Incident awareness and Command &amp; Control Moodle modules now live</li> </ul>							
<u>EP annual report areas of concern/improvement</u>							
<ul style="list-style-type: none"> <li>• No concerns currently</li> <li>• Improvements/lessons learnt from exercises/incidents incorporated into plans and training</li> <li>• Emergency Planning (known as Major Incident awareness) now mandatory but only 3 yearly. Needs to be an annual requirement due to number of changes and significant events over past few years and months.</li> </ul>							
<u>Emergency Preparedness Resilience and Response (EPRR) National Core Standards</u>							
<ul style="list-style-type: none"> <li>• HEFT are reporting Fully Compliant against the 2017 core standards</li> </ul>							
<u>EPRR national standards areas of concern/improvement</u>							
<ul style="list-style-type: none"> <li>• No current concerns</li> <li>• Building on current successes to make further improvements to plans and training.</li> <li>• Business Continuity audit to commence in October 2017</li> <li>• Head of Emergency Planning sitting on National project group developing National Occupational Standards for EPRR</li> <li>• Head of Emergency Planning sitting on National project group developing Strategic Commander Training.</li> </ul>							
<b>Recommendation(s):</b>							
<b>The Board is asked to consider the information set out in this report</b>							
To approve the Emergency Planning annual report (attached)							
To note and accept the HEFT compliance against national core standards (attached)							
<b>Assurance Implications:</b>							
Board Assurance Framework	Y/N	BAF Risk Reference No.					
Performance KPIs year to date	Y/N	Resource/Assurance Implications (e.g. Financial/HR)		N			
Information Exempt from Disclosure	N	If yes, reason why.					
Identify any Equality & Diversity issues		NONE					
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							

Heart of England NHS Foundation Trust

# **Emergency Planning Team Year End Report for the period April 2016 – March 2017**



**April 2017**

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## **Position Statement**

This annual report details the work carried by the Emergency Planning Team (EPT) to ensure that Heart of England NHS Foundation Trust (HEFT) is able to meet its Statutory Obligations as an NHS Category 1 Responder and to support the local NHS structures within the NHS England West Midlands area.

During the period April 2016 – March 2017, the Trust and the NHS locally have seen many changes in the structures, processes and personal.

To ensure that HEFT meets its obligations the EPT has focused on the following work streams.

- 2016 review of NHS England Core Standards for HEFT
- Full Training Program for all staffing groups
- Continuation of the implementation of Initial Operational Response (IOR) across the 3 main hospitals, Community Trust and Trusts satellite sites
- Exercise Hightail, Multi Agency exercise, planning & delivery
- Exercise TriStar, local joint NHS Trusts exercise, planning & delivery
- Membership of the following NHS & Local Government Work Groups
  - Local Health Resilience Forum
  - National planning group for implementation of National Occupational Standards
  - West Midlands Conurbation Telecommunication Sub Group
  - Local Health Resilience Partnership
- Moodle training packages
- Replacement and revalidation of the CBRN response capability at Good Hope Hospital post theft (September 2016)
- Review of HEFT Emergency Incident Plans
- Review of Clinical Areas and Community Services Business Continuity & Lockdown Plans across the Trust
- Support during Incidents & Exercises

The following sections cover these work streams in greater detail.

### **2016 National Core Standards**

In 2013, NHS England released the National Core Standards for all NHS Healthcare providers in order for Trusts/Organisations to assess themselves against a set of National Core Standards. This was the first time that all NHS Organisations in England were assessed against the same set of standards for Emergency Planning and Business Continuity.

Since 2013, the EPT have been developing the plans, exercises and training to move the Trust to fully compliant. The Trust has continued to report fully compliant in all EPRR aspects of the National Core Standards since 2015 and this has continued into 2016/17.

## **2016 Emergency Incident Plans Review**

There are a wide range of Trust emergency incident plans that have been reviewed during 2016. These plans are split in to two types - Core and Supporting Plans.

These plans are available in the each of the Trusts control rooms, ED's and on the Intranet.

The following plans have been reviewed and approved over the past 12 months with the main changes to the documentation due to changes in NHS structures, national policies & plans and the Civil Contingencies definition of a Major Incident. The plans have also been amended to incorporate the lessons learned from both exercises and actual activation of plans.

### **Core Plans**

- Chemical Incident Plan which includes Biological, Radiological & Nuclear Incidents(CBRN) – All sites, geographical differences incorporated into the plan
- Internal Disaster Plan
- Major Incident Plans – Site specific, including Mass Casualty Plans for BHH
- Strategic Plan

### **Supporting Plans**

- Adverse Weather Plan – Heatwave and Cold Weather
- Business Continuity & Lockdown Plans – Department/area specific plans
- Business Continuity Policy
- Community CBRN Plan – New for 2016
- Evacuation & Shelter
- Flu Plan
- Fuel Plan – One plan covers all sites
- Lockdown Policy
- Operation Consort – One plan covers all sites, geographical differences incorporated into plan
- Overview Plan
- Pandemic Influenza – One plan covers all sites – geographical differences incorporated into plan
- Prison Emergency Response Plan – Good Hope only

- Threat Plan – Replaces Bomb Threat Plan

## **Training Programme**

All levels of staff across the Trust have continued to attend and participate in the training & exercise programme for the last financial year. Between 1<sup>st</sup> April 2016 & 31<sup>st</sup> March 2017 111 training sessions have been delivered and 968 staff members have attended training across the main 3 hospital sites as well as the Chest Clinic, Community and Satellite sites.

The calendar year 2016 has seen the Trust hit a record training attendance for EP with 1,056 staff attending 127 training sessions across the Trust.

The information detailed in Appendix 2 shows a breakdown of the training across the Trust

As of October 2016, Major Incident awareness training has been included in the Trusts Mandatory Training Programme. To aid with the delivery of this training, a number of training sessions will be available on Moodle from April 2017. (Appendix 4 details the modules that will be available on Moodle).

To ensure that all staff within the Trust had an awareness of the Trusts emergency planning arrangements & procedures, the EPT produced a Major Incident & Internal Disasters booklet called 'What's the plan'. This was sent out with the staff payslips in October, has been emailed to all new employees at HEFT as part of their new starter packs since May 2016 and to new junior doctors recording an overall compliance currently of 99%. The moodle modules will replace the booklet to ensure a more robust and auditable route of awareness/training.

In order for staff to be competent in their roles within emergency planning, the team are working with Mandatory Training and reviewing the frequency of training requirement. Currently, it is listed as a 3 yearly requirement for booklets even though we have produced them annually and the EP team feel that this training – completion of a moodle module – should be a mandatory annual requirement given the significant changes nationally and internationally within both emergency planning and terrorist attacks.

The EPT have also attended the following Department of Health funded courses to support and add value to the Trusts training programme.

- BTEC Level 3 Education & Training
- Incident Management Course
- Structured Debriefing Course

## Exercises

As part of the Trust statutory obligations within the Civil Contingencies Act 2004, it is a mandatory requirement to carry out the following exercises:-

- Live exercise, once every 3 years or activation of the Trusts Emergency Incident Plans to respond to an incident
- Desk Top exercise, once a year
- Communications exercise, twice yearly

Appendix 6 details the exercises that the Trust or the EPT have been involved with which meet our statutory obligations.

**Live Exercise** – Due to activations of Trust Command & Control procedures for the separate Ward 21 & ED floods at BHH, no live exercises have been undertaken as these supersede live exercises. There have also been a number of other exercises and activations of the Trusts Emergency Incident Plans requiring response to incidents over this period (reference Appendix 7).

**Desk Top Exercise** – During 2016/17 the EPT planned and delivered two large multi-agency desk top exercises as detailed below.

### **Exercise Tristar, 25<sup>th</sup> April 2016**

This was a combined NHS Acute Trust table top exercise involving all 3 hospital sites across HEFT, Birmingham Children's Hospital (BCH) and University Hospital Birmingham (UHB) with partner agencies such as WMAS & NHS England in support. The exercise tested our Major Incident & Mass Casualty plans against a Paris style Marauding Terrorist Firearms Attack (MTFA) taking place at multiple sites across Birmingham using the casualty load from the Paris attacks.

The aims of the exercise were:

- To test the NHS England/WMAS Mass Casualty regulation plans
- To test the Trust responses to a mass casualty
- To test communications within and outside the Trusts
- To look at the longer term effects of the incident, within and outside the Trust

### **Exercise Hightail, 6<sup>th</sup> June 2016**

Exercise Hightail was a multi-agency table top exercise testing a wide scale evacuation of a number of key buildings with significant vulnerabilities – a large

acute hospital site (BHH), a medium secure psychiatric facility and a large secondary school along with a significant number of residential premises.

The aim of the exercise was to test the Trusts Evacuation & Shelter plan, Threat Plan & the multi-agency response to vehicle borne bomb threats requiring a wide area evacuation and the total evacuation of the Heartlands site.

Due to the success of this exercise, this is now an 'off the shelf' exercise for other Trusts & organisations to use in conjunction with their local Policing unit.

Other desk top exercises are run through the Trust emergency incident training programme for ED, Tactical (Silver) Control, Strategic (Gold) Command and other key areas annual training program.

**Communications Exercise** – With support from Switchboard the Trust & EPT run 4 communications test throughout the calendar year – both in and out of hours.

The EPT & staff from other departments have also represented the Trust at a number of exercises held by partner agencies as well as supporting other Trust and colleagues to deliver their training programme, as detailed in Appendix 6.

A new training and exercise programme for 2016 – 2017 has been written with delegate numbers already exceeding the dates booked.

## **Incidents**

Between the 1<sup>st</sup> April 2016 & 31<sup>st</sup> March 2017 there have been 7 incidents across the Trust that have been managed through the Trusts Command & Control systems in & out of hours.

The types of incidents that have occurred at the Trust include the following

- Business Continuity Issues
- CBRN Capability Theft
- Flooding
- IT Failures
- Road Traffic Collision
- Suspect Package

A detailed report of the three main incidents is list below

### **Flood, Ward 21 Heartlands Hospital – 21:40hrs, 18<sup>th</sup> May 2016**

The incident was due to a tap fitting coming loose and the pressure of the water throwing it from the pipework causing a fountain of hot water at around 21.00hrs. Due to a seized stopcock the tap was unable to be isolated causing a significant amount of water on the ward – up to a max depth of approx. 8 inches. West Midlands Fire & Rescue Service (WMFS) were on site pumping out the water. The Shift Engineer was already on the ward and had called more senior estates staff to escalate the problem.

As per the NHS England EPRR framework our control rooms were up and running at both tactical and strategic level within 30 mins of the call going out – national requirement is that this is achieved within 45mins. An assessment of the situation was made with the night sister providing a briefing to Tactical Control which was passed to Strategic Command.

NHS England were contacted as part of our cascade and the 1<sup>st</sup> on Director called and briefed on the situation. NHS England offered support as required and agreed that in order for us to manage the incident he would contact the CCG and advise them of the situation also.

All response staff expected in turned up and additional staff too, over and beyond what was expected. This included additional senior managers from estates and G4S.

The situation was managed, patient safety maintained and no harm came to any patient. There were 22 patients on the ward at the time. Whilst plans for evacuation were considered and made the situation was resolved and once safety of electrics and water from infection control perspective were confirmed an evacuation was no longer required.

The incident was stood down at approximately 00.50 once all parties were assured that everything was back to normal.

A hot debrief was held post incident where several issues were highlighted that would need mitigating overnight and a full assessment first thing on the morning of the 19<sup>th</sup> May.

The full debrief report is available via the Emergency Planning Team

### **Flood, Emergency Department Heartlands – 13:23hrs, 14<sup>th</sup> June 2016**

An Internal Disaster was declared due to sewage flooding into the Paediatric ED area, back corridor of Majors A & B and ED X-Ray during an extreme summer storm.

The Trusts drainage is a combined system which means both waste and storm drains merge into one and away from the Trust. Due to the extreme amount of rainfall the storm drains were unable to cope which in turn meant that the waste drainage was unable to enter the storm drains causing it to back up which resulted in flooding.

This instigated the setup of both Tactical (silver) Control and Strategic (Gold) Command on the Heartlands site.

Tactical Control was in place by 13:30hrs with a full command and control team and Strategic Command was in place by 13:45hrs. An assessment of the situation was made with the tactical controller providing a briefing to Strategic Commander.

The Strategic Commander, making reference to the NHS England Major Incident Algorithm, declared a Major Incident to NHS England West Midlands – Birmingham, Solihull & Black Country at 14:37hrs.

Strategic (Gold) Command made contact with and informed the CCG Director on Call of this at 14:42hrs.

A total of 71 patients were evacuated from the ED department. These patients were moved as appropriate to either theatre recovery, minors, assessment areas and out patients for on-going management.

West Midlands Ambulance Service was fully supportive of the Trust during this time and worked with us to put progressive and fluid diverts where required. All surrounding trusts were also supportive with agreement for patients to go to a number of trusts specific to their needs i.e. stroke and trauma patients to UHB and children to BCH.

WMFS were quickly on scene to assist with the pumping out of the emergency department and worked closely with the trust Estates and ED staff to ensure this was done as quickly as possible.

A hot debrief was carried out directly after the incident and a full multi-agency structured debrief was conducted with a number of lessons learnt identified and an action plan was put in place.

### **CBRN Response Equipment Theft Good Hope – 26<sup>th</sup> September 2016.**

On the morning of the 26<sup>th</sup> September, the EPT discovered and reported to the Police the theft of the CBRN response trailer from the GHH. On investigation it was found that the trailer was stolen on the previous evening.

The EPT notified the NHS England & WMAS that we can only carry out Initial Operation Response (IOR – dry decon) at GHH until further notice. Due to the established links that the EPT have and contracts in place, a loan decontamination shelter was delivered to GHH by 17:00hrs on the 26<sup>th</sup> September 2016.

Over the weeks post the theft 80% of the response equipment was recovered by West Midlands Police as part of their investigations and reports from the public. A full list of the missing kit and replacement costs are detailed in appendix '5'.

The week following the theft, over 100 ED & Estates staff were released to attend the training for setting up the loan shelter.

Not only did this theft have an impact on the EPT & the GHH ED staff but also on to the Estates & Facilities Teams who gave up storage space near to ED so that staff could access the decontamination equipment but also financially. The Estates team provided funds towards the new storage unit but also in the servicing of the equipment on its return from the Police.

As of the 5<sup>th</sup> January 2017, the original CBRN response kit went live at GHH.

The EPT has responded to each of these incidents appropriately whether it is through attendance personally by a member of the team or through suitable advice.

A full list of Incidents across the Trust is detailed in Appendix 7.

## **Business Continuity Management & Lockdown Plans**

As in previous years the BCM & Lockdown project has been one of the biggest projects for the EPT during 2016. A complete annual review of Business Continuity Plans & Lockdown Plans in all Clinical areas and each Community Service was carried by the EPT. Due to changes in structures and the physical relocations this project had a 6 month impact on the Team where in previous years the review lasted 3 months.

The plan review process for 2017 is to extend the BCM review to include non-clinical areas of the Trust. The clinical area BCM's will be carried out with the Divisional Matrons and the Lockdown plans with the Ward/Department Managers. The plans will then be forwarded to each Division's Clinical Directors for ratification.

The Trust BCM review completion & ratification figures for 2016 are as follows:

<b>Area/Site</b>	<b>BCM &amp; Lockdown</b>	<b>Ratification</b>
Heartlands	93%	91%
Good Hope	100%	100%
Solihull	100%	100%
Community Services	100%	100%

## **Team Expenditure**

As in the previous financial year the Trust has been under financial constraints and the EPT budget was reduced. Appendix 9 details a breakdown of the EPT's expenditure. Training & the GHH theft have been the biggest expenditure for this financial year.

The total expenditure for this financial year is £15,236.74 with the main expenditure in the following 5 areas. See appendix 9 for complete listing.

- BCM Project £87.82
- General office supplies & miscellaneous items £419.16
- GHH Theft £4,181.10
- Response kit £3,491.16
- Training £7,057.50

A full breakdown list of all items purchased & expenditure by the team is available upon request.

## **Local Health Resilience Partnership (LHRP)**

As part of the NHS England Emergency Planning Structure, Kellie Jarvis attends the bi-monthly LHRP meetings on behalf of the Trust Accountable Emergency Officer.

The role of the LHRP is to deliver the National Emergency Planning, Response & Resilience (EPRR) Strategy at a local level and to establish a local Health Risk Register.

During 2016, Kellie Jarvis has continued to represent both our Trust and the provider trusts nationally with the implementation & creation of the NHS wide National Occupation Standards (NOS) for the Command and Control within NHS organisations.

## **Local Health Resilience Forum (LHRF)**

The LHRF is a forum of Emergency Planning Officers from NHS & Local Authority and forms the LHRP working group. This group meets monthly to work on the issues as directed by the LHRP.

This year the EPT has supported the LHRF with the creation and auditing of the Emergency Planning Best Practice and currently with the review of the Mutual Aide document to support Trusts with key information and details during a Major Incident.

## **Newsletter**

The EPT publishes the monthly Emergency Planning Newsletter 'Resilience Within'. This continues to receive positive comments from staff and departments across the Trust. During the 2016 Peer Review, this was demonstrated as good practice. A number of Trusts across the West Midlands have requested the newsletter template to use within their own organisation.

The newsletters brief the staff at all levels on various Emergency Planning and other departments subjects & policies (Appendix 8) including

- Adverse weather (Heatwave & Cold weather)
- BCM Updates and principles of BC
- Exercises – Types, dates & locations
- Incidents
- New national directives, plans & apps
- New Plans across the Trust
- Tips of the month
- Training – Types, dates & location
- What's new?

Support staff who volunteer to book on to our training programmes such as Loggist Training or Control Room Awareness session have come from the 'Resilience Within' circulation.

## **Joint Emergency Services Interoperability (JESIP)**

As part of the national JESIP strategy of collaborative working with partner agencies, we met with West Midlands Fire Service to discuss support available with decontamination of patients. At this meeting the distribution of resources within the Fire Service and national stocks were discussed and we were given the opportunity to acquire some surplus to requirement CBRN response kit. This has resulted in the Trust receiving approximately £15,000 worth of additional response equipment with no cost implications.

As a Trust we were instrumental in ensuring other Trusts were also able to benefit from this equipment rather than it just being disposed of.

### **Changes to Birmingham, Solihull & the Black Country Response**

During 2016 the response role of the Provider Incident Director of the NHS England West Midlands Incident Response Plan was disbanded by the Acute CEO's.

The Provider Tactical Advisers Rota, for which Kellie Jervis is one of four EPO's who cover this, is currently under review. Three options have been submitted to the Acute CEO's March monthly meeting to discuss the future and funding of the staff on this rota.

The CEO's have agreed that this rota is to stay in place with funding split equally between all trusts within Birmingham, Solihull & the Black Country.

Concerns have been raised in regards to a managed response to an incident where one or more acute hospitals have been activated and who will provide Provider level advice/ guidance to the NHS England Incident Director as well as other organisations and agencies during the response phase.

**Appendix 1  
Team Structure**

**Chief Executive  
Dame Julie Moore**



**Executive Director of Operations  
(Accountable Emergency Officer)  
Jonathan Brotherton**



**Head of Emergency Planning  
& Business Continuity  
Kellie Jervis (Lead at BHH)**



**Emergency Response Support Officer  
Ian Ford (Lead at GHH & Birmingham Chest Clinic)**



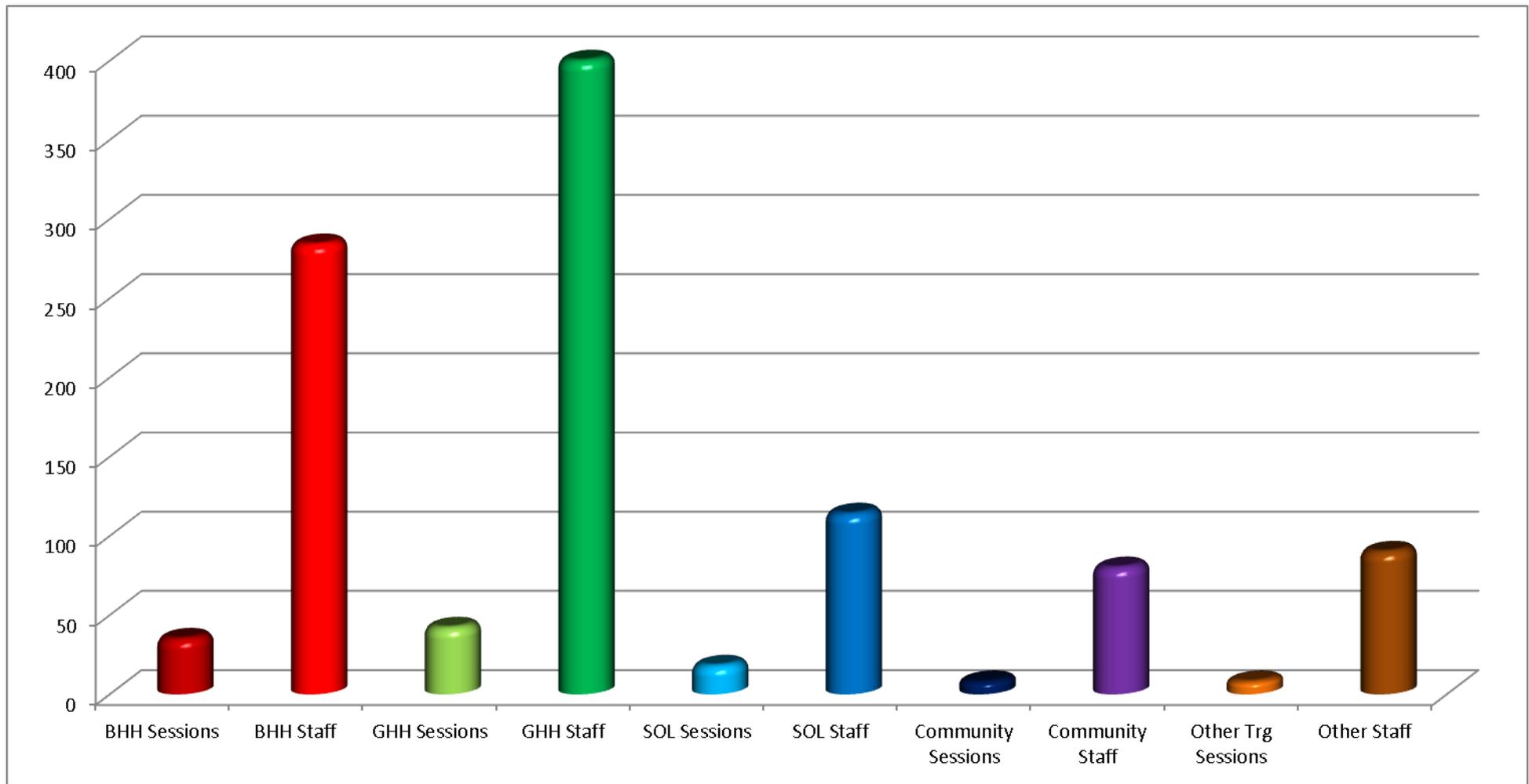
**Emergency Response Support Officer  
Marie Ingram (Lead at SOL & Community Services)**

**Appendix 2  
Training Graphical Results**

**HEFT Training Matrix for period Apr 16 - Mar 17 based on sites**

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total
BHH Sessions	2	3	8	6	1	5	5	4	1	0	0	0	35
BHH Staff	28	19	81	59	12	25	30	21	9	0	0	0	284
GHH Sessions	6	1	4	1	3	13	5	3	1	3	1	1	42
GHH Staff	29	83	38	9	15	107	57	36	8	5	10	3	400
SOL Sessions	1	1	2	3	5	1	1	0	0	1	1	2	18
SOL Staff	7	6	11	23	28	8	10	0	0	2	4	15	114
Community Sessions	2	0	2	1	0	0	0	0	0	1	1	1	8
Community Staff	9	0	18	10	0	0	0	0	0	20	9	14	80
Other Trg Sessions	1	1	0	0	0	0	2	1	1	1	0	1	8
Other Staff	5	0	18	0	0	0	56	2	1	2	0	6	90
<b>Total HEFT Sessions</b>										<b>111</b>	<b>Total HEFT Staff</b>		<b>968</b>

As of 31<sup>st</sup> March 2017



**Appendix 3**  
**Training Delivered by the Emergency Planning Team**

Type	Sessions Numbers	Staff Numbers	+/- Against 2015 – 2016
Command & Control	23	176	+
Communications Tests	3	N/A	Same
Emergency Department Staff	28	224	-
Estates Staff	8	63	+
Exercises & Others	12	160	+
IOR (Dry Decon)	10	86	+
ITU Awareness	12	156	New
Loggist	10	48	+
Replacement Decon Shelter	5	55	New – Due to GHH theft
<b>Total</b>	<b>111</b>	<b>968</b>	<b>+276 Delegates -32 Sessions</b>

## Appendix 4 Moodle Training

Course	Release Date (Estimated)	Staff Groups
Emergency Planning Generic Awareness	June 2017 (awaiting Moodle release)	All Trust staff
Emergency Department	Nov 2017 (awaiting Moodle release)	All ED staff across the Trust
Command & Control	LIVE - April 2017	All staff who form part of the on call manager or senior on call rota's
Loggist	2018	

**Appendix 5**  
**Good Hope Hospital CBRN Response Kit Theft**

CBRN Equipment			Status	Cost
Item	Components	No		
Trailer		X 1	New Container – purchased & installed	£1,500
Tent	Frame	X1	Returned	-
	Canvas	X1	Returned – loan tent procured	£750
	Floor Mats	X 4	New order – purchased & delivered	£140
	Power Point	X 1	New order – purchased & delivered	-
	Pump	X 2	1 x purchased & delivered	£261.20
	Hosepipe	X 1	1 x purchased & delivered	£30
	Hose Attachments	Numerous	Returned – Guns replaced due to damage	£79.90
	Buckets	X 6	Returned	-
	Sponges	X20	Missing – Transferred kit from BHH & SOL	-
	Detergent	X 1	Returned	-
	Bladder	X 1	1 x purchased & delivered	£765
	Door Strips	X 2	On order	£30
	Tannoy	X 1	Missing – not replacing	-
	Trolley	X 1	New order – purchased & delivered	£625
Chemical Suits (PRPS)	PRPS Small	X 3	Returned but missing camel back	-
	PRPS Medium	X 4	3 returned – 1 opened & now used as training suit. 1 transfer from SOL	-
	PRPS Large	X 3	Returned but missing camel back	-
	PRPS X Large	X 2	Returned but missing camel back	-
	Immediate Suits	X 6	2 missing – replaced with spare stock	-
Dis-Robe & Re-Robe	Re-Robe Adult	X 20	13 Returned – 7 missing/damaged	Not replacing missing/damaged equipment at this stage
	Dis-Robe Adult	X 20	18 Returned – 2 missing/damaged	
	Re-Robe Juvenile	1 Box	7 Returned – 3 missing/damaged	
	Dis-Robe Juvenile	1 box	9 Returned – 1 missing/damaged	
	Re-Robe Baby/Inf	1 box	10 Returned	
	Dis-Robe Baby/Inf	1 box	9 Returned – 1 missing/damaged	
	Meid-Wrap Blankets	1 Box	Missing – not replacing	
Electrical Items	Generator	1	Missing – not replacing	-
	tri-pod lights	X 2	Missing – not replacing due to external lights	-
	Water Heater	X 1	Returned – missing fuel tank	-
	Ext leads	X 3	Missing – not replacing	-
Sundry Items	Paper roll	X 6	Missing – replaced with BHH & SOL kit	-
	Fuel tank (10 Gallons)	X 1	Missing – Estates reviewing	Awaiting Costs
	Washing liquid (500ml)	X 1	Returned	-
<b>Total Cost</b>				<b>£4,181.10</b>

**Appendix 6**  
**Exercises Held & Attended**

Date	Event	Type of Exercise	Location	Trust or other Agency	Delegates or Level	Comments
25 Apr 16	Exercise Tri Star	Table Top	UHB	Multi-agency	All Command Levels	Joint MTFA table top exercise written by Kellie Jervis & EPO's from UHB and Birmingham Children's Hospital
Various dates	Test of MI cascade	Communications	Cross site	Trust	Trust Cascade system	Quarterly test of the Trusts MI communication cascade both in and out of hours
6 Jun 16	Exercise High Tail	Table Top	West Midlands Police – Tally Ho	Trust led multi-agency	All Command Levels	Multi-agency table top exercise coordinated and written by HEFT & West Midlands Police to test the total evacuation of Heartlands Hospital due to bomb threat
26 Jun 16	Exercise Alcazar	Table Top	Leicester	NHS England	All Command Levels	Regional mass casualty exercise ran by NHS England to test the NHS & WMAS Regional Mass Casualty plans
18 Jan 17	Community Services	Table Top	Solihull Council	Multi-agency	Tactical (Silver)	Table top exercise to test the activation of rest centres in the event of an evacuation of a residential area in Solihull
14 Mar 17	Exercise Vital Signs	Table Top	Leicester	NHS England	All Command Levels	West & East Midlands Networks exercise for a mass casualty incident

**Appendix 7**  
**Trust Incidents (Up to the 31<sup>st</sup> March 2017)**

No	Type	Date	Site	Information
1	Flooding	18 <sup>th</sup> May 16	BHH – W21	Broken tap caused a major flood out of hours on Ward 21. Tactical & Silver Controls activated and responded
2	Infrastructure – Business Continuity	12 <sup>th</sup> June 16	GHH – W24	Loss of both lifts to Ward 24 causing issue with transfer of medic patients
3	Flooding	14 <sup>th</sup> June 16	BHH – ED & X-ray	Loss of ED area including evacuation of patients and full divert in place. Full Command & Control in place
4	IT Failure	19 <sup>th</sup> – 20 <sup>th</sup> July 16	Site wide	Different IT issues across the Trust
5	Road Traffic Collision (RTC)	22 <sup>nd</sup> July 16	Solihull	RTC at North Entrance involving an elderly driver and elderly lady pushing a pram
6	Theft – Business Continuity	26 <sup>th</sup> Sept 16	Good Hope	CBRN trailer stolen
7	Suspicious Package	25 <sup>th</sup> Dec 16	BHH – Pathology	Suspect package identified and local arrangements put in place. Police & Fire attended site and local cordon put in place.
8				
9				
10				

## Appendix 8 Newsletter Example

# Resilience Within...

January 2017

### Contact the team.....

Kellie Jarvis – Head of Emergency Planning & Business Continuity – Ext 40266 – [kelly.jervis@heartofengland.nhs.uk](mailto:kelly.jervis@heartofengland.nhs.uk)

Ian Ford – Emergency Response Support Officer – Ext 43077 – [ian.ford@heartofengland.nhs.uk](mailto:ian.ford@heartofengland.nhs.uk)

Marie Ingram – Emergency Response Support Officer – Ext 40806 – [marie.ingram@heartofengland.nhs.uk](mailto:marie.ingram@heartofengland.nhs.uk)

Sharepoint - <http://sharepoint10/sites/emergencyplanning>

### CitizenAID...

Military and security experts in the UK have developed an app called CitizenAID, which offers the public a step-by-step guide to saving lives in the event of a terror attack.

The UK threat level remains at 'severe' there is no intelligence that this is to change, this app has been developed for the public to be as prepared as possible in an incident, due to the latest terror incident that have occurred.



### Business Continuity (BCM) review 2016...

The BCM & Lockdown review is now completed for 2016 and have been ratified by the Clinical Directors & add to Sharepoint.

The site completion figures stand as follows:

- BHH – 93%
- GHH – 100%
- SOL – 100%
- Community – 100% complete

### Cold Weather...

From the 1<sup>st</sup> November – 31<sup>st</sup> March, Public Health England & the Trusts Cold Weather plan will be implemented.

As per the Cold Weather Plan, regular updates will be available on the communication bulletins & Emergency Planning Share point site.

If snow or severe cold weather is forecast & you know that traditionally you have problems in getting to work, please ensure you review your rota with your line manager when alerts are issued and not on the day.



### Plan Review...

The following plans have been ratified by the Emergency Planning Group in December 2016 & added to Sharepoint

- Threat Plan
- Evacuation & Shelter
- Internal Disaster
- Prison Plan
- Cold Weather
- Pandemic Flu

### Decon Shelter GHH...

The New shelter is now in place and all the equipment & PRPS boxes have been moved to it.

In the event of an activation, the key must be requested off the Nurse in Charge of ED.

### Training...

The end of Year Emergency Incident training figures are complete for 2016 and it has been a record year. January – December 2016 has seen 1056 staff attend 127 sessions across the Trust

BHH – 331 delegates & 38 sessions  
GHH – 411 delegates & 45 sessions  
SOL – 115 delegates & 16 sessions  
Other – 199 delegates & 28 sessions

For 2017 **NEW Moodle** training packages will be available for all staff to complete and the face to face training will be more practical sessions. The attached flyer details the 2017 dates for the On Call Manager & Directors and Loggist Training.

## Appendix 9 Team Expenditure

The following figures are from the 1<sup>st</sup> April 2016 – 1<sup>st</sup> March 2017. A full breakdown of all expenditure is available through the EPT.

Category	Comments	Total Expenditure
Business Continuity Programme	Includes the following: <ul style="list-style-type: none"> <li>• Stationery</li> <li>• Folders</li> </ul>	£87.82
CBRN Response Kit Theft – GHH	Includes the following: <ul style="list-style-type: none"> <li>• Replacement kit</li> <li>• Loan of equipment</li> <li>• New storage unit</li> </ul>	£4,181.10
Response Equipment	Equipment used or to support the Trust in response to incidents. <ul style="list-style-type: none"> <li>• Radio equipment</li> <li>• Calibration of equipment</li> <li>• CBRN equipment</li> <li>• Service contract</li> </ul>	£3,491.16
Sundry Items	Includes the following: <ul style="list-style-type: none"> <li>• Stationery</li> <li>• IT equipment</li> <li>• Office equipment</li> </ul>	£419.16
Training	Includes the following: <ul style="list-style-type: none"> <li>• Courses</li> <li>• Printing costs</li> <li>• Travel</li> </ul>	£7,057.50
<b>Total Costs</b>		<b>£15,236.74</b>

## **Appendix 10**

### **Commonly used Acronyms**

BHH	Birmingham Heartlands Hospital
CBRN	Chemical Biological Radiological Nuclear
CCA	Civil Contingencies Act
COBR	Cabinet Office Briefing Rooms
COMAH	Control of Major Accident Hazards
DH	Department of Health
DPH	Director of Public Health
ED	Emergency Department
EPRR	Emergency Preparedness, Resilience and Response (DH)
EPT	Emergency Planning Team
GHH	Good Hope Hospital
ICC	Incident Coordination Centre
IMT	Incident Management Team
IRP	Incident Response Plan
IOR	Initial Operational Response
JESIP	Joint Emergency Services Interoperability
LHRF	Local Health Resilience Forum
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
NHS	National Health Service
NHS England	NHS England
PHE	Public Health England
SAGE	Scientific Advice to Government in Emergencies
SCG	Strategic Coordinating Group (Multiagency Strategic Command)
SITREP	Situation Report
SOL or SH	Solihull Hospital
SR	Sub Region - the local presence of the NHS England
STAC	Scientific and Technical Advice Cell
Team	HEFT Emergency Planning Team
WMAS	West Midlands Ambulance Service
WMFS	West Midlands Fire & Rescue Service
WMP	West Midlands Police

## NHS England Core Standards for Emergency preparedness, resilience and response

v5.0

The attached EPRR Core Standards spreadsheet has 6 tabs:

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

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

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

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

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

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

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

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

Core standard		Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers
<b>Governance</b>								
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Y	Y	Y	Y	Y
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y	Y	Y	Y	Y	Y
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y	Y	Y	Y	Y	Y
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y	Y	Y	Y	Y	Y
<b>Duty to assess risk</b>								
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, Heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites)	Y	Y	Y	Y	Y	Y
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks e.g.. Flooding, COMAH sites etc.	Y	Y	Y	Y	Y	Y
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y	Y	Y	Y	Y	Y
<b>Duty to maintain plans – emergency plans and business continuity plans</b>								
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Y	Y	Y	Y	Y

Core standard		Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers
9	Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y	Y	Y	Y	Y	Y
10		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y			Y
11		Severe Weather (Heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y
12		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y	Y	Y			Y
13		Mass Countermeasures (e.g. mass prophylaxis, or mass vaccination)	Y	Y	Y			Y
14		Mass Casualties	Y	Y	Y			Y
15		Fuel Disruption	Y	Y	Y	Y	Y	Y
16		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y	Y	Y	Y	Y	Y
17		Infectious Disease Outbreak	Y	Y	Y			Y
18		Evacuation	Y	Y	Y			Y
19		Lockdown	Y	Y	Y			Y
20		Utilities, IT and Telecommunications Failure	Y	Y	Y		Y	Y
21	Excess Deaths/ Mass Fatalities	Y	Y	Y				

Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers
22	having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			Y			
23	firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			Y			
24	<p>Ensure that plans are prepared in line with current guidance and good practice which includes:</p> <ul style="list-style-type: none"> <li>• Aim of the plan, including links with plans of other responders</li> <li>• Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions</li> <li>• Trigger for activation of the plan, including alert and standby procedures</li> <li>• Activation procedures</li> <li>• Identification, roles and actions (including action cards) of incident response team</li> <li>• Identification, roles and actions (including action cards) of support staff including communications</li> <li>• Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed</li> <li>• Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents</li> <li>• Complementary generic arrangements of other responders (including acknowledgement of multi-agency working)</li> <li>• Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes</li> <li>• Contact details of key personnel and relevant partner agencies</li> <li>• Plan maintenance procedures</li> </ul> <p>(Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))</p>	Y	Y	Y	Y	Y	Y
25	<p>Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.</p>	Y	Y	Y	Y	Y	Y
26	<p>Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.</p>	Y	Y	Y	Y	Y	Y
27	<p>Arrangements explain how VIP and/or high profile patients will be managed.</p>	Y	Y	Y			Y
28	<p>Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content</p>	Y	Y	Y	Y	Y	Y
29	<p>Arrangements include a debrief process so as to identify learning and inform future arrangements</p>	Y	Y	Y	Y	Y	Y
<b>Command and Control (C2)</b>							

Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Y	Y	Y	Y	Y	Y
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	Y	Y	Y		Y	Y
32	Documents identify where and how the emergency or business continuity incident will be managed from, i.e. the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	Y	Y	Y		Y	Y
33	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.	Y	Y	Y	Y	Y	Y
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.	Y	Y	Y		Y	Y
35	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Y		Y			
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Y		Y			
<b>Duty to communicate with the public</b>							
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Y	Y	Y			Y
	<p>Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about:</p> <ul style="list-style-type: none"> <li>- Any immediate actions to be taken by responders</li> <li>- Actions the public can take</li> <li>- How further information can be obtained</li> <li>- The end of an emergency and the return to normal arrangements</li> </ul> <p>Communications arrangements/ protocols:</p> <ul style="list-style-type: none"> <li>- have regard to managing the media (including both on and off site implications)</li> <li>- include the process of communication with internal staff</li> <li>- consider what should be published on intranet/internet sites</li> <li>- have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.</li> </ul>						

Core standard		Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers
38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	Y	Y		Y	Y
<b>Information Sharing – mandatory requirements</b>								
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and include DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supersedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	Y	Y		Y	Y
<b>Co-operation</b>								
40	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	Y	Y			Y
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y	Y	Y	Y	Y	Y
42	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y	Y	Y			Y
43	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				Y			
44	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y			
45	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y	Y	Y			Y
46	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared							
47	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months							
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y	Y	Y			Y
<b>Training And Exercising</b>								

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers
49	Arrangements include a current training plan with a training needs analysis and on-going training of staff required to deliver the response to emergencies and business continuity incidents	<ul style="list-style-type: none"> <li>• Staff are clear about their roles in a plan</li> <li>• A training needs analysis undertaken within the last 12 months</li> <li>• Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type.</li> <li>• Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate</li> <li>• Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective</li> <li>• Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective</li> </ul>	Y	Y	Y	Y	Y	Y
50	Arrangements include an on-going exercising programme that includes an exercising needs analysis and informs future work.	<ul style="list-style-type: none"> <li>• Exercises consider the need to validate plans and capabilities</li> <li>• Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties.</li> <li>• Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years.</li> <li>• If possible, these exercises should involve relevant interested parties.</li> <li>• Lessons identified must be acted on as part of continuous improvement.</li> <li>• Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective</li> </ul>	Y	Y	Y	Y	Y	Y
51	Demonstrate organisation wide (including on call personnel) appropriate participation in multi-agency exercises		Y	Y	Y			Y
52	Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y	Y	Y		Y	Y

Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Y	Y	Y	Y			Y	<ul style="list-style-type: none"> <li>Ensuring accountable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas</li> <li>Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible.</li> <li>Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles.</li> <li>Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles.</li> <li>Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation.</li> <li>That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.</li> </ul>	Jonathan Brotherton, Executive Director of Operations, is the designated AEO			
Y	Y	Y	Y			Y	<ul style="list-style-type: none"> <li>Ensuring accountable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas</li> <li>Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible.</li> <li>Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles.</li> <li>Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles.</li> <li>Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation.</li> <li>That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.</li> </ul>	Work programme, exercise programme, training programme. Exercise/incident report/recommendations/action plans. Exercise/incident/training logs available.			
Y	Y	Y	Y			Y	<ul style="list-style-type: none"> <li>Ensuring accountable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas</li> <li>Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible.</li> <li>Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles.</li> <li>Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles.</li> <li>Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation.</li> <li>That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.</li> </ul>	The Overview of Emergency Planning Arrangement and Site specific Major Incident Plans are in place and have been ratified by the Emergency Planning Group. The Overview and MIP's have all been reviewed and ratified in March 2017.			
Y	Y	Y	Y			Y	<ul style="list-style-type: none"> <li>Ensuring accountable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas</li> <li>Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible.</li> <li>Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles.</li> <li>Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles.</li> <li>Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation.</li> <li>That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.</li> </ul>	The Head of Emergency Planning and Business Continuity reports to the AEO directly and through the Emergency Planning Group. EPRR, Incidents briefing, plan validation and Core Standards are set Emergency Planning Group agenda items. This feeds to the Board through the AEO and twice yearly assurance reports to the Safety Group. Agenda & papers available on the Trust public website, <a href="http://www.heartofengland.nhs.uk/trust-board-papers-and-meetings">www.heartofengland.nhs.uk/trust-board-papers-and-meetings</a>			
Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments</li> <li>Version control</li> <li>Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages</li> <li>Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans.</li> <li>Sharing appropriately once risk assessment(s) completed</li> </ul>	The National & Local Risk Assessments are used to populated the Health Risk Register developed by the Local Health Resilience Forum. From this Risk Register training and exercises programmes are developed. Training programme is available and submitted to the Emergency Planning Group quarterly and annually to NHS England. The risk register is part of the Overview of Emergency Planning Arrangements - Appendix 1 page 17. Annual review of BCM & lockdown plans.			
Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments</li> <li>Version control</li> <li>Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages</li> <li>Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans.</li> <li>Sharing appropriately once risk assessment(s) completed</li> </ul>	The risk register is in line with the LHRP & LRF risks. See appendix 1, page 17 of the Overview of Emergency Planning Arrangements.			
Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments</li> <li>Version control</li> <li>Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages</li> <li>Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans.</li> <li>Sharing appropriately once risk assessment(s) completed</li> </ul>	Is shared through the Emergency Planning Group. The Overview of Emergency Planning Arrangements is stored on the intranet and shared with partner agencies. Risk registers reviewed at both LHRF and LHRP, the LRF risk assessments/reviews feed into the LHRF/LHRP.			
Y	Y	Y	Y		Y	Y	<ul style="list-style-type: none"> <li>Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments</li> <li>Version control</li> <li>Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages</li> <li>Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans.</li> <li>Sharing appropriately once risk assessment(s) completed</li> </ul>	Major Incident Plans in place and are annually reviewed. Current plan ratified in March 2017			

Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG	Action to be taken	Lead	Timescale
Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>identify locations which patients can be transferred to if there is an incident that requires an evacuation;</li> <li>outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation;</li> <li>take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres;</li> </ul>	<p>Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.</p> <p>Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.</p> <p>Green = fully compliant with core standard.</p>			
Y					Y		<ul style="list-style-type: none"> <li>include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required;</li> <li>make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support</li> </ul>	BCM Plan in place and ratified by the Emergency Planning Group in September 2017. Annual BCM & lockdown plan reviews undertaken & BCM Audit to commence October 2017.			
Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met.</li> <li>for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.</li> </ul>	Specific plans for Cold weather, Heatwave plans and winter/surge management plans. Current Heatwave plan ratified in June 2017. Both heatwave and cold weather plans are reviewed annually to ensure they align to the national plans.			
Y	Y	Y	Y	Y	Y	Y		Operational Pandemic Flu Plan - Ratified by Emergency Planning Group September 2016. Currently under review to go to emergency planning group in December 2017.			
	Y	Y				Y		N/A - PHE & NHS England responsibility			
	Y	Y				Y		Annex in BHH Major Incident Plan, ratified at emergency planning group in March 2017. Currently being reviewed against the lessons learnt from recent terror attacks.			
Y	Y	Y	Y	Y	Y	Y		Trust has Fuel Shortage Plan ratified by the Emergency Planning Group in September 2017.			
Y	Y	Y	Y		Y	Y		See this as an NHS England Sub Regional level plan as more coordination depending on where beds are. Normal working process link with critical care network and bed bureau response. Included within Overview of Emergency Planning Arrangements document and also detail in BHH Action Card 2. West Midland Mass Casualty planning in progress, awaiting plan.			
Y	Y	Y	Y		Y	Y		Trust has a VHF plan which is developed by Infection Prevention Control Team. A major outbreak plan has been co-written between IPCT & EP following lessons learnt from Salmonella outbreak. Reviewed and ratified September 2016. Head of EP is part of LHRP working group looking at new and emerging threats and the West Midlands response incorporating the lessons learnt from ebola as per LHRP risk register.			
Y	Y	Y	Y	Y	Y	Y		Evacuation & Shelter plan was exercised as part of a large scale multi agency table top exercise in June 2016. The plan was then reviewed and amended to reflect the lessons learnt from the exercise prior to being ratified by the Emergency Planning Group in December 2016.			
Y					Y	Y		Individual lockdown plans for clinical areas and overarching document. Overarching document ratified by the Emergency Planning Group September 2017.			
Y	Y	Y	Y	Y	Y	Y		Incorporated into Risk Assessment section of the Overview of Emergency Planning Arrangements document - Page 8 2017 review underway for ICT & utilities, completed for telecomms.			
	Y	Y				Y		The trust has plans in place to extend the mortuary capacity via external agencies. Excess death & mass fatalities plans fall under local authority responsibility			

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								N/A			
								N/A			
Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions:</li> <li>Being able to provide evidence of an approval process for EPRR plans and documents</li> <li>Asking peers to review and comment on your plans via consultation</li> <li>Using identified good practice examples to develop emergency plans</li> <li>Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down</li> <li>Version control and change process controls</li> <li>List of contributors</li> <li>References and list of sources</li> <li>Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).</li> </ul>	Emergency Incident, lockdown & Business Continuity Plans are in place, are reviewed annually in line with current guidance & good practice which are then ratified by the Emergency Planning Group. MIP for all 3 sites ratified by Emergency Planning Group in March 2016. Annual review of BCP across the Trust are well underway and are due to be completed at the end of September 2017. Agendas and minutes available.			
Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>On call Standards and expectations are set out</li> <li>Include 24-hour arrangements for alerting managers and other key staff.</li> </ul>	All automated cascades are linked to On-Call rotas, changes to details uploaded to exchange database nightly. Post incident a review is carried out and informs the change in plans and procedures. This system was last activated in August 2017 as part of an Internal Disaster Activation. NHS England Critical & Major Incident Algorithms are embedded within the Trusts plans. All plans reviewed & training delivered since 2016 reflect the new national incident classifications. All plans define activation process, roles & responsibilities. BCM plans clearly define escalation/identification of whether an BCM incident or emergency incident.			
Y	Y	Y	Y	Y	Y	Y		All covered by department Business Continuity Plans/Templates. Directorate risk registers are in place.			
Y								Operation Consort plan for Protected Principle reviewed & ratified September 2017. VIP liaison action cards (part of MIP) for visiting VIP's.			
Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>Specify who has been consulted on the relevant documents/ plans etc.</li> </ul>	Stakeholders and partner agencies are included in plan writing where appropriate. Prison Plan - HMP (YOI) Swinfen Hall, Weather Plan - SMBC, Operation Consort - WMP, Fuel Plan - LRF. All plans are shared with appropriate Partner Agencies. i.e. MIP's shared with NHS England Sub Region. Two large scale multi agency table top exercise written & participated in by HEFT in April & June 2016 and participated in Regional exercise in March 2017. July 2017 joint live exercise with WMFS planned but postponed due to WMFS pulling out - new date to be confirmed.			
Y	Y	Y	Y	Y	Y	Y		Included within the validation section of the Overview of Emergency Planning Arrangements document. All debrief reports go to the Emergency Planning Group. Latest include Ward 21 & ED flooding's at Heartlands Hospital in 2016 and Pathology Fire at Heartlands Hospital in August 2017.			

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Y	Y	Y	Y			Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	All automated cascades are linked to On-Call rotas, changes to details uploaded to exchange database nightly. Communications exercises are carried out at least 4 times a year. Last one undertaken 12th July 2017 - report signed off in September by Emergency Planning Group. Live activations of the cascade system on the for an Internal Disaster cascade on the 26th July 2017 for GHH & 6th August 2017 at BHH.			
Y	Y	Y	Y			Y	Training is delivered at the level for which the individual is expected to operate (i.e. operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	There is a training programme in place for all those with key roles in an incident. Dates are sent out for staff to book on to. Changes to mandatory training within the Trust currently on going will enhance this further. Kellie Jervis is part of the national group looking at the National Occupational Standards and a second National Group looking at Strategic Commander training. This will be incorporated into the Trusts training programmes.			
Y	Y	Y	Y	Y	Y	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.	Each Incident plan identifies where the control rooms and the Action Cards for of the key roles Including a Decision Loggist. Each control has it own guide and equipment is checked monthly by the Emergency Planning Team			
Y	Y	Y	Y	Y	Y	Y		Action Cards for both Decision Loggists and General Loggists included in all plans			
Y	Y	Y	Y	Y	Y	Y		Included in the Strategic (Gold) Commanders Action Card. Copies of the NHS England National Sitrep are located in the control rooms and form part of the Incident Response & Personal Log Books. Also included in both the On-Call and Senior On-Call Aide Memoires.			
								Detailed in Trust CBRN plan. Access to Public Health advice through the on call PHE pager and access to Police & HART through Tactical Adviser at ECS when activated.			
								Detailed in Trust CBRN plan and involve Medical Physics department at UHB			
Y	Y	Y	Y		Y	Y	<ul style="list-style-type: none"> <li>• Have emergency communications response arrangements in place</li> <li>• Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies)</li> <li>• Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders</li> <li>• Using lessons identified from previous information campaigns to inform the development of future campaigns</li> <li>• Setting up protocols with the media for warning and informing</li> <li>• Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'.</li> <li>• Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes.</li> <li>• Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.</li> </ul>	The Director of Communications is an initial responder at Strategic (Gold) level and each site has a designated communications officer to manage the media all of which have specific action cards. We also have a full time communications team which covers all HEFT sites, form part of the emergency planning group and have developed and ratified a media management plan. Social media is used daily by this team.			

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Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.</li> </ul>	<p>Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.</p> <p>Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.</p> <p>Green = fully compliant with core standard.</p>			
Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>Where possible channelling formal information requests through as small as possible a number of known routes.</li> <li>Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups.</li> <li>Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s).</li> <li>Social networking tools may be of use here.</li> </ul>	Each site has 2 separate phone providers connected through separate switches. The Trust has secure HF radio system located in the control rooms with radios for each assigned key areas. All 3 sites have the ability to communicate with NHS organisations located in the Conurbation and the ECS through the NHS England HF Radio System funded through the provider trusts.			
Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and membership is quorate.</li> <li>Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups</li> <li>Taking lessons learned from all resilience activities</li> <li>Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives</li> <li>Establish mutual aid agreements</li> <li>Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues</li> <li>Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area</li> </ul>	Information is shared through the LHRP, monthly LHRF's & Solihull Resilience Group. All plans are shared with key stakeholders reference question 28.			
Y	Y	Y	Y	Y	Y	Y		NHS England Sub Region represents NHS Organisations in the West Midlands Conurbation LRF. This an LHRF agenda item.			
Y	Y	Y	Y	Y	Y	Y		Plans are share with Cat 1 & 2 organisations as well as attending multi-agency exercises. There is a monthly LHRF meeting bringing together EP Leads across the Conurbation.			
Y	Y	Y	Y	Y	Y	Y		Trust plans cover some mutual aid arrangement and there is also a Conurbation wide mutual aid document to be used during an incident.			
	Y	Y				Y		N/A			
		Y				Y		N/A			
Y			Y		Y			The Trust supports the NHS England Sub Regions Incident Response rota as well as attending the LHRP & LHRF. Also relevant NHS England documents i.e. Critical/Major Incident algorithm & sitreps, embedded in the Trust plans to support information flow across Cat 1 Responders.			
		Y						N/A			
	Y	Y						N/A			
Y	Y		Y			Y		Adrian Stokes (former AEO) wrote to LHRP to inform them that Kellie Jervis will be the HEFT representative with full authority to act on it's behalf (21.05.14). As per the May 2016 LHRP TOR's, Kellie Jervis attends the LHRP as a Senior Manager with full authorisation to act on behalf of the Trust as per the Core Membership.			

Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Y	Y	Y	Y	Y	Y	Y	<ul style="list-style-type: none"> <li>• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice</li> <li>• Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles</li> <li>• Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises</li> <li>• Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs.</li> <li>• Developing and documenting a training and briefing programme for staff and key stakeholders</li> <li>• Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidents have been taken forward</li> <li>• Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate)</li> <li>• Communications exercise every 6 months, table top exercise annually and live exercise at least every three years</li> </ul>	The Trusts Emergency Planning annual training programme, delivered through the Emergency Planning Team, is aligned to the National Occupational Standards (NOS) agreed locally through the Local Health Resilience Partnership. Major incident awareness became a mandatory subject in Oct 2016. TNA written & submitted in June 2017 to mandatory training group; currently looking to get it changed from a 3 yearly requirement to an annual requirement. Moodle package developed and went live in June 2017 and this will replace the current annual booklet on payslips.			
Y	Y	Y	Y	Y	Y	Y		Lessons learnt from exercises, new guidance and incidents form part of the training programme. A three hour table top exercise and 30 minute ELearning (Moodle) package forms part of the annual training session for on call staff. Live exercise with WMFS was planned for July 2017 but WMFS pulled out, rescheduled date to be confirmed. Last communications exercise undertaken 12th July 2017. Live incident 6th August 2017, Pathology fire - critical incident declared to CCG. Internal disaster plan activated, once incident resolved de-escalated to BCM incident. ED/Crit Care/Theatre table top 15th September Heartlands Critical Care table top 26th September 2017. Joint HEFT & West Midlands Police Casualty Bureau planned for November 2017 (Date to be confirmed). Post exercise, West Midlands Police Casualty Bureau looking to use HEFT relatives response as an example of good practise.			
Y	Y	Y	Y			Y		Staff from the trust have attended the following multi-agency events: Exercise Dark Star, Nov 2015 (Regional NHS England Ex), Exercise Tristar, Apr 2016 (Mass Cas exercise including NHS Partners) & Exercise Hightail, June 2016 (HEFT exercise with all blue light services, army, Council, Education, NHS Partners and National Express). The Trust also participated in NHS England Regional exercises - "Alcazar" in June 2016 and "Vital Signs" in March 2017. Supported a local provider trust by jointly facilitating their table top exercise in July 2017.			
Y	Y	Y	Y			Y		There is an annual Emergency Planning training programme for Strategic (Gold) Commander & Tactical (Silver) Controllers. These are aligned to current NOS and will reflect new NOS when this work is completed, full training records of all EPRR training and exercise participation are held and maintained by the Emergency Planning Team. As HEFT are part of National working group for Strategic Commander training, this will be incorporated alongside the NOS.			

Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	P11	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
<b>2015 Deep Dive</b>																			
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a public Board/Governing Body meeting for sign off within the last 12 months.	<ul style="list-style-type: none"> <li>The organisation has taken the LHRP agreed results of their 2016/17 NHS EPRR assurance process to a public Board meeting or Governing Body, within the last 12 months</li> <li>The organisations can evidence that the 2016/17 NHS EPRR assurance results Board/Governing Body results have been presented via meeting minutes.</li> </ul>	Y	Y	Y	Y	Y	Y	Y	Y	Y				<ul style="list-style-type: none"> <li>Organisation's public Board/Governing Body report</li> <li>Organisation's public website</li> </ul>	Public Trust Board 24 Oct 2016. Agenda & all papers available on the Trust public website, <a href="http://www.hearofengland.nhs.uk/trust-board-papers-and-meetings">www.hearofengland.nhs.uk/trust-board-papers-and-meetings</a>			
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	<ul style="list-style-type: none"> <li>There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report</li> </ul>	Y	Y	Y	Y	Y	Y			Y				<ul style="list-style-type: none"> <li>Organisation's Annual Report</li> <li>Organisation's public website</li> </ul>	Emergency Planning Team annual report to Board 24 Oct 2016, available on the Trust public website, <a href="http://www.hearofengland.nhs.uk/trust-board-papers-and-meetings">www.hearofengland.nhs.uk/trust-board-papers-and-meetings</a>			
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	<ul style="list-style-type: none"> <li>The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio.</li> <li>The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR portfolio via their public website and annual report</li> <li>The Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio is a regular and active member of the Board/Governing Body</li> <li>The organisation has a formal and established process for keeping the Non-executive Director/Governing Body Representative briefed on the progress of the EPRR work plan outside of Board/Governing Body meetings</li> </ul>	Y	Y	Y	Y	Y	Y	Y	Y				Y	<ul style="list-style-type: none"> <li>Organisation's Annual Report</li> <li>Organisation's public Board/Governing Body report</li> <li>Organisation's public website</li> <li>Minutes of meetings</li> </ul>	AEO formally named within Emergency Planning Team annual report & Core Standards, submitted to Public Trust Board 24 Oct 2016. Agenda & papers available on the Trust public website, <a href="http://www.hearofengland.nhs.uk/trust-board-papers-and-meetings">www.hearofengland.nhs.uk/trust-board-papers-and-meetings</a>			
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	<ul style="list-style-type: none"> <li>The organisation has an internal group that meets at least quarterly that agrees the EPRR work priorities and oversees the delivery of the organisation's EPRR function.</li> </ul>	Y	Y	Y	Y	Y	Y	Y	Y				Y	<ul style="list-style-type: none"> <li>Minutes of meetings</li> </ul>	Emergency Planning Group meets quarterly. Twice yearly reports from Emergency Planning Group to Health & Safety Group. Reports, agenda & minutes are available.			
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	<ul style="list-style-type: none"> <li>The organisation's Accountable Emergency Officer is a regular attendee at the organisation's meeting that provides oversight to the delivery of the EPRR work program.</li> <li>The organisation's Accountable Emergency Officer has attended at least 50% of these meetings within the last 12 months.</li> </ul>	Y	Y	Y	Y	Y	Y			Y			Y	<ul style="list-style-type: none"> <li>Minutes of meetings</li> </ul>	Whilst AEO does not attend the Emergency Planning Group meetings, it is chaired by the Head of Emergency Planning & SCM, who is directly accountable to the AEO. Therefore AEO is kept fully apprised. Twice yearly reports from Emergency Planning Group to Health & Safety Group chaired by the Interim Director of Governance.			
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	<ul style="list-style-type: none"> <li>The organisation's Accountable Emergency Officer is a regular attendee at Local Health Resilience Partnership meetings</li> <li>The organisation's Accountable Emergency Officer has attended at least 75% of these meetings within the last 12 months.</li> </ul>	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	<ul style="list-style-type: none"> <li>Minutes of meetings</li> </ul>	Formal letter provided to LHRP giving full delegated authority to Head of Emergency Planning & SCM (21.05.14) by the AEO. Head of Emergency Planning & SCM has attended all LHRP meetings on behalf of the Trust.			

Hazardous materials (HAZMAT) and chemical, biological, radiological and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)		Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale	
Q	Core standard	Clarifying information					Evidence of assurance					
Preparedness												
53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	The Trust has both a CBRN Plan and a CBRN Community Services Plan these have been reviewed & ratified at the June 2017 Emergency Planning Group.			
54	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	Y	Y	Y	Y	• Site inspection • IT system screen dump	Plans are available on the Intranet, all 3 sites ED's, Control Rooms and satellite sites			
55	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	Y	Y	Y	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	CBRN forms part of the risk register in the Overview of Emergency Arrangements and is linked to the CBRN, Major Incident & Internal Disaster Plans.			
56	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y			• Resource provision / % staff trained and available • Rota / rostering arrangements	This forms part of all ED nursing staff & Estates staff annual training programme.			
57	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	Y	Y	Y	Y	• Provision documented in plan / procedures • Staff awareness	On declaration/activation of the CBRN plan, specialist advice is notified/contacted			
Decontamination Equipment												
58	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: <a href="http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf">http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf</a> ) • Initial Operating Response (IOR) DVD and other material: <a href="http://www.jesip.org.uk/what-will-jesip-do/training/">http://www.jesip.org.uk/what-will-jesip-do/training/</a>	Y	Y	Y	Y	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	Yes - reference CBRN Checklist. This also forms part of the monthly EPRR audit check sheets			
59	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Y				No, however, as per the capability expectations of WMAS we are able to mount a 4 hour response to an incident with the number of suits we have. In addition to these we also have immediate suits which offer the same respiratory protection but are not waterproof and therefore can be used for triage but not for decontamination process.			
60	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		Y				This is part of the monthly EPRR audit check sheets carried out by staff from the Emergency Planning Team.			
61	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Y				We have an annual maintenance contract with GRS across all 3 sites and equipment is also checked during training. Part of the monthly EPRR audit check sheets carried out by the Emergency Planning Team. Ram Genes calibrated Oct 2015.			
62	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y				PPE is disposed of through Trust Facilities Policy. If used and replacements are required, NHS England's CBRN flow chart is incorporated in the plan			
Training												
63	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		Y		Y				Emergency Planning Team have been trained to deliver this training to the appropriate staffing groups			
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: <a href="http://www.jesip.org.uk/what-will-jesip-do/training/">http://www.jesip.org.uk/what-will-jesip-do/training/</a>	Y	Y	Y	Y	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	Training is reviewed annual and amended to reflect changes in policy and procedures. IOR has been included in the training since 2015. The Emergency Planning Team have completed the HART PRPS train the trainer course (2015 & 2016).			
65	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		Y		Y				A full list of trained staff is kept up to date by the Emergency Planning Team.			

Hazardous materials (HAZMAT) and chemical, biological, radiological and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental Health care providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	Core standard	Clarifying information										
66	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	<ul style="list-style-type: none"> <li>Including, where appropriate, Initial Operating Response (IOR) and other material: <a href="http://www.jesip.org.uk/what-will-jesip-do/training/">http://www.jesip.org.uk/what-will-jesip-do/training/</a></li> <li>Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: <a href="http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf">http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf</a>)</li> </ul>	Y	Y	Y	Y	Y		This is part of the Trusts CBRN & CBRN Community Service Plans and forms part of the annual training programme.			

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

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
<b>EITHER: Inflatable mobile structure</b>			
E1	Inflatable frame	N/A	
E1.1	Liner	N/A	
E1.2	Air inflator pump	N/A	
E1.3	Repair kit	N/A	
E1.2	Tethering equipment	N/A	
<b>OR: Rigid/ cantilever structure</b>			
E2	Tent shell	3 - 1 per site	
<b>OR: Built structure</b>			
E3	Decontamination unit or room	N/A	
<b>AND:</b>			
E4	Lights (or way of illuminating decontamination area if dark)	Tent area flood lit	
E5	Shower heads	2 - per tent	
E6	Hose connectors and shower heads	2 - per tent	
E7	Flooring appropriate to tent in use (with decontamination basin if needed)	Yes	
E8	Waste water pump and pipe	3 - 1 per tent	BHH & SOL replaced 2015, GHH replaced 2016
E9	Waste water bladder	3 - 1 (1,000 litre) per sit	
<b>PPE for chemical, and biological incidents</b>			
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).	No, however, as per the capability expectations of WMAS we are able to mount a 4hour response to an incident with the number of suits we have. In addition to these we also have immediate suits which offer the same respiratory protection but are not waterproof and therefore can be used for triage but not for decontamination process.	
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme	Yes (Decommissioned live PRPS as no training suits provided)	Still waiting official training suits from NHS England raised again during July 2017 LHRF meeting & annual CBRN meeting.
<b>Ancillary</b>			
E12	A facility to provide privacy and dignity to patients	Yes	
E13	Buckets, sponges, cloths and blue roll	Yes	
E14	Decontamination liquid (COSHH compliant)	Yes	
E15	Entry control board (including clock)	Yes	Clocks purchased and installed July 2017
E16	A means to prevent contamination of the water supply	Yes, bladder if required. Agreement with Seven Trent not required as standard	
E17	Poly boom (if required by local Fire and Rescue Service)	N/A	
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)	Yes BHH - 13 adult, 5 juvenile, 2 baby Yes GHH - 18 adult, 9 juvenile, 9 baby Yes SOL - 2 boxes adult, 1 box juvenile, 1 baby	
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)	Yes BHH - 16 adult, 1 box juvenile, 2 baby Yes GHH - 13 adult, 7 juvenile, 10 baby Yes SOL - 3 boxes adult, 1 box juvenile, 1 box baby	
E20	Waste bins	Waste bin bags/bins to be taken out when required	
	Disposable gloves	Yes	
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe	Yes - part of dis-robe packs (fish knife) for patient clothes removal, Cold triage nurse scissors to be thrown into tent for emergency PRPS removal.	
E22	FFP3 masks	Powered filters in PRPS suits and FFP3 level filters in immediate suits	
E23	Cordon tape	Yes	
E24	Loud Hailer	Yes - per site	
E25	Signage	Yes	
E26	Tabbards identifying members of the decontamination team	No - PRPS/Immediate suits sufficient identification of staff	
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.	Instructions for obtaining kits from PHE within CBRN plan	See Joint Holding letter - NHS England Gateway ref 02719 and PHE Gateway ref 2014-595
<b>Radiation</b>			
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)	6 - 2 per site	
E29	Hooded paper suits	Immediate suits - located at each site	
E30	Goggles	Immediate suits - located at each site	
E31	FFP3 Masks - for HART personnel only	Immediate suits - located at each site	
E32	Overshoes & Gloves	Immediate suits - located at each site	





HEART OF ENGLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

MONDAY 23 OCTOBER 2017

<b>Title:</b>	<b>AUDIT COMMITTEE ANNUAL REPORT</b>
<b>Presented by</b>	Karen Kneller, Chair, Audit Committee
<b>Responsible Director:</b>	David Burbridge, Director of Corporate Affairs
<b>Contact:</b>	David Burbridge, Director of Corporate Affairs, Ext. 43297
<b>Purpose:</b>	<p>To provide the Board of Directors with the Audit Committee Annual report.</p> <p>The report provides a summary of the Audit Committee's work and its opinion of the adequacy and effectiveness of the Trust's risk management, control and governance processes.</p>
<b>Confidentiality Level &amp; Reason:</b>	None
<b>Annual Plan Ref:</b>	N/A
<b>Key Issues Summary:</b>	<p>The attached report summarises the Audit Committee's opinion that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board of Directors.</p> <p>It provides details of the information supporting that opinion, the role and operation of the Committee, the Committee's conclusions and its identified priorities for 2017/18.</p>
<b>Recommendation:</b>	<p>The Board of Directors is asked to <b>receive</b> the report and <b>note</b> the Audit Committee's identified priorities for 2017/18.</p>

<b>Authorised by:</b> K Kneller	<b>Date:</b> October 2017
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## HEART OF ENGLAND NHS FOUNDATION TRUST

### BOARD OF DIRECTORS

MONDAY 23 OCTOBER 2017

## 2016/17 ANNUAL REPORT TO THE BOARD OF DIRECTORS

### 1 Introduction

- 1.1 The Committee's chief function is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control, risk management and governance and also its arrangements for securing economy, efficiency and effectiveness.
- 1.2 In order to discharge this function, the Audit Committee prepares an annual report for the Board and also for the Chief Executive in her role as Accounting Officer. This report includes information provided by the Trust's Internal and External Auditors and by other assurance providers.

### 2 Audit Committee's Opinion

- 2.1 The Board will recognise that no assurance given can ever be absolute. The best assurance which can realistically be provided to the Board is that there are no major weaknesses in the Trust's risk management, control and governance processes and in its other relevant arrangements.
- 2.2 The Audit Committee's opinion, based on the material summarised in section 3 below, is that considerable progress has been made in addressing the major weaknesses in the Trust's risk management, control and governance processes and in its other relevant arrangements, that existed at the time of, and indeed, led to, the intervention by Monitor in October 2015. Whilst further work is continuing and the changes made need to become embedded, the Audit Committee believes that the Board of Directors may place a reasonable amount of reliance on such processes and arrangements. This extends, in the Committee's opinion, to compliance with regulatory requirements, including Health & Safety at Work Act and associated Regulations, FT Code of Governance, CQC Essential (Fundamental) Standards and the process for preparing the Annual Governance Statement (AGS).
- 2.3 Specific areas where further work is required include the Information Governance Toolkit and the Risk Management process.

### 3 Information supporting the Committee's Opinion

Summarised below are the key sources of information and assurance that the Audit Committee has taken into account in arriving at the opinion expressed above.

#### 3.1 External Audit

- 3.1.1 The audit opinion of the External Auditors, KPMG, for 2016/17 was qualified. 'This opinion was based on the fact that whilst

the Trust has not received any new enforcement undertakings in year, there were a range of enforcement undertakings issued in previous years, covering areas of financial sustainability, operational performance and governance which are still in place as at 31 March 2017. With the exception of this, they were satisfied that, in all other significant respects the Trust has in place proper arrangements to secure, economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

- 3.1.2 As part of the Quality Accounts Audit for 2016/17, KPMG has audited two mandated performance indicators '18 weeks referral to treatment' and 'A&E four-hour wait', as well as a local indicator 'stat dose of prescribed antibiotics administered within an hour' which was chosen by the Council of Governors.
- 3.1.3 The Trust received a clean limited assurance opinion on the content of the 2016/17 Quality Report 18 week incomplete RTT pathways
- 3.1.4 The A&E four-hour wait was not subject to a limited assurance opinion based on the design of the process in place to capture data for ambulance arrivals. In line with last year, the Trust starts the clock for ambulance arrivals at the time of registration rather than when handover occurs or 15 minutes after the ambulance arrive at A&E. The clock start is predominantly within 5 minutes of ambulance arrival. The crews book in with the receptionist located in ED with the HALO or in main ED reception, the patient is then handed over to the clinical team. The Board of Directors has agreed that this practice is in the best interests of the patient.
- 3.1.5 The local indicator 'stat dose of prescribed antibiotics administered within an hour', chosen by the Council of Governors, was not subject to a limited assurance opinion as KPMG had been unable to gain evidence to confirm the accuracy of data sample records where the prescribed and administered times were the same.
- 3.1.6 KPMG's full audit report was provided to the Audit Committee in May 2017.
- 3.1.7 The External Auditors made seven recommendations on the financial statements 2016/17 work. The key recommendation relates to limiting access to the Trusts server room to IT staff.
- 3.1.8 During the year, the Chair of Audit Committee met privately with the External Auditors.
- 3.1.9 The Audit Committee members also met privately with the External Auditors. This type of meeting, which is in line with best practice in corporate governance, provides an important opportunity for the Committee members and/or the External

Auditors to identify and discuss any confidential concerns or issues.

## 3.2 Internal Audit

- 3.2.1 Deloitte's Head of Internal Audit Opinion is derived from the reviews of three core internal audits (key financial controls, payroll, CQC, information systems management and board assurance framework (BAF) and risk management). Each of the three reviews received "*moderate*" opinion. Consequently, the Head of Internal Audit Opinion for 2016/17 states that for the Core Internal Audit Programme Opinion "*substantial assurance can be given. As while there is a basically sound system.....there is some evidence of non-compliance that may put some of the system objectives at risk*".
- 3.2.2 The Head of Internal Audit Opinion for board assurance framework and risk management received 'moderate' assurance "*on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control*".
- 3.2.3 During the financial year 2016/17 Internal Audit issued nine core internal audit reports and one performance report of which one internal audit report received full assurance and five substantial assurance and three moderate assurance for core internal reports".
- 3.2.4 Due to operational pressures, the timing of external reviews and reporting timelines, three reviews (patient administration system, CQC and information governance) have not been completed.
- 3.2.5 One performance review (medical equipment library) and one follow-up up review (quality indicators) were undertaken. As a result of carrying out the reviews no areas of control weakness relating to governance, risk management or internal controls impacted on the overall '*substantial*'.
- 3.2.6 During the year, the Chair of Audit Committee met privately with the Internal Auditors.
- 3.2.7 The Audit Committee members also met privately with the Internal Auditors. This type of meeting, which is in line with best practice in corporate governance, provides an important opportunity for the Committee members and/or the Internal Auditors to identify and discuss any confidential concerns or issues.
- 3.2.8 The current internal audit contract is in its third year and was due to expire as at 31 March 2017. Because of the uncertainty over the duration of a future contract award, due to the

proposed organisational change, it was agreed that the contract was extended on a flexible basis in the short term.

### 3.3 Other Assurance Providers

#### 3.3.1 Local Counter Fraud Specialist (LCFS)

- a) The LCFS service is provided by Deloitte. The Audit Committee received and approved the Annual Plan relating to counter fraud work. The number of days allocated in the Annual Plan for counter fraud work for 2016/17 was 100 days.
- b) During the course of the year, the Committee received regular progress reports, together with an Annual Report. 67 days were spent on proactive counter fraud work and a further 30 days on undertaking preliminary enquiries into 24 referrals and investigations.
- c) The proactive work plan included a review of single tender waivers, cash-handling within the catering department, patient travel expenses, overseas visitors, on-site private patient work carried out in the trust and pre-employment agency checks.

#### 3.3.2 Financial Reporting

- a) Throughout the reporting year, the Committee received regular progress reports on the Single Tender Quotes/Approvals.
- b) The Committee reviewed the 2016/17 pre-audited annual accounts and annual report at the 24 May 2017 meeting and recommended to the Board of Directors their signature by the Accounting Officer.

#### 3.3.3 Management

- a) The Committee received quarterly updates on clinical governance audit activity, complaints, incidents and claims; a bi-annual health & safety report; annual reports on compliance with the Freedom of Information Act 2000; compliance with the policy on controlled documents; IG Toolkit compliance and research governance.
- b) The Trust undertook a revaluation of the land and buildings of the Trust under MEAV (modern equivalent asset valuation) required within the Trust's accounting policies.
- c) It approved the revised Local Anti-Fraud, Bribery and Corruption Policy

- d) It further received regular updates from management on progress with the implementation of agreed management action resulting from recommendations contained in internal audit reports (e.g. quality indicators follow-up). Where implementation of agreed recommendations was not achieved within the recommended timeframe, the Committee sought explanations from management as to the reasons for such delays and assurance that recommendations would be implemented.
- e) The Committee considered the threat of cyber attack and requested an update on the security in place at the Trust.
- f) The Committee received the annual report on Compliance with the Monitor's Code of Governance. It was concluded that the Trust would have to make the same declarations under the 'comply and explain' rule as in previous financial years as the Trust decided not to obtain external advisors to market test the remuneration levels of the chair and other NEDs at least once every three years.
- g) The Committee further reviewed and recommended the draft Annual Governance Statement (AGS) at the 24 May 2017 meeting and recommended to the Board of Directors their signature by the Accounting Officer.

## **4 The Role and Operation of the Audit Committee**

### **4.1 Membership of the Committee**

4.1.1 The members of the Committee during 2016/17 were as follows:

Ms Karen Kneller – Chair

Mr Andy Edwards

Prof Jon Glasby (up to 31 March 2017)

Mrs Jackie Hendley (from June 2016)

Dr Mike Kinski (from June 2016)

Dr Jammi Rao (resigned 31 May 2016)

4.1.2 The members of the Committee disclosed their interests, which included the following, in the Trust's Register of Interests:

**Ms Karen Kneller** - CEO , Criminal Case Review Commission; Fee paid judge Social Entitlement Chamber; Fitness to Practice Member for General Dental Council and Vice Chair (unremunerated) of BRAP, an equalities think tank.

**Mr Andy Edwards** - Couch Perry & Wilkes - in receipt of annuity following business sale until May 2019; Voluntary role as a business mentor for the Prince's Trust

**Prof Jon Glasby** - Professor / Head of School, University of Birmingham; Senior Fellow, NIHR School for Social Care Research; Fellow of Royal Society of Arts; Board Member – Campaign for Social Services.

**Ms Jackie Hendley** – Director - SC Advisory Services Ltd; Director - Smith Cooper - IT Services Ltd; Director – Smith Cooper Ltd; Partner/Member – SHH 101 LLP.

**Dr Mike Kinski** - Prof of Business Change – Middlesex University; NED – Bristol City Council Holding Company; NED – Forest Coachlines Pty Ltd (Australia).

**Dr Jammi Rao** - Director - Gorway Global Ltd; Board Director - Welcome CIC; Trustee - Faculty of Public Health; Visiting Professorship - Public Health, School of Health, Staffordshire University

4.1.3 The Committee’s principal support officer throughout the year was the interim Director of Corporate Affairs. The Chief Financial Controller, Director of Finance, Chief Nurse; Director of Operations; Director of Workforce & OD, together with representatives of both the External and Internal Auditors attended the meetings of the Committee as a matter of course. Other directors and officers of the Trust attended meetings of the Committee as and when required.

4.2 Operation of the Committee

4.2.1 Meetings and attendance

The Committee is required to meet at least four times a year. A total of six ordinary meetings took place during 2016/17 and were attended as follows:

Director	Meetings attended
Ms Karen Kneller – Chair	All
Mr Andy Edwards	All
Prof Jon Glasby (up to 31 March 2017)	3
Mrs Jackie Hendley (from June 2016)	3 of 4
Dr Mike Kinski (from June 2016)	3 of 4
Dr Jammi Rao (resigned 31 May 2016)	2 of 2

The quorum for meetings of the Committee is two members. All ordinary meetings of the Committee during the period were quorate.

#### 4.2.2 Self-assessment

The annual self-assessment for 2016/17 is under way and its findings will be reported to the Board of Directors.

#### 4.2.3 Annual Cycle

The Committee has also maintained its practice of agreeing an annual cycle of business which is designed to facilitate forward planning and to assist the Committee in ensuring that all aspects of its terms of reference are being fulfilled.

#### 4.2.4 Reports

During the reporting period, the Audit Committee submitted formal reports to the Board of Directors' meetings following each Audit Committee meeting.

## **5 Priorities for 2017/18**

The Committee has identified the following priorities for attention during the 2017/18 financial year:

- 5.1 Monitoring and reviewing the effects of changes in the general economic climate (including BREXIT) on the Trust's financial position and the Trust's ability to recruit and retain a sufficiently skilled workforce;
- 5.2 Monitoring the proposed acquisition with University Hospitals Birmingham NHS Foundation Trust;
- 5.3 Monitoring and assessing the Trust's ICT systems to include functionality, security arrangements against cyber risks and exploring the need to procure additional 'cyber insurance';
- 5.4 Monitoring the effectiveness and robustness of the Trust's quality systems (including Data Quality), with particular regards to the assurance requirements for the Quality Report;
- 5.5 Continue to monitor the effectiveness and robustness of the Trust's risk management systems and its Assurance Framework;
- 5.6 Continuing to make best use of the Internal Auditors, as the "eyes and ears" of the Committee, by regularly reviewing the scope of their work so as to ensure that it appropriately reflects both the risks currently faced or anticipated and the Trust's current priorities; and
- 5.7 Reviewing accounting policies to ensure that they remain appropriate and keeping a watching brief on the ongoing impact of the introduction of International Financial Reporting Standards.

**6 Recommendation**

The Board of Directors is asked to receive this report on the work of the Audit Committee during the 2016/17 financial year.

**Karen Kneller**  
**Chair of the Audit Committee**  
**October 2017**

# HEART OF ENGLAND NHS FOUNDATION TRUST

## BOARD OF DIRECTORS

23rd OCTOBER 2017

<b>Title:</b> Development of Chemotherapy Capacity and Improved Environment							
<b>From:</b> Jonathan Brotherton				<b>To:</b> Trust Board			
<b>The Report is being provided for:</b>							
Decision	Y	Discussion	N	Assurance	N	Endorsement	N
<b>Purpose:</b> To request approval for the capital and revenue investment required for the development of a low risk chemotherapy day unit facility within the Bruce Burns Unit at Solihull Hospital as set out in the full business case delivered to the Chief Executives Group (CEG).							
<b>Key points/Summary:</b>							
<ul style="list-style-type: none"> <li>Chemotherapy activity has grown by 26% from 2013/14 to 2016/17, with Directorate total income having increased by £2.5m (excluding specialist drugs) with minimal recurrent investment.</li> <li>Insufficient chemotherapy and supportive treatment capacity available to meet current and future demand.</li> <li>Maintained compliance with Cancer Performance Targets is at risk for first treatment regime and waits for subsequent treatments are currently circa 14 days over pathway target date.</li> <li>Current environment is over-crowded requiring improvement measures to ensure safety, privacy and dignity for patients, improved efficiency and reduction in medication errors linked to environment.</li> <li>There is a need to improve staff morale as demonstrated within staff survey with turnover being 11% YTD and sickness rates within Day Unit at 7% over last 12 month period.</li> <li>Preferred option is to transfer low risk chemotherapy and supportive treatments out of Ward 19 Day Unit to part of Bruce Burns Unit at Solihull Hospital (24 chairs required at Solihull in year 1 2018/19 rising to 31 chairs in year 3 2020/21) in order to improve safety and environmental issues. In doing so enable the development of legacy space to deliver high risk chemotherapy (5 remaining chairs), develop Community Transplant and Acute Oncology Service provision that will support reduction in ward LOS, Emergency Department attendances, improved patient care and increased income.</li> </ul>							
<b>Recommendation(s):</b>							
<ul style="list-style-type: none"> <li>The Board is asked to consider the information set out in this report and approve the total investment required to develop a low risk chemotherapy unit facility within the Bruce Burns Unit at Solihull Hospital. This requires capital investment and one off set up costs of £625k in 2017/18. There is also a need for revenue investment of £1.586m in 2018/19 that includes an uplift in staffing (38.13 WTE), resulting in an Income and Expenditure (I&amp;E) deficit of £343k. This moves to a total investment of £1.953m and I&amp;E surplus of £562k in year 3 2020/21. Within these revenue costs £535k is currently being incurred at risk to support operational pressures.</li> </ul>							
<b>Assurance Implications:</b>							
Board Assurance Framework	N	BAF Risk Reference No.					
Performance KPIs year to date	Y	Resource/Assurance Implications (e.g. Financial/HR)			Y (Finance/Estates)		
Information Exempt from Disclosure	N	If yes, reason why.					
Identify any Equality & Diversity issues		None					
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							

## 1. SUMMARY

Development of a low risk chemotherapy and supportive treatment unit facility within Bruce Burns Unit at Solihull Hospital in order to:

- Provide adequate chemotherapy and supportive treatment capacity to meet current and future demand; capacity modelling indicates shortfall of up to 12 chairs in year 1 2018/19, rising up to 26 chairs by year 5 2022/23.
- Maintain compliance with Cancer Performance Targets; currently compliance is at risk for first treatment regimen and waits for subsequent treatments are currently circa 14 days over pathway target date.
- Provide an environment that ensures safety, privacy and dignity for patients and in doing so improve patient experience.
- Improve staff morale in order to reduce and sickness rates within Day Unit.
- Develop Ward 19 Day Unit legacy space in order to deliver high risk chemotherapy (5 remaining chairs), develop Community Transplant and Acute Oncology Service provision that will support reduction in ward LOS, ED attendances, and improved patient care and increased income.
- Investment and uplift required in current Day Unit workforce to support two separate Day Unit facilities (BHH and SHH).
- Investment in the Directorate over the last five years includes recruitment to 2.0 WTE Consultant Haematologists (2016 and 2017), substantiation of 2.0 WTE ACPs (2017) and the development of a supportive treatment area in the Sheldon Unit at GHH (2017 charitable funded).

## 2. BACKGROUND

Chemotherapy and supportive treatments are currently provided across three hospital sites; Ward 19 Day Unit at BHH, Sheldon Unit at GHH and OPD at SHH. The environment on Ward 19 is overcrowded, being multifunctional and a continued increase in Day Unit activity has impacted on chemotherapy and supportive treatment appointments being available in a timely and safe manner.

### Current Clinical Haematology Activity and Income 2013 to YTD

The Business Case that supports this report recognises previous year on year growth in activity and income within the Haematology and Oncology Directorate and the requirement to rebalance demand and capacity as illustrated in tables below:

Clinical Haematology Activity Year on Year					
Activity Type	2013/14	2014/15	2015/16	2016/17	2017/18 - M6 YTD
Daycase - non chemotherapy	9,351	8,728	10,120	10,175	5,880
Elective	423	677	332	370	142
Emergency	175	914	225	234	94
Outpatients	88,855	86,757	85,533	82,635	43,601
Unbundled - Chemotherapy	9,846	10,053	11,532	12,362	6,410
<b>Total Daycase &amp; Chemotherapy</b>	<b>19,197</b>	<b>18,781</b>	<b>21,652</b>	<b>22,537</b>	<b>12,290</b>

Clinical Haematology Activity Year on Year Growth - %				
Activity Type	2014/15	2015/16	2016/17	Cumulative Growth
Daycase - non chemotherapy	(6.66%)	15.95%	0.54%	8.81%
Elective	60.05%	(50.96%)	11.45%	(12.53%)
Emergency	422.29%	(75.38%)	4.00%	33.71%
Outpatients	(2.36%)	(1.41%)	(3.39%)	(7.00%)
Unbundled - Chemotherapy	2.10%	14.71%	7.20%	25.55%
<b>Total Daycase &amp; Chemotherapy</b>	<b>(2.17%)</b>	<b>15.29%</b>	<b>4.09%</b>	<b>17.40%</b>

Clinical Haematology Income Year on Year - £k					
Activity Type	2013/14	2014/15	2015/16	2016/17	2017/18 - M6 YTD
Daycase - non chemotherapy	4,009	3,477	3,887	3,961	2,123
Elective	824	667	500	570	241
Emergency	708	1,434	775	811	448
Other	3,499	3,458	3,796	4,497	3,081
Outpatients	5,879	5,823	6,551	6,961	3,507
Unbundled - Chemotherapy	2,881	2,831	3,167	3,458	1,765
<b>Total Daycase &amp; Chemotherapy</b>	<b>17,800</b>	<b>17,690</b>	<b>18,676</b>	<b>20,258</b>	<b>11,165</b>

Clinical Haematology Activity Year on Year Growth - £k				
Activity Type	2014/15	2015/16	2016/17	Cumulative Growth
Daycase - non chemotherapy	(532)	410	74	(48)
Elective	(157)	(167)	70	(254)
Emergency	726	(659)	36	103
Other	(41)	338	701	998
Outpatients	(56)	728	410	1,082
Unbundled - Chemotherapy	(50)	336	291	577
<b>Total Daycase &amp; Chemotherapy</b>	<b>(110)</b>	<b>986</b>	<b>1,582</b>	<b>2,458</b>

### Expected Future Growth

Detailed analysis has demonstrated the required capacity year on year over the next five years (12 extra chairs required in 2018/19). The tables that follow demonstrate expected year on year growth based on historic chemotherapy and day case growth of 7.54% and 6.9% respectively. Projected figures include 4% immunotherapy growth year on year:

Chairs and Activity by Year						
Detail	2017/18 (current)	2018/19	2019/20	2020/21	2021/22	2022/23
BHH Chairs	17	5	5	5	5	5
GHH Chairs	14	14	14	14	14	14
SOL Chairs	2	24	27	31	34	38
<b>Total Chairs</b>	<b>33</b>	<b>43</b>	<b>46</b>	<b>50</b>	<b>53</b>	<b>57</b>
Daycase Activity	11,931	12,754	13,634	14,575	15,581	16,656
Chemotherapy Activity	12,816	13,782	14,822	15,939	17,141	18,433
Immunotherapy Activity		533	554	577	600	624
<b>Total Activity</b>	<b>24,747</b>	<b>27,069</b>	<b>29,010</b>	<b>31,091</b>	<b>33,322</b>	<b>35,713</b>

Additional chairs stated in 2021/22 and 2022/23 would not be included in the initial design plan for Bruce Burns due to capacity restrictions.

Activity Growth Year on Year								
Detail	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Cumulative Growth	Cumulative Growth - %
Daycase Activity	11,931	823	880	941	1,006	1,075	4,725	39.60%
Chemotherapy Activity	12,816	966	1,040	1,117	1,202	1,292	5,617	43.83%
Immunotherapy Activity		533	21	23	23	24	624	
<b>Total Activity</b>	<b>24,747</b>	<b>2,322</b>	<b>1,941</b>	<b>2,081</b>	<b>2,231</b>	<b>2,391</b>	<b>10,966</b>	

Chairs and Income by Year						
Detail	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
BHH Chairs	17	5	5	5	5	5
GHH Chairs	14	14	14	14	14	14
SOL Chairs	2	24	27	31	34	38
<b>Total Chairs</b>	<b>33</b>	<b>43</b>	<b>46</b>	<b>50</b>	<b>53</b>	<b>57</b>
Daycase Activity - £k	4,275	4,570	4,885	5,223	5,583	5,968
Chemotherapy Activity - £k	3,538	3,804	4,091	4,400	4,731	5,088
Immunotherapy Activity - £k	0	147	153	159	166	172
<b>Total Activity - £k</b>	<b>7,813</b>	<b>8,521</b>	<b>9,129</b>	<b>9,782</b>	<b>10,480</b>	<b>11,228</b>

Income Growth Year on Year - £k							
Detail	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Cumulative Growth
Daycase Activity - £k	4,275	295	315	338	360	385	1,693
Chemotherapy Activity - £k	3,538	266	287	309	331	357	1,550
Immunotherapy Activity - £k	0	147	6	6	7	6	172
<b>Total Activity</b>	<b>7,813</b>	<b>708</b>	<b>608</b>	<b>653</b>	<b>698</b>	<b>748</b>	<b>3,415</b>

### Resources Required to Deliver Activity

The workforce required to support high risk chemotherapy (5 chairs) that will remain at BHH and low risk chemotherapy at SHH (24 chairs) is 89.3 WTE requiring an uplift of 38.13 WTE in 2018/19. Further staffing for subsequent years is included in tables below:

Current Funded and Worked Establishment						
Staff Type	Funded		Worked		Difference	
	WTE	£ - k	WTE	£ - k	WTE	£ - k
Consultant	1.00	125	1.00	125	0.00	0
Qualified Nursing	13.77	523	16.27	615	(2.50)	(92)
Unqualified Nursing	4.60	103	4.60	103	0.00	0
A&C Support	6.80	152	6.80	152	0.00	0
Dietician	0.00	0	1.00	38	(1.00)	(38)
Pharmacy	25.00	902	32.00	1,245	(7.00)	(343)
<b>Total</b>	<b>51.17</b>	<b>1,805</b>	<b>61.67</b>	<b>2,278</b>	<b>(10.50)</b>	<b>(473)</b>

Establishment by Year								
Staff Type	2017/18		2018/19		2019/20		2020/21	
	WTE	£ - k						
Consultant	1.00	125	2.00	251	2.00	253	2.00	254
Qualified Nursing	13.77	523	26.58	1,006	27.58	1,042	28.58	1,080
Unqualified Nursing	4.60	103	13.25	284	13.25	286	14.25	311
A&C Support	6.80	152	8.17	185	8.17	185	8.17	185
Dietician	0.00	0	1.00	38	1.00	38	1.00	39
Pharmacy	25.00	902	38.30	1,407	40.70	1,473	43.10	1,570
<b>Total</b>	<b>51.17</b>	<b>1,805</b>	<b>89.30</b>	<b>3,171</b>	<b>92.70</b>	<b>3,277</b>	<b>97.10</b>	<b>3,439</b>

Change in Establishment to Current Establishment						
Staff Type	2018/19		2019/20		2020/21	
	WTE	£ - k	WTE	£ - k	WTE	£ - k
Consultant	1.00	126	1.00	128	1.00	129
Qualified Nursing	12.81	484	13.81	520	14.81	557
Unqualified Nursing	8.65	181	8.65	183	9.65	208
A&C Support	1.37	33	1.37	33	1.37	33
Dietician	1.00	38	1.00	38	1.00	39
Pharmacy	13.30	505	15.70	571	18.10	668
<b>Total</b>	<b>38.13</b>	<b>1,367</b>	<b>41.53</b>	<b>1,473</b>	<b>45.93</b>	<b>1,634</b>

Total revenue investment of £1.586m in 2018/19, as detailed in table below, results in an Income and Expenditure (I&E) deficit of £343k moving to a total investment of £1.953m and I&E surplus of £562k in year 3 2020/21.

<b>Revenue Income and Expenditure Impact</b>			
<b>Expense Type</b>	<b>2018/19 - £k</b>	<b>2019/20 - £k</b>	<b>2020/21 - £k</b>
Pay	(1,367)	(1,473)	(1,634)
Non Pay	(219)	(270)	(319)
Run Rate Reduction	535	540	546
Revised Expenditure	(1,051)	(1,203)	(1,407)
Income	708	1,316	1,969
I&E Change	(343)	113	562

### 3. ACTION

It is proposed to immediately commence:

- A full Estates design brief
- Recruitment process
- Procurement process

### 4. RECOMMENDATION(S)

The Board is asked to consider the information set out in this report and approve the total investment required to develop a low risk chemotherapy unit facility within the Bruce Burns Unit at Solihull Hospital. This requires capital investment and one off set up costs of £625k in 2017/18. There is also a need for revenue investment of £1.586m in 2018/19 that includes an uplift in staffing (38.13 WTE), resulting in an Income and Expenditure (I&E) deficit of £343k. This moves to a total investment of £1.953m and I&E surplus of £562k in year 3 2020/21. Within these revenue costs £535k is currently being incurred at risk to support operational pressures.

### 5. NEXT STEPS

- Commence full Estates design brief
- Develop implementation plan

# Full Business Case

## 1. Purpose

The purpose of this case is to request the Board of Director's approval in respect of the plans and proposals outlined to increase capacity for the delivery of chemotherapy and supportive treatments at Heart of England NHS Foundation Trust (HEFT) and to address the environmental safety issues and capacity shortfalls identified within Ward 19 Day Unit. This will enable improved maintained delivery of care for patients, improve staff morale and continued compliance with access targets.

## 2. Current Position

The Directorate had identified the need for additional capacity to meet demand as part of its business plan in 2016 and Directorate Strategy (Appendix A). Prior to this an Infusion Suite Capacity Business Case (including Rheumatology provision) at Solihull was put on hold in 2015.

In November 2016 the Executive Team undertook a safety visit to review the Chemotherapy Unit at Heartlands Hospital based on Ward 19 Day Unit. This review made recommendations for the Directorate to improve patient experience and safety by developing plans to increase Day Unit capacity. In December 2016 the Directorate presented its short-term plan to improve issues identified and subsequently submitted an outline business case in March 2017 to Trust Operations Group (TOG) requesting support and approval for the development of alternative options to develop additional capacity and improve environmental issues and care.

Even with the mitigation work to date and that which is on-going there is an identified shortfall of 8 extra chairs (as at 2015/16), these chairs would be required to improve safety within the Day Unit based on current demand and capacity. Appendix B demonstrates a breakdown of work to date and total capacity and demand.

Executive support has been given to the Directorate in conjunction with the Asset and Estate Management Teams to confirm capacity required now and into the future and identify potential estate options for the development of an alternative Day Unit facility for low risk chemotherapy and supportive treatment regimens.

### Current Service

The Haematology and Oncology Service provides chemotherapy and supportive treatments across three sites and runs 5 days a week (Saturday lists are held to support shortfalls in capacity for blood transfusions), with treatments ranging from 15 minutes to 8 hours. Ward 19 Day Unit at Heartlands Hospital (having 17 treatment chairs) sees around 1,500 attendances per month. Chemotherapy treatments have increased by 25.5% from 2013 to date with circa 49% of this activity taking place on Ward 19 Day Unit (Good Hope Sheldon Unit 42% and Solihull OPD 9%). Typical

demand for Ward 19 Day Unit is 350 patients a week, equating to an average of 70 per day.

Investment has recently been agreed to develop the OT area within the Sheldon Unit at Good Hope Hospital to create a separate supportive treatment unit funded by charitable funding. This unit will support capacity in the Sheldon Unit by releasing chemotherapy chair capacity and will also allow the transfer of circa 31 Ward 19 Day Unit patients per week. The outline business case that preceded this business case requested the recruitment at risk to 2 WTE Band 5 and Band 6 nurses (as recommended by acuity review undertaken in November 2016) this additional workforce will rotate between GHH and BHH to support additional capacity created.

Ward 19 Day Unit is located alongside the Oncology and Haematology Ward within Ward 19 footprint. Within this area there are consultation rooms for out-patient clinic attendance; treatment rooms for apheresis, bone marrow transplant and other procedures; other clinical support services including CNS's, pharmacy and phlebotomy, all serviced from one reception desk and waiting area, with patient chairs also on the corridor to provide further waiting capacity. All these services operate from one side of the Ward 19 footprint with the Day Unit staff having to resort to creating a sub-waiting area by placing chairs on the corridor outside of the Day Unit and Phlebotomy room. This has created a congested environment in which patients and carers attend as well as staff have to work.

Whereas performance data demonstrates that provision for first chemotherapy treatment regime is good, subsequent chemotherapy and supportive treatment regimens are frequently not being booked within recommended pathway timelines (typically 14-21 days dependent on regimen) due to capacity constraints.

### Income and Activity

Activity	13/14		14/15		15/16		16/17		17/18 YTD M6	
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Internal NHSI Plan	Actual	Internal NHSI Plan
Block / Manual	119	8	135	159	105	145	132	97	1,476	66
Day Case	9,351	7,158	8,728	8,858	10,120	11,112	10,175	11,063	5,880	5,029
Elective	423	595	677	380	332	821	370	454	142	125
Emergency	175	134	914	157	225	181	234	266	94	132
Other	527	191	713	546	837	987	1,151	816	645	502
Outpatients	88,855	88,230	86,757	90,154	85,533	88,826	82,635	86,399	43,601	40,802
Unbundled HRGs	9,846	9,336	10,053	9,961	11,532	10,542	12,362	11,571	6,410	6,214
Ambulatory Care	0	0	0	0	1	0	0	0	0	0
Emergency Assess	0	0	0	0	2	0	0	0	0	2

Block/Manual activity demonstrates BMT activity and excludes drug activity and income. 2017/18 also includes 1,389 Boots Dispensing episodes hence BMT activity at M6 is 87 episodes.

Day Case activity encompasses all Day Unit activity that is not directly associated with chemotherapy as this is captured within Unbundled HRGs. This includes supportive treatments, including blood transfusion, line flushes, hormone injections etc.

Unbundled HRG activity above includes delivery of exclusively oral chemotherapy, simple parenteral chemotherapy at first attendance, more complex parenteral

chemotherapy at first attendance, complex chemotherapy including prolonged infusional treatment at first attendance, subsequent elements of chemotherapy cycle and chemotherapy regimens not on the national list. Chemotherapy activity has increased by 25.5% since 2013/14 to date due to demographical changes and treatment developments.

Income	13/14		14/15		15/16		16/17		17/18 YTD M6	
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Internal NHSI Plan	Actual	Internal NHSI Plan
Block / Manual	£3,488,097	£3,313,291	£3,441,437	£3,534,420	£3,773,981	£3,004,329	£4,470,571	£3,570,920	£3,066,296	£2,292,614
Day Case	£4,008,591	£3,286,024	£3,476,920	£4,448,733	£3,887,342	£4,600,621	£3,960,542	£4,272,456	£2,123,287	£2,070,636
Elective	£823,502	£1,021,571	£666,724	£888,254	£500,368	£1,201,413	£569,632	£696,974	£240,604	£211,204
Emergency	£707,627	£493,946	£1,434,072	£846,922	£774,923	£336,699	£811,371	£978,345	£447,593	£475,000
Other	£12,300	£4,396	£16,641	£12,744	£19,226	£22,593	£26,729	£19,690	£15,577	£12,116
Outpatients	£5,878,968	£5,648,744	£5,823,232	£5,826,784	£6,551,410	£5,753,232	£6,960,505	£6,544,796	£3,507,128	£3,429,289
Unbundled HRGs	£2,880,560	£2,845,898	£2,830,712	£2,819,064	£3,166,849	£2,819,044	£3,458,469	£3,193,981	£1,764,929	£1,724,635
Ambulatory Care	£0	£0	£0	£0	£450	£0	£0	£0	£0	£797
Emergency Assess	£0	£0	£0	£0	£1,503	£0	£0	£0	£0	£0
<b>Total</b>	<b>£17,799,646</b>	<b>£16,613,870</b>	<b>£17,689,739</b>	<b>£18,376,922</b>	<b>£18,676,053</b>	<b>£17,737,931</b>	<b>£20,257,820</b>	<b>£19,277,162</b>	<b>£11,165,415</b>	<b>£10,216,293</b>

The BMT service realised circa £3.1m for the period 2016/17 (£2.4m YTD) having treated 76 patients however these patients would have been managed predominantly as inpatients.

To be noted is that overall out-patient activity includes anticoagulation that has shown a downturn over past year due to AQP provision. However, other haematology and oncology referrals have increased, currently 7% over plan at Month 6.

Despite income increasing from circa £17.8m in 2013/14 to £20.2m in 2016/17 there has been minimal recurrent investment made in relation to Ward 19 and Day Unit environment.

#### Financial Expenditure Performance as at Month 4 (2017/18)

£000	Year 1 Budget	Year 1 Actual	Year 1 Variance	Year 2 Budget	Year 2 Actual	Year 2 Variance	YTD Budget	YTD Actual	YTD Variance
<b>Income non-contract</b>	(5,676)	(5,465)	(211)	(256)	(397)	141	(78)	(139)	61
<b>Pay</b>	7,453	8,560	(1,107)	8,498	8,740	(242)	2,859	3,006	(147)
<b>Non Pay</b>	26,037	26,707	(670)	26,645	27,320	(675)	8,639	9,586	(947)
<b>TOTAL</b>	<b>27,814</b>	<b>29,802</b>	<b>(1,988)</b>	<b>34,886</b>	<b>35,633</b>	<b>(777)</b>	<b>11,420</b>	<b>12,453</b>	<b>(1,033)</b>

The Directorate is £1m overspent YTD.

The key reasons for the £1m YTD overspend are as follows:

- Medics £86k overspent YTD – Agency costs over and above substantive posts to meet increased out-patient activity, cancer and 18 week RTT requirements.
- Nursing & Midwifery £68k overspent YTD – Bank and Agency utilisation that is partially offset with Qualified Nursing underspends due to vacancies. The overspend for agency and bank costs are mainly due to providing cover for vacancies, additional capacity, sickness and post recruited at risk to Ward 19 and Day Unit BHH.
- The non-pay position is £947k overspent in month that is cost pressure due to drugs, increased activity impacting radiology, blood and lab equipment costs. Note - Drugs is currently being reconciled back to income to understand the variation. In 2016/17 the Directorate over-performed by circa £1.8m (including drugs and devices).
- CIP – Unachieved CIP £97k YTD, although there is an expectation to deliver a non-recurrent drugs rebate saving of £338k in September that will enable Directorate target to be met.

The above is offset by over performance income of circa £61k YTD due to income associated with the timing of drugs expenditure.

#### Previous Business Case Investments

- Recruitment to New Consultant Haematologist (2016) £120k per year - approved at Trust Board to bridge the medical gap at that time, however, continued growth and recent clinical activity analysis has demonstrated continued medical capacity shortfall. Failure to expand this workforce would have led to further shortfalls in workforce required to deliver Direct Clinical Care activity
- Substantiation of ACP workforce (April 2017) £42k total investment to maintain support to medical and nursing workforce in the continued delivery of clinical activity. Failure to substantiate this workforce would have led to further shortfalls in workforce required to deliver Direct Clinical Care activity.
- Outline Business Case: Development of Chemotherapy Capacity and Improved Ward 19 Day Unit Environment (March 2017) - Trust Operations Group agreement to recruitment 'at risk' to 2 WTE Band 5 and Band 6 plus 1 WTE Band 7 Pharmacist to support safe chemotherapy delivery. This business case proposes to substantiate this workforce within the proposed staffing model.
- Additional Consultant Haematologist (July 2017) – approved at CEAG for the recruitment to 1 WTE Consultant Haematologist and increase in 2 Direct Clinical Care PAs between two existing consultant job plans. This case identified that there was still a gap of 1 WTE that would be addressed within the workforce plan within this Capacity business case.

#### Productivity & Efficiency of Current Service

Compliance with National Targets is good as evidenced in this section:

- Two Week Wait Referrals for Haematology remains consistently compliant at

- 100% against  $\geq 93.5\%$  standard.
- RTT is consistently compliant across the haematology and oncology subspecialties. Status as at week 28<sup>th</sup> August 2017:

Specialty	Current RTT status
Clinical Oncology	100.00%
Haematology	100.00%
Haematology (Clinical)	100.00%
Haematology Anti-Coagulant	100.00%
Medical Oncology	100.00%

The Directorate strives to maintain RTT compliance and two week waits across the subspecialty areas through the increase in clinics and appointment slots, however this has had a detrimental effect on current job plans whereby consultants are providing more DCC activity and less SPA in order to achieve compliance.

- Trust data indicating percentage of patients receiving first definitive treatment for cancer within 31 days of a cancer diagnosis for all cancers (National Target  $\geq 96.5\%$ ) and percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer (National Target  $\geq 85.5\%$ ) demonstrates that Haematology is compliant for both targets:

Specialty	1 <sup>st</sup> Cancer Treatment within 31 days $\geq 96.5\%$		1 <sup>st</sup> Cancer Treatment within 62 days $\geq 85.5\%$	
	July 16	YTD	July 16	YTD
Gynaecology	100%	100%	85.71%	82.61%
Lung	100%	97.22%	77.78%	70%
<b>Haematology</b>	100%	100%	100%	95.12%
Skin	100%	100%	100%	100%
Breast	97.73%	100%	94.12%	100%
Head & Neck	100%	100%	33.33%	For validation
Lower GI	100%	100%	96.15%	80.49%
Upper GI	100%	100%	73.91%	82.35%
Urology	98.73%	98.39%	92.77%	89.19%

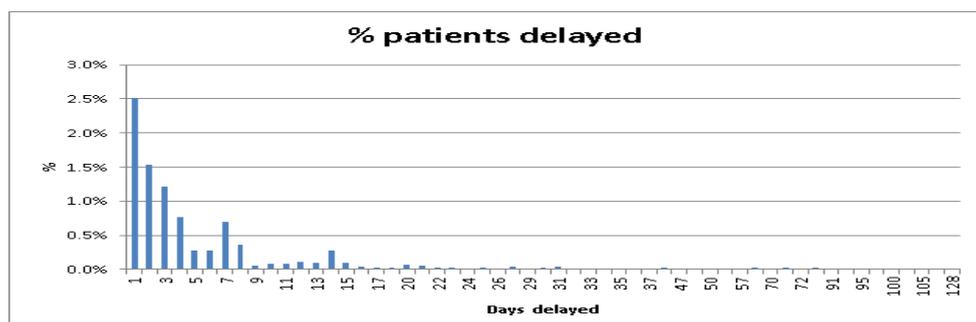
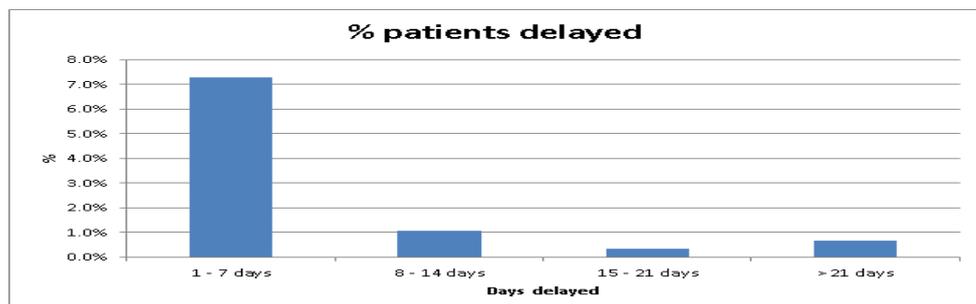
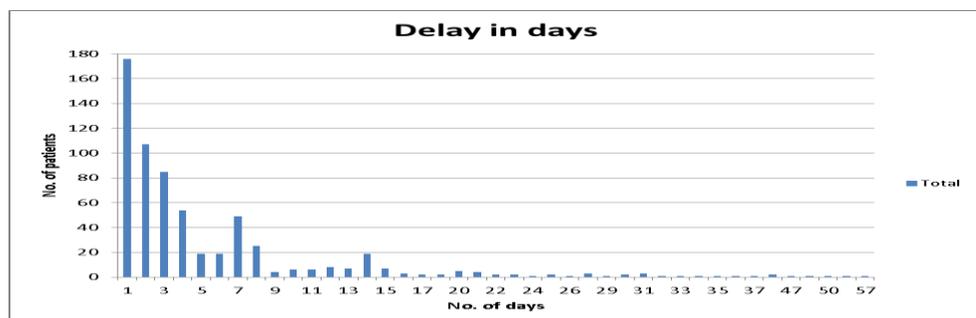
Oncological chemotherapy treatments will be included with the other site specific performances that will include surgical and radiotherapy treatment.

- There are no national or local indicators to determine efficiency for subsequent chemotherapy treatment regimens as these are condition/pathway driven, however, the majority of chemotherapy pathways allow 14 or 21 days between each treatment to allow patients to recover and blood levels to stabilise. Current

waits range from 0 to 14 days over this required date.

- The graphs over the page demonstrate second and subsequent chemotherapy treatments (by patient numbers and percentage for days delayed) that were booked after the recommended target date for the period Oct 2016 - Feb 2017 (target dates are dependent on chemotherapy regime and should typically be booked within 14-21 days).

The data has been adjusted to demonstrate 'capacity planning' delays. Caveat: the assumption is that all 'reason for delays' have been recorded appropriately however extract analysis would suggest that the longer delays may have been caused for other reasons e.g. patient cancelled, patient ill, regimen changed.



## Benchmarking Data

Performance for subsequent treatment anti-cancer drugs (31 days) December 2016

<b>Admitted Patients: PROVIDER</b>	<b>TOTAL</b>	<b>WITHIN 31 DAYS</b>	<b>AFTER 31 DAYS</b>	<b>TREATED WITHIN 31 DAYS</b>
BURTON HOSPITALS NHS FOUNDATION TRUST	1	1	0	100.00%
GEORGE ELIOT HOSPITAL NHS TRUST	18	18	0	100.00%
HEART OF ENGLAND NHS FOUNDATION TRUST	47	47	0	100.00%
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS FT	15	15	0	100.00%
THE DUDLEY GROUP NHS FOUNDATION TRUST	7	7	0	100.00%
UNIVERSITY HOSPITALS BIRMINGHAM NHS FT	32	32	0	100.00%
UNIVERSITY HOSPITALS COV & WARWICKS NHS FT	10	10	0	100.00%
<b>Non-admitted Patients PROVIDER</b>	<b>TOTAL</b>	<b>WITHIN 31 DAYS</b>	<b>AFTER 31 DAYS</b>	<b>TREATED WITHIN 31 DAYS</b>
BURTON HOSPITALS NHS FOUNDATION TRUST	2	2	0	100.00%
GEORGE ELIOT HOSPITAL NHS TRUST	1	1	0	100.00%
HEART OF ENGLAND NHS FOUNDATION TRUST	13	13	0	100.00%
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS FT	10	10	0	100.00%
THE DUDLEY GROUP NHS FOUNDATION TRUST	9	9	0	100.00%
THE ROYAL WOLVERHAMPTON NHS TRUST	25	25	0	100.00%
UNIVERSITY HOSPITALS BIRMINGHAM NHS FT	26	26	0	100.00%
UNIVERSITY HOSPITALS COV & WARWICKS NHS FT	8	8	0	100.00%

HEFT consistently comply in meeting any subsequent chemotherapy treatments that fall within the 31 day target, as do other boundary Trusts, as demonstrated above. However, current waits at HEFT for further subsequent treatments required at day 14 or 21 are up to 14 days over required date. The performance data above is split by inpatient and day case attendance and demonstrates a higher number of patients are admitted for chemotherapy regimens than other Trusts listed.

Comparatively, HEFT have a total of 32 treatment chairs across three sites for a population of 1.2m, with UHB having 46 treatment chairs for a population of 1.07m.

SACT data (Jan-Dec 2016) highlights HEFT is the second largest unit in the region based on patient numbers and associated high numbers of chemotherapy regimens. As a Centre for Excellence, HEFT continue management longer for specialist diseases such as myeloma, including the management of adverse effects.

NHS England Area Team > Hospital Trust	Number of patients	Number of tumour records	Number of regimens	Number of cycles
Birmingham and the Black Country	<b>18,116</b>	<b>19,121</b>	<b>27,139</b>	<b>105,538</b>
Birmingham Children's Hospital NHS Foundation Trust	194	206	381	834
Burton Hospitals NHS Foundation Trust	481	531	1,037	2,431
George Eliot Hospital NHS Trust	669	693	959	4,443
Heart of England NHS Foundation Trust	2,306	2,333	3,032	13,276
Sandwell and West Birmingham Hospitals NHS Trust	1,059	1,091	1,362	4,128
Shrewsbury and Telford Hospital NHS Trust	1,394	1,761	2,116	8,277
South Warwickshire NHS Foundation Trust	929	933	1,416	7,891
The Dudley Group NHS Foundation Trust	504	504	535	571
The Royal Wolverhampton NHS Trust	1,132	1,138	1,340	1,483
University Hospitals Birmingham NHS Foundation Trust	1,629	1,645	2,089	6,692
University Hospitals Coventry & Warwickshire NHS Trust	2,094	2,119	2,947	14,805
University Hospitals of North Midlands NHS Trust	2,915	3,301	4,397	17,123
Walsall Healthcare NHS Trust	646	665	1,158	3,506
Worcestershire Acute Hospitals NHS Trust	1,983	2,019	4,081	18,050
Wye Valley NHS Trust	181	182	289	2,028

### 3. Issue to be Resolved

Despite recent work and plans to date within Directorate to improve capacity and safety, the following issues remain:

- **CAPACITY:** Specialised services NHSE standard commissioning states that cancer services should ensure that effective scheduling and appropriate scheduling tools are used to ensure patient choice and improved access to services in order to maximise efficiency; effective scheduling is compromised due to an inadequate number of chemotherapy chairs within Ward 19 Day Unit resulting in an inability to provide adequate chemotherapy and supportive treatment capacity to meet current and future demand.

There are difficulties with flexibility within service to meet the demand for patients who require neo-adjuvant chemotherapy treatment to support a curative prognosis as there is often a small window of opportunity to administer chemotherapy required.

A further impact on capacity, during this year and increasingly year on year, will be created with the onset of NICE recommendations to provide immunotherapies

for patients with renal and lung cancers in a second line setting. This will lead to patients undergoing treatment more often and for a longer period of time. It is projected that this will increase activity by 2% (circa 180 extra patients per year initially) for lung cancers, with an expectation that this treatment will be rolled out for other cancers including haematological. This will see patients attending the Day Unit more often and for a longer period of time. As yet there are no clear indications of the exact impact this will have.

- **DELAYS:** Specialised service NHSE commissioning standard contract states that chemotherapy should be delivered timely, within waiting time targets, and treatment regimens should be maximised as day case rather than delivered as an inpatient,

Despite meeting 31 and 62 day targets for initiation of first treatment the Directorate has a current waiting time of up to 28 days post target date. Current waits for second and subsequent treatments required at day 14 or 21 are up to 14 days over required date.

In order to avoid excessive treatment delays some patients are being admitted as inpatients for their treatment, which in-turn impacts on ward bed availability (circa 182 patients for 12 month period requiring chemotherapy are admitted to the ward rather than to the Day Unit and incur a longer stay).

Reducing or delaying the dose of chemotherapy will reduce the dose intensity of treatment. This practice may achieve some reduction in toxicity, but may also decrease the therapeutic effect of the treatment for some curative treatments.

Although patient feedback has historically been very good, particularly relating to staff, there have been informal and formal complaints stating that patients have had to wait longer than their chemotherapy pathway target date and also long waits for treatment to commence on the day of treatment, some being up to 4 hours.

- **ENVIRONMENT:** The Chemotherapy Peer Review report (April 2013) stated having “insufficient” space for treatment “*at Heartlands hospital could be detrimental to patient experience*”. This is currently has risk score of 12 on the Directorate risk register. Mitigations to date have included Saturday sessions, increased navigation provision, chemotherapy at Solihull, MIDRU and in the community.

To fully comply with Specialised services NHSE standard commissioning contract for cancer chemotherapy delivery the service is required to ensure interventions are carried out in a facility that is fit for purpose, provides a safe environment of care, has adequate privacy for patients, minimises risk to patients, staff and visitors and ultimately ensures that patients have a positive experience of care. The contract refers to risks that relate to limited capacity, overall environment to include outpatients and clinical support services e.g. pharmacy and phlebotomy.

There is an urgent need to improve patient experience and quality of care for patients attending Ward 19 Day Unit in reducing an overcrowded environment caused by a sub-optimal sized unit. This situation is further impacted by the proximity of chemotherapy chairs within the Day Unit that compromises patient privacy and dignity.

Young cancer patients (18 to 24 years) undergo their chemotherapy within the same area as older adults. The Teenage Cancer Trust recommend that such patients be treated in a designated and suitable age related environment. Ward 19 Day Unit is not able to fulfill this requirement due to limited space.

Ward 19 footprint does not offer any capacity to develop Haematology and Oncology services further due to lack of space, such as further development of Acute Oncology Service (AOS) that would support timely intervention for patients requiring advice and care and avoid unnecessary admissions, and also Community Bone Marrow Transplant (BMT) Service which would support reduction in length of stay for patients requiring BMT.

- **STAFF:** Capacity issues and overcrowded environment has had a negative impact on nursing staff retention for those working in the Day Unit environment (11% YTD turnover), with high sickness rates (7% YTD) for nursing staff both over Trust targets. Low staff morale within the Directorate was a theme captured within this year's Staff Survey.

There has been limited investment in pharmacy staff commensurate with increased chemotherapy activity that has led to a demoralised workforce and high numbers of IR1s due to drug related near misses of which the main cause has been pharmacy related errors (see Appendix C). A recent local investigation has been undertaken to address clinical and office space for the pharmacy team on the Ward 19 footprint without compromising the provision of other clinical services that has proved challenging in view of limited space available.

#### 4. Case for Change

There is an urgent need to provide appropriate and adequate capacity for on-going chemotherapy services which match current and forecasted demand. This requires a facility fit for purpose with the ability to grow in line with future demand based on the demographic forecasts for the catchment population. This requirement is driven by a necessity to:

- Provide capacity to manage demonstrated year on year increase in activity (25.5% increase since 2013/14 to YTD) for chemotherapy and supportive cancer care activity and additional growth associated with NICE recommendations for increased immunotherapy treatments.
- Provide a reduction in waiting times to improve access and ability to schedule cancer treatment for first and subsequent regimes particularly those patients requiring adjuvant and neo-adjuvant chemotherapy.

- Comply with specialised services NHSE standard commissioning contract for cancer chemotherapy delivery and ensure environment in which the treatments are delivered is fit for purpose. Improve patient experience by improving the quality of the environment in which treatments are delivered. To ensure a comfortable, safe and secure environment for delivery of high risk chemotherapy drugs and supportive treatments where privacy, dignity and compassionate care is achieved for all patients. This has been frequently raised in patient feedback/surveys (formal and informal including complaints).
- Support continued development of chemotherapy trial regimes.
- The ability to develop pathways further e.g. Community BMT, AOS, apheresis, Teenage Cancer Services, and develop new pathways and services such as outreach chemotherapy as additional capacity is created and legacy space is developed.
- Improve staff morale and retention across the nursing, medical and clinical support workforce that will in turn improve patient care and experience.

Current capacity modelling (2017/18) and planned growth has identified the need to increase chemotherapy and supportive treatment capacity by circa 12 chairs (taking total required to 29 chairs) in year 1 (2018/19) rising to a total of 26 by year 5 (taking total requirement to 43 chairs) – refer to Appendix D.

## **5. Internal Stakeholder Support**

The development of this business case has been recommended and supported by the Trust Executive Team and developed by key members of the clinical and management team from within Division 4 and the Directorate of Clinical Haematology and Oncology. Engagement and involvement has been sought from other interdependent clinical and non-clinical support services i.e. Pharmacy, Pathology, Blood Bank, Asset Management and ICT.

Preparatory progress updates have been made to the Director of Operations and Deputy CEO throughout 2017.

Trust Operations Group and Executive Performance Reviews have also been kept up to date with progress.

This business case is also a key objective of the Trust and the Directorate's Strategy 2017-20.

## **6. External Stakeholder and Commissioner Support**

Upon approval of the Business Case further discussions and engagement will be sought from the following key groups:

- External providers of estate or capacity solutions
- Patients
- Local CCGs and Specialist Commissioners
- WMAS

## 7. Business Case Benefits

Benefit	Performance outcome
Provision of increased capacity for chemotherapy and supportive treatment regimens	<ul style="list-style-type: none"> <li>• Increased access to capacity for treatment regimens (first and subsequent) enabling scheduling of appointments within specific pathway timeframes.</li> </ul>
Compliance with NHSE Specialised Services standard commissioning contract – ‘fit for purpose environment’	<ul style="list-style-type: none"> <li>• Improved patient, relative and staff experience.</li> <li>• Reduction in environmental related incident reporting associated with safety, waiting times, privacy and dignity.</li> </ul>
More flexible capacity to deal with variability in demand	<ul style="list-style-type: none"> <li>• Maximum utilisation of appointment/chair slots – 95% patients offered date within recommended standard for treatment regimen (demonstrated by scheduling reports – ‘Bookwise’).</li> <li>• Ability to develop new pathways including clinical trials.</li> <li>• Increase in extra and new income related activity (£708k Year 1)</li> <li>• Legacy space created to support further development of Acute Oncology Services, community BMT service, apheresis and reduction in LOS on Ward 19</li> </ul>
Improved patient experience when attending Ward 19 Day Unit	<ul style="list-style-type: none"> <li>• Cessation of concerns/complaints raised by patients in relation to treatment waiting times and environment (2016-17 6 complaints)</li> </ul>
Positive impact on staff morale and wellbeing	<ul style="list-style-type: none"> <li>• Positive staff feedback upon appraisal and staff survey</li> <li>• Decrease in staff turnover to be in line with Trust standard of 9.98%</li> <li>• Decrease in staff sickness to be in line with Trust standard of 4.3%</li> </ul>

## 8. Option Appraisal

In light of the issues identified within this Business Case and to support the established increase in activity, the basic requirement is to provide a facility and environment that is fit for purpose and provides adequate capacity to cope with the demand now and capacity demand in the future and in by doing so ensure the delivery of care is safe with the appropriate for all patients who use the service. In order to fulfill this and provide the expansion of service provision required to deliver care, the following options are have been explored:

## **Option 1**

Do nothing.

This is not a viable option to be considered in light of:

- Current level demand versus capacity available.
- Inability to deliver appropriate and safe level of care due to environmental issues, confirmed at Executive Review in November 2016 and at recent meetings with the Executive Team.
- Directorate's inability to meet National performance standards moving forward and limited access to second and subsequent treatments.
- Note there will be a requirement to substantiate the agreed over-establishment of 2 WTE Band 5 and Band 6 nurses and 1 WTE Band 7 Pharmacist that were agreed at risk (Budget impact £177k, revenue impact £101k).

## **Option 2 (Preferred Option)**

To provide additional capacity and a fit for purpose environment through the refurbishment of the vacated Bruce Burns Unit at Solihull Hospital. Proposed plans involve relocation of low risk chemotherapy and supportive treatment delivery from Ward 19 Day Unit to part of Bruce Burns at Solihull Hospital.

The proposal requires the relocation of 12 of the current 17 chairs from Ward 19 Day Unit to an area on Bruce Burns Unit that will be redesigned to create a fit for purpose low risk chemotherapy and supportive treatment unit that includes procedure rooms, clinic rooms and staff areas (Appendix I and J). The 5 remaining chairs on Ward 19 Day Unit will facilitate high risk chemotherapy and BMT provision. The legacy space will be redesigned to support current and potential expansion of Acute Oncology Service provision and future development of community transplant provision subject to business cases.

The total area required to accommodate the proposed low risk chemotherapy unit is that of 50% of the Bruce Burns Unit based on the specification set out by the Directorate. Refurbishment costs have been estimated at circa £455K (includes initial £10k for formal final redesign brief to confirm costs), with recurrent revenue costs of circa £65K; this will need to be confirmed with more detailed design meetings and a full design brief to establish the full extent of service to be delivered from the unit.

In terms of time scales to deliver the final agreed build plan, it is estimated from the date of final scheme approval to be 14 - 18 weeks. This is subject to approval of a single waived tender that will reduce the procurement process (4 – 5 weeks on tendering / analysis of costs and 8 -10 weeks on design process). Work will be undertaken with the contractor similar to a Design and Build so that specific information is built up as the scheme progresses. The above reduction in time makes a saving estimated at circa £15 – 20k dependent on the complexity of the final scheme detail.

Initial Facilities costs will be £55k Year 1 including initial clean and set up (Year 2 £45k). Porter support not required as this is an ambulatory provision.

#### Advantages:

- Will create the required capacity to address current and future demand until Year 3 (2019/20) providing the potential to maximise efficiency and increase capacity to meet projected growth and future service development requirements and also provide a solution to the environmental issues identified on Ward 19 Day Unit. This facility will enable the provision of 31 spaces for chemotherapy chairs, dependent on local environmental planning, based on an open plan format with partitioned zones to support privacy and dignity.
- By year 5 there will be a requirement to have 35 chairs at Solihull and this environment will allow future consideration to 6 / 7 day working to facilitate this and also to provide a potential for a further 5 chairs for infusions provided by other services e.g. Rheumatology and Gastroenterology.
- Release current chemotherapy regimens undertaken on the ward to be delivered in the Day Unit on Ward 19 thus releasing ward bed capacity (around one bed per day) and enhancing patient experience and flow.
- Allow the development of a designated young patient area within the unit.
- Enable the cessation of Saturday lists (saving of £31k) that will offset against current revenue costs for this provision.
- Enable the cessation of Marie Curie SLA by transfer of blood transfusions performed at Marie Curie (saving of £31k) and also transfer of outpatients from Solihull Out Patient Department as this will be offset against current costs for this provision.
- New unit will become a fit for purpose dedicated chemotherapy and supportive treatment centre by 18/19 and will enable the re-modelling of Ward 19 Day Unit legacy space to provide high risk chemotherapy and a procedures environment that will facilitate expansion of Community Bone Marrow Transplant (BMT) provision in a dedicated environment supporting Directorate's vision for community based care by having designated capacity within Ward 19 Day Unit for outpatient autologous stem cell transplants. Currently this provision is predominantly ward based with extend length of stays of up to 3 weeks.
- Enable Directorate to develop its Acute Oncology Service (AOS) further with the development of an AOS assessment area on Ward 19 Day Unit that will allow the management of acute oncology patients outside of Emergency Department (ED) and Acute Medical Unit (AMU). The current Ward 19 based triage provision will also be able to link into this development; this provision currently picks up post chemotherapy patients by bringing them directly to the ward rather than going through ED and AMU. Both provisions being based in this legacy space will ultimately result in reduction of LOS, better patient care and overall health cost benefits and admission avoidance.
- Enable Chemotherapy Service to work towards anatomical site specific chemotherapy sessions (across Solihull and Heartlands) that will reduce drug wastage and increase productivity and efficiency within pharmacy process as it will allow Pharmacy to 'campaign manufacture' drugs within the ADU i.e.

make several patients treatments together, at the same time, rather than separately. This will create cost savings through vial sharing of high cost drugs.

- In developing a designated chemotherapy unit and making Ward 19 Day Unit a safer environment this would in turn support the retention and recruitment of high quality nursing staff as the Trust's Haematology and Oncology Service will become a more appealing place for staff to work and develop.
- A Solihull based provision will provide local access to chemotherapy and supportive treatments in addition to decongesting Heartlands Ward 19 Day Unit.
- Infrastructure for support services and facilities already in place with Solihull Hospital, requiring minimal uplift e.g. adult emergency access, on-site pharmacy, general and cytotoxic waste removal etc.
- Minimal ICT infrastructure works required.
- Relatively short lead time of approximately 6 months from design brief to completion for use.

### Disadvantages

- Refurbishment cost circa £455K and recurrent revenue costs of circa £65k however revenue costs are partially offset by additional income (18/19 Vs 15/16), savings from cessation of Saturday lists and Marie Curie SLA.
- New ICT infrastructure to be installed at cost of circa £19k.
- New facility will not be based within the community setting, however together with the Sheldon Day Unit based at Good Hope Hospital, service provision will be better located for the patient population.
- This option will require utilisation of up to 50% of the Bruce Burns Unit footprint however this area will be located completely at the rear section of the unit, allowing the fore area of the unit to be utilised by another service if required.

### Option 3

To provide additional capacity through the development of an externally located facility via a commercially leased building similar to Castle Vale Renal Unit. Proposed plans involve relocation of low risk chemotherapy and supportive treatment as outlined in Option 2 to be delivered in an external unit to the Trust.

The option to secure rental accommodation off Trust site is estimated to be £80-100k per annum, with Asset Management revenue costs at circa £100k per annum, Capital cost for fit out of the unit to be circa £1–2m dependent on final design brief to establish the full extent of service to be delivered from the unit. The estimated time frame is 12-18 months from approval to completion.

### Advantages:

- Facility based within community setting.
- As outlined in Option 2 with the exception of disadvantages below:

## Disadvantages:

- Significant cost for fit out, revenue and lease charges.
- Estimated lead time is up to 18 months to deliver from negotiations with the land lord, initial design brief through to completion.
- Infrastructure for support services not already in place e.g. pharmacy (drugs) transport, blood bank, adult emergency support, removal of waste including cytotoxic medical records, portering etc.
- ICT infrastructure not in place that would require detailed planning and increased cost.

## 9. Financial Appraisal

The table below outlines all Options appraised:

Financial Appraisal	Option 1	Option 1	Option 2	Option 2	Option 2	Option 2	Option 2	Option 2	Option 2	Option 3	Option 3
	Wte	£000	£000	Wte	£000	Wte	£000	Wte	£000	Wte	£000
	Year 1	Year 1	17/18	18/19	18/19	19/20	19/20	20/21	20/21	Year 1	Year 1
<b>CAPITAL EXPENDITURE</b>		Nil	-455								-2,000
<b>NON RECURRENT SET UP</b>		Nil	-170								0
<b>REVENUE EXPENDITURE</b>		-101	0		-1,051		-1,203		-1,407		-1,225
<b>Pay</b>											
Nurse Qualified Band 5	2.00	-63		3.63	-114	4.63	-146	5.63	-180	3.63	-114
Nurse Qualified Band 6	1.00	-38		6.98	-268	6.98	-271	6.98	-274	6.98	-268
Nurse Qualified Band 7				0.25	-11	0.25	-12	0.25	-12	0.25	-11
Nurse Unqualified Band 2				7.87	-163	7.87	-165	7.87	-166	7.87	-163
Nurse Unqualified Band 3				0.78	-18	0.78	-18	1.78	-41	0.78	-18
Admin & Clerical - Band 4				0.30	-8	0.30	-8	0.30	-8	0.30	-8
Admin & Clerical - Band 3				1.07	-25	1.07	-25	1.07	-25	1.07	-25
Dietician-Band 6				1.00	-38	1.00	-38	1.00	-39	1.00	-38
CNS-Band 7				1.95	-89	1.95	-90	1.95	-91	1.95	-89
Consultant				1.00	-126	1.00	-128	1.00	-129	1.00	-126
Pharmacy Workforce				13.30	-505	15.70	-571	18.10	-668	13.30	-505
<b>Subtotal Pay</b>	<b>3.00</b>	<b>-101</b>		<b>38.13</b>	<b>-1,367</b>	<b>41.53</b>	<b>-1,473</b>	<b>45.93</b>	<b>-1,634</b>	<b>38.13</b>	<b>-1,367</b>
Non Pay											
Clinical Supplies					-104		-134		-173		-104
Equipment							-22		-33		
Training					-3		-3		-3		-3
Utilities					-13		-13		-14		13
Cleaning					-55		-45		-46		-55
Capital Charges					-44		-53		-51		-44
Asset Management											-100
Other - Lease											-100
<b>Subtotal Non Pay</b>		<b>0</b>			<b>-219</b>		<b>-270</b>		<b>-319</b>		<b>-393</b>
Revenue/Efficiency Savings (WLI)					535		540		546		535
<b>GRAND TOTAL REVENUE</b>		<b>-101</b>			<b>-1,051</b>		<b>-1,203</b>		<b>-1,407</b>		<b>-1,225</b>
<b>INCOME</b>											
Activity		0			708		1316		1969		708
<b>GRAND TOTAL INCOME</b>											
<b>CONTRIBUTION/(GAP)</b>		<b>-101</b>			<b>-343</b>		<b>113</b>		<b>562</b>		<b>-517</b>

The full financial appraisal for Option 2 is attached at Appendix E to I to demonstrate workforce, non-pay, set up costs required and predicted activity/income associated with this option.

## Affordability

Table below demonstrates total investment required year on year:

<b>Cost Summary</b>	<b>Yr 1</b>	<b>Yr 2</b>	<b>Yr 3</b>
<b>Budget impact Revenue</b>	-1,586	-1,744	-1,953
<b>Capital and Set up Costs</b>	0	-22	-33
<b>Total</b>	-1,586	-1,765	-1,986

The capital investment and one off set up costs (£625k) in 2017/18 ahead of revenue investment of £1.586m in 2018/19 that includes an uplift in staffing (38.13 WTE), resulting in an Income and Expenditure (I&E) deficit of £343k moving to a total investment of £1.953m and I&E surplus of £562k in year 3 2020/21

In Years 1 to 3 it is estimated that due to increased levels of activity, based on previous year on year growth and the pending increase in immunotherapy treatments, this will generate recurrent additional income of circa £708k in addition to efficiency savings of £535k as a result of cessation of Saturday and Marie Curie sessions plus removal of posts at risk that are currently included in run rate.

Additional income will be generated through other activity increases as described in Activity Assumptions below. Ward 19 Day Unit and Chemotherapy activity has grown by 25.5% from 2013/14, circa £17.8m to £20.2m in 2016/17.

This increase in activity will potentially need to go through NHSE service development process and/or be tabled as a Trust plan for formal sign off. This increase relates to growth and efficiency rather than development of a new service however as this is an expansion of capacity this will require additional NHSE payments.

Further to approval of this business case, an application will be made for charitable funding to support set up costs of £170k that are currently included in Income and Expenditure assumptions for this case.

### Activity Assumptions

Activity assumptions are based on year on year growth, 25.5% overall from 2013/14. Day Case activity has increased by 6.9%, Unbundled HRGs (chemotherapy) 7.54% and it is anticipated that the pending continued increase in immunotherapy treatments in line with NICE recommendations will realise and increase in activity at around 4% initially. The release of legacy space on Ward 19 Day Unit will enable efficiencies of service delivery and development of AOS and Community Transplant Service.

### Staffing Expenditure

Financial Appraisal table above summarises the initial staffing expenditure for uplift of 38.13 WTE in 2018/19 (£1.366m), which assumes continuation of current staff

levels to support new unit and residual service that will remain on Ward 19 Day Unit (5 high risk chairs) plus required incremental uplift for additional chairs (29 to 36 chairs Year 1 to Year 3) . The costings identified demonstrate full year impact assuming no delays in approval of this business case or recruitment. Breakdown of staffing analysis against service provision is included in Appendix H for Pharmacy including workforce benchmarking and Appendix I for medical, nursing and other support services.

### Capital Expenditure

Refurbishment of Bruce Burns Unit circa £455k aligned to location (Appendix J) and agreed final schedule of accommodation with non-recurrent set up costs of £170k (Appendix G). Upon approval of this Business Case an application for charitable funding will be made to offset set up costs.

## **10. Preferred Option**

Option 2 is the preferred option as it will:

- Create the required capacity to address current and future demand (projected to Year 2020/21) having the potential to provide increased capacity to meet growth and service development requirements and also provide a solution to the environmental issues identified on Ward 19 Day Unit.
- Release current chemotherapy regimens undertaken on Ward 19 to be delivered in the Day Unit on Ward 19 thus releasing ward bed capacity and enhancing patient experience and flow.
- Infrastructure for support services and facilities already in place with Solihull Hospital, requiring minimal uplift e.g. adult emergency access, on-site pharmacy, general and cytotoxic waste removal etc.
- Requires minimal ICT infrastructure works compared to an external unit provision.
- Relatively short lead time of approximately 6 months from design brief to completion for use.

## **11. Implementation/Phasing**

<b>Milestone</b>	<b>Timescale for delivery</b>	<b>Monitoring mechanism</b>
Develop estates plan with Asset and Estates Management Team (to include full design brief)	1 month from TOG approval for full Design Brief. 3 months from approval by CEAG for Estates Plan	<ul style="list-style-type: none"> <li>• Project Team</li> <li>• PID</li> <li>• Project plan monitoring against milestones</li> <li>• Regular reporting to TOG</li> </ul>
Develop estates and workforce transitional transfer plan	3 months	<ul style="list-style-type: none"> <li>• Project Team</li> <li>• Estates Plan milestones</li> <li>• Project Plan milestones</li> </ul>

Recruitment of staff	4 months prior to implementation of increased capacity in Solihull Unit to support local induction, orientation and specialist training.	<ul style="list-style-type: none"> <li>Recruitment policy and respective timeframes</li> <li>Clinical/chemotherapy training plans.</li> <li>Staff rotation plans between BHH and SHH</li> </ul>
Development of protocols e.g. SOPs, pharmacy delivery plans	3 months prior to implementation of increased capacity availability	<ul style="list-style-type: none"> <li>Project work stream plans and targets reporting to Directorate Project Lead</li> </ul>
Submit progress paper to Trust Operations Group	6 months	<ul style="list-style-type: none"> <li>Project work stream reports</li> </ul>

## 12. Risk Assessment and Management

The role of the clinical and operational leads as part of the implementation phase is to develop robust Standard Operating Procedures driven by multi-disciplinary assessment (nursing, medical and pharmacy) to address and mitigate areas of risk that are identified as a result of the delivery of chemotherapy and supportive treatments within new environment.

## 13. Measuring Successful Delivery of the Case

Benefit	Performance Outcome	Data Source	Date of first review	Responsible Lead
Provide increased capacity for chemotherapy and supportive treatment regimes	Maximum utilisation of 29 treatment chairs by end of Year 1, 32 Year 2 and 36 Year 3	Bookwise activity reports	1 month post implementation	Group Manager
Reduced waits for second and subsequent chemotherapy regimes	No waits for subsequent treatment pathway dates as a result of capacity	Bookwise activity reports Complaints re capacity eliminated	3 months post implementation	Lead Chemotherapy Nurse

Compliance with NHSE Specialised Services standard commissioning contract – fit for purpose environment	Improved patient, relative and staff experience  Reduction of environmental related incident reporting associated with safety, waiting times, privacy and dignity	Patient feedback and experience surveys  Complaints / Compliments  Datix reports  Staff survey.	3 months post implementation	Lead Chemotherapy Nurse
Improved patient experience when attending Day Unit on all sites	Reduction in patients waiting for their treatment to begin  Reduction in negative feedback and complaints raised	Bookwise – booked appointment Vs start time  Patient Satisfaction surveys, complaints data	1 month post implementation  3 months post implementation	Lead Chemotherapy Nurse  Group Manager
More flexible capacity to deal with variability in demand	Treatment delivered at correct time for specific pathway	Bookwise activity reports	3 months post implementation	Lead Chemotherapy Nurse
Positive impact on staff morale	Sickness levels in line with Trust targets (4.3%)  Staff turnover in line with Trust targets	Exit interviews and staff feedback / survey and sickness management process	6 months post implementation	Matron

#### 14. Formal Sign Off

Name	Role	Date of sign off of final case before submission to Board
Julian Miller	Director of Finance	16 <sup>th</sup> October 2017
Jonathan Brotherton	Director of Operations	16 <sup>th</sup> October 2017
Vijay Suresh	Divisional Director, Division 4	23 <sup>rd</sup> September 2017

Andrew Clements	Head of Operations, Division 4	16 <sup>th</sup> October 2017
Theresa Price	Head of Operations, Division 1	16 <sup>th</sup> October 2017
Ann Edgar	Head Nurse, Division 4	23 <sup>rd</sup> September 2017
Mike Taylor	Head of Estates	23 <sup>rd</sup> September 2017
Chris Davies	Head of Facilities	23 <sup>rd</sup> September 2017
Angeline Jones	Chief Financial Controller	23 <sup>rd</sup> September 2017
Michael Archer	Head of Contracting	23 <sup>rd</sup> September 2017
Adam Winstanley	Finance Manager, Division 4	16 <sup>th</sup> October 2017

## 15. Conclusion

There remains an urgent need to provide appropriate and adequate capacity for on-going chemotherapy services that match current and forecasted demand. This requires a facility that is fit for purpose with the ability to grow in line with future demand based on the activity forecasts and the drivers as described in Section 4 – Case for Change. Option 2 recommends the investment to develop increased capacity and an improved safe environment for Day Unit and Chemotherapy activity through the development of part of the Bruce Burns Unit at Solihull (to include clinical support functions e.g. pharmacy and phlebotomy) and for the respective workforce models that will be required to deliver this service.

## 16. Recommendations

The Board is asked to consider the information set out in this report and approve the total investment required to develop a low risk chemotherapy unit facility within the Bruce Burns Unit at Solihull Hospital. This requires capital investment and one off set up costs of £625k in 2017/18. There is also a need for revenue investment of £1.586m in 2018/19 that includes an uplift in staffing (38.13 WTE), resulting in an Income and Expenditure (I&E) deficit of £343k. This moves to a total investment of £1.953m and I&E surplus of £562k in year 3 2020/21. Within these revenue costs £535k is currently being incurred at risk to support operational pressures.

## APPENDIX A: Directorate Strategy

### Clinical Haematology and Oncology

Core Purposes Current Position		Clinical Quality	Patient Experience	Workforce	Research & Innovation
<b>HOW</b>	Plan	Actions		Progress to date	End State Ambition
	Improve Day Unit capacity, safety and environment	a) Chemotherapy Capacity & Environment business case b) Implement, continue and further develop Kay Kendall service c) Expansion of cancer centre at GHH Sheldon Unit via refurbishment of OT area for delivery of supportive treatments d) Staff restructure /Extended opening hours of Day Unit e) Closed chemotherapy systems unit case f) Recruitment at risk of B5 and B6 nurses g) Provision of additional area to be used by pharmacy for prevention of drug errors.		a) Case submitted to TOG on 7/9/17 (to include immunotherapies expansion) b) On-going and in place. c) Approval for refurbishment and grant for charitable funds of £72k granted. d) Completed e) Completed f) In progress g) Completed	Fit for purpose Day Unit ensuring adequate capacity, resource and optimal environment for delivery of safe care to patients.
	Develop AOS/CUP provision further	a) Business case to increase workforce		a) Business case in pipeline, plans to develop service in line with options available as part of legacy space. Dependant on chemotherapy capacity case approval.	<ul style="list-style-type: none"> <li>Reduced LOS</li> <li>Admission avoidance</li> <li>Improved patient experience</li> </ul>
	Community transplant service	a) Scoping phase		a) In progress; plans to develop service dependant on chemotherapy capacity case approval.	<ul style="list-style-type: none"> <li>Reduced LOS</li> <li>Admission avoidance</li> <li>Improved patient experience</li> </ul>
	Development of o/p chemotherapy	a) Kay Kendall/Richmond service provision b) Chemo @ Home		a) In place /scoping further development b) Scoping phase	Care closer to home
	Chemo prescribing	a) PICS b) Additional pharmacy staff		a) Development phase with UHB b) Recruitment of B7 pharmacist at risk Additional pharmacy staff required I included in chemotherapy capacity business case.	<ul style="list-style-type: none"> <li>E-Prescribing- PICS</li> <li>Fit for purpose pharmacy workforce that meets current and future demand.</li> </ul>
	Other advancements to support core purpose	a) Recruitment: 1 WTE Haematology Consultant and increase of 2PA's (existing consultants). b) Business case: ACP's substantive c) Recruitment : Myeloid disorders CNS d) Recruitment : Clinical fellow (Charitable funds) e) Review CNS provision		a) Approved at CEAG for recruitment at risk. Recruitment in progress. b) Completed and approved c) Completed and approved d) Completed and approved e) Scoping phase	Fit for purpose workforce that meets current and future demand.
Core Purposes - Where we want to be		Clinical Quality	Patient Experience	Workforce	Research & Innovation

## APPENDIX B

### Current Activity Vs Available Capacity

Available capacity demonstrated in table below includes current Ward 19 Day Unit, recent and on-going capacity opportunities with a status on progress.

Assumptions made are on the release of as many non-chemotherapy treatments as possible out of the Day Unit, which has 17 treatment chairs, to other areas in order to increase its actual chemotherapy capacity. Treatment allocation is based on chair schedules modelled from a chair utilisation audit over differing typical three week periods. This demonstrated that:

- 3% of all treatments take 6-8 hours
- 3% of all treatments take 4-6 hours
- 10% of all treatments take 2-4 hours
- 54% of all treatments take <2hrs and >30 minutes
- 29% of all treatments take <30 minutes

These assumptions are used throughout the paper to determine treatment chair shortfalls currently and how many more chairs will be required in the future versus further potential options.

Capacity identified in Table A is post adjustment of Day Unit nurses' working hours (0800-1800 Monday to Friday) and treatment chair scheduling to ensure maximum productivity and efficiency.

Existing Capacity Available / Created and Plans in Progress	Treatment Numbers taken out of Day Unit (non-chemo or short regime chemo)	Weekly Chemotherapy & Supportive Treatment Capacity Available / Created	Status and Comments
17 Day Unit chairs (250 patients)	N/A	250 Chemo & Supportive Treatments	Once capacity options in place - 250 patients a week maximum to ensure environmental safety. 1.0 WTE pharmacist uplift as agreed at TOG.
Creation of rapid chair in the day unit	60	7.5 Chemo only Treatments	In progress - once staffing levels allow (May 2017). 2.0 WTE nurse uplift as agreed at TOG.

Good Hope OT area (inc. transfer of venesections)	31	10.5 Chemo only Treatments	In progress – Charitable capital release agreed (circa £74k refurbishments and £25k equipment from charitable funds) and refurbishment. Lead time to be confirmed. There has been 2.0 WTE nurse uplift to GHH to support this as agreed at TOG.
Maximise Marie Curie Hospice	10	5 Chemo only Treatments	In place – SLA to value of £30k per annum to provide blood transfusions
Maintain Richmond Primary Care Clinic	7-8 Treatments	2.5 Chemo only Treatments	In place – SLA to the value of £8.5k per annum
<b>TOTAL CAPACITY CREATED</b>	<b>275.5 Treatments</b>		
<b>TOTAL DEMAND</b>	<b>415 Treatments</b>		Includes circa 29 (7%) treatments waiting over recommended cycle/pathway date
<b>CAPACITY SHORTFALL</b>	<b>139 Treatments (equates to 8 chairs)</b>		

## APPENDIX C

### Review of Cancer Service Medication Incidents: Mar 2016 - Jul 2017

A total of 137 medication incidents were reported between 1<sup>st</sup> March 2016 and 31<sup>st</sup> July 2017 that related to Cancer Services (see locational breakdown in Table A). Of the 137 incidents reported there were none reported as severe harm; 1 reported as moderate harm and 9 incidents were reported as being low harm. Drug error themes are demonstrated in Table B below.

**Table A**

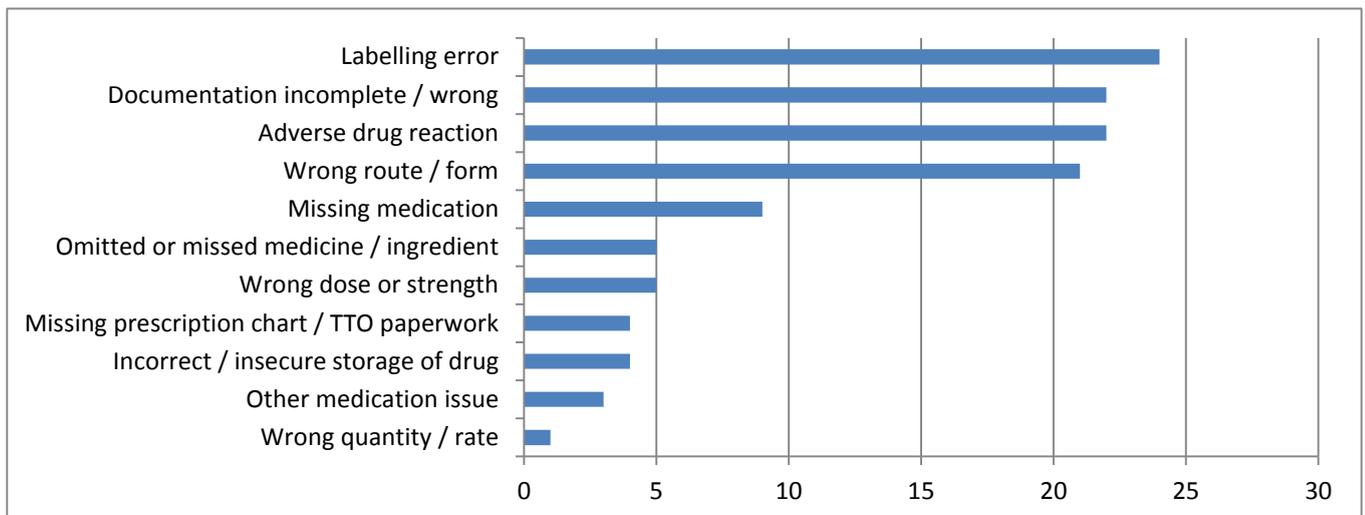
Location	No. of incidents
Heartlands Ward 19 Day Unit	75
Heartlands Ward 19	31
Pharmacy Satellite Unit (Ward H19)	23
Pharmacy Aseptic Dispensing Unit	4
Good Hope Haem/Onc Day Case Unit and OPD	4

A breakdown of the incidents with regards to stage of error is given below to help identify any themes for further discussion & decision.

#### Limitations

This report does not provide comment on whether the reported level of harm on Datix correlates with the patient outcomes. This report does not verify the selection of categories for each of the reported incidents entered by the incident reporter. Finally this report includes all open and closed incidents within Datix.

**Table B**



Although reporting of incidents has not directly been linked to environmental issues on Ward 19 footprint, post incident reflection has indicated that lack of space and interruptions due to shared space has contributed to drug errors in the past. Recent mitigation has included the release of an extra room on Ward 19 footprint for pharmacy to utilise.

## APPENDIX D

### FUTURE ACTIVITY AND CAPACITY SHORTFALLS (Heartlands and Solihull)

	Year 1 (18/19)	Year 2 (19/20)	Year 3 (20/21)	Year 4 (21/22)	Year 5 (22/23)
<b>Projected outturn/week*</b>	497	549	607	671	741
<b>Treatment Capacity Shortfall</b>	226	279	336	400	470
<b>Chairs required in addition to existing 17 chairs</b>	12	15	19	22	26
<b>Phased year on year increase in chairs required to meet projected outturn</b>	12 <i>(initial uplift due to current shortfall)</i>	3	4	3	4
<b>Total chairs required for BH and SH provision</b>	<b>29</b>	<b>32</b>	<b>36</b>	<b>39</b>	<b>43</b>

\*Projected outturn includes Solihull outpatient chemotherapy activity, treatments currently delivered in the Marie Curie hospice, with the intention of this being delivered within the new unit, and capturing delayed subsequent treatments.

## APPENDIX E: Budget Impact – Workforce and Run Rate Efficiencies

Current Funded and Worked Establishment						
Staff Type	Funded		Worked		Difference	
	WTE	£ - k	WTE	£ - k	WTE	£ - k
Consultant	1.00	125	1.00	125	0.00	0
Qualified Nursing	13.77	523	16.27	615	(2.50)	(92)
Unqualified Nursing	4.60	103	4.60	103	0.00	0
A&C Support	6.80	152	6.80	152	0.00	0
Dietician	0.00	0	1.00	38	(1.00)	(38)
Pharmacy	25.00	902	32.00	1,245	(7.00)	(343)
<b>Total</b>	<b>51.17</b>	<b>1,805</b>	<b>61.67</b>	<b>2,278</b>	<b>(10.50)</b>	<b>(473)</b>

Establishment by Year								
Staff Type	2017/18		2018/19		2019/20		2020/21	
	WTE	£ - k						
Consultant	1.00	125	2.00	251	2.00	253	2.00	254
Qualified Nursing	13.77	523	26.58	1,006	27.58	1,042	28.58	1,080
Unqualified Nursing	4.60	103	13.25	284	13.25	286	14.25	311
A&C Support	6.80	152	8.17	185	8.17	185	8.17	185
Dietician	0.00	0	1.00	38	1.00	38	1.00	39
Pharmacy	25.00	902	38.30	1,407	40.70	1,473	43.10	1,570
<b>Total</b>	<b>51.17</b>	<b>1,805</b>	<b>89.30</b>	<b>3,171</b>	<b>92.70</b>	<b>3,277</b>	<b>97.10</b>	<b>3,439</b>

## APPENDIX F

Predicted growth assuming current growth rates and including uplift for increasing development of immunotherapy treatments at 4% growth year on year:

Chairs and Income by Year						
Detail	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
BHH Chairs	17	5	5	5	5	5
GHH Chairs	14	14	14	14	14	14
SOL Chairs	2	24	27	31	34	38
<b>Total Chairs</b>	<b>33</b>	<b>43</b>	<b>46</b>	<b>50</b>	<b>53</b>	<b>57</b>
Daycase Activity - £k	4,275	4,570	4,885	5,223	5,583	5,968
Chemotherapy Activity - £k	3,538	3,804	4,091	4,400	4,731	5,088
Immunotherapy Activity - £k	0	147	153	159	166	172
<b>Total Activity - £k</b>	<b>7,813</b>	<b>8,521</b>	<b>9,129</b>	<b>9,782</b>	<b>10,480</b>	<b>11,228</b>

**APPENDIX G : Set up Costs for 24 Chairs at Solihull Hospital**

Items to be procured	Number	Year 1	Year 2	Year 3
<b>TREATMENT AREA</b>	Uplift	12 (24)	3 (27)	4 (31)
Treatment chairs	12	15,699	3,925	5,233
Cabinet	12	3,288	822	1,096
Drip stand	12	1,731	433	577
Relative chair	12	852	213	284
Dressing trolley - small	7	1,190	170	170
Nursing stool	7	875	125	125
Infusion pumps	12	24,000	6,000	8,000
Infusion pump consumables	24	13,184	3,296	4,394
Clinical & Non Clinical Clean and set up		12,180	-	-
Linen Trolley	4	216	-	54
Macerator (capital cost)	1	-	-	-
Screen	1	701	-	-
Mobile Out patient beds	2	2,600	-	-
Double procedure trolleys	2	222	-	-
<b>RECEPTION AREA</b>				
Reception seating - beam chairs sets of 4	6	2,154	-	359
Reception desk	1	1,164	-	-
Reception chairs	2	165	-	-
<b>PHLEBOTOMY</b>				
Pentra	1	17,500	-	-
Pentra maintenance costs	1		3,000	3,000
Phlebotomy chairs	2	3,390	-	-
phlebotomy stools	2	250	-	-
Blood fridge	1	3,827	-	-
<b>CONSULTATION ROOMS X 2</b>				
Desk	2	900	-	-
Chair	2	212	-	-
Mobile o/p beds	2	2,600	-	-
Cambridge chair - 4 people	2	1,700	-	-
Coffee table	2	240	-	-
<b>Management/Coordination Areas</b>				
Filing cabinets - pt	4	460	-	115
Hot desk	2	900	-	-
Chairs	3	318	-	-
Office desk (mgr/coordinator/navigator)	3	1,200	-	-
Chairs (office/staff /education rm)	20	1,420	-	-
Treatment area reception desk	1	1,164	-	-
Flip table	2	624	-	-
Cambridge chair - 4 people	1	850	-	-
Coffee table	1	240	-	-
Chair	1	106	-	-
Filing cabinets - staff	4	460	-	-
<b>Staff Room</b>				
Seats - staff room	4	282	-	-
Coffee table	2	120	-	-
Microwave	1	100	-	-
Fridge - staff	1	300	-	-
<b>ICT</b>				
COW	3	3,300	-	1,100
Computers inc. licence, nertwork & cabling	7	18,600	-	2,658
Printer/fax/copier	2	520	-	-
<b>TOTAL</b>		141,804	17,984	27,165
Total Inc VAT		<b>170,165</b>	<b>21,581</b>	<b>32,598</b>

## APPENDIX H

### Chemotherapy Day Unit – Pharmacy Staffing and Benchmarking Data

#### 1. Current workload (Table 1)

Pharmacy BHH Day Unit/Ward 19 Establishment – 5 day service (9 -5pm)

	BHH	GHH	SH	Total
<b>Current Total Chairs</b>	17 (chemo & supportive)	14 (chemo & supportive)	2	33
<b>Average Monthly items</b>	2700	2300	800	5800
<b>Current Workforce Ward and Day Units</b>				<b>Total WTE</b>
Pharmacist 8b	1			1
Pharmacist 8a	1.3	0.3		1.6
Pharmacist 7	2	1		3
Pharmacist 6	0.5			0.5
Technician 7		1		1
Technician 6 (inc. ADU)		1		1
Technician 5	2	1	0	3
Technician 4	2	1.4	0.5	3.9
<b>Current Pharmacy Workforce ADU</b>				
AP Pharmacist 8a	1			1
ADU Pharmacist Band 7	0.5			0.5
ADU Pharmacist Band 6	0.5			0.5
Technician Band 5	2			2
Technician Band 4	2			2
ATO Band 3	4			4

#### 2. New Model – initial (year 1) Establishment\* (Table 2)

	BHH	GHH	SH	Total	WTE Increase including 20%
<b>New Chemo Chair Distribution</b>	5	14 (chemo only)	24 (14 chemo only)	33	
<b>Average expected Monthly items</b>	800 ( 8 items per chair)	2800 (10 items per chair)	3200 ( 12x10 + current SH 800)	7600	
<b>New Ward and Day Units Pharmacy Workforce</b>					
Pharmacist 8b	1			1	0
Pharmacist 8a	1.8	1	1	3.8	+2.65
Pharmacist 7	1	1.5	2.5	5	+2.4
Pharmacist 6		1		1	+0.6

Technician 7	1			1	0
Technician 6 (Inc. ADU)	1		1	2	+ 1.2
Technician 5	1	2	2	5	+ 2.4
Technician 4	1	2	2.5	5.5	+1.92
ATO	1			1	+1.2
<b>New Workforce ADU</b>					
AP Pharmacist 8a	1			1	0
ADU Pharmacist Band 7	1			1	+0.6
ADU Pharmacist Band 6	1			1	+0.6
Technician Band 5	3			3	+1.2
Technician Band 4	3			3	+1.2
ATO Band 3	4			4	0

\*staffing establishment for the pharmacy element of 5 additional chairs for Gastro and Rheumatology chairs not included (Retain in main pharmacy department)

The above staffing includes the current known staffing shortfall within pharmacy cancer services due to the year on year growth in the last 2 years that has not received funding.

### 3. Pharmacy Workload Increases (Table 3)

Site	Apr 2015 – Feb 2016	Apr 2016 – March 2017
<b>GHH workload</b>	+ 6.2%	+ 6%
<b>SH workload</b>	+ 3%	+ 15%
<b>BHH workload</b>	+ 10.5%	+ 4%
<b>TOTAL INCREASE</b>	<b>+ 19.7%</b>	<b>+25%</b>

This is currently being covered by a number of locum posts outside of Haematology and Oncology and Pharmacy Directorate staffing establishments to improve the safety of the service.

The staffing shortfall accounts for 47% of the WTE staffing increase as required in Table 2.

### 4. Current Pharmacy shortfall (Table 4)

Current Shortfall	WTE	WTE +20%
<b>Pharmacist 8a</b>	1	1.2
<b>Pharmacist 7</b>	1	1.2
<b>Pharmacist 6</b>	1	1.2
<b>Technician 5</b>	1.5	1.8
<b>Technician 4</b>	1.5	1.8
<b>ATO 3</b>	1	1.2

## 5. Growth – based on predicted SH chair numbers (Table 5)

Below is a projection of staffing increase required for Solihull expected growth over a 5 year period.

Total ( inc 20% on- cost)	Year 2	Year 3	Year 4	Year 5
Additional chairs ( SH only)	3	4	3	4
Total SH chemo chairs	15	21	25	29
Monthly Items increase	+ 600	+800	+600	+800
<b>Ward and Day Unit Pharmacy Workforce</b>				
Pharmacist 8b				
Pharmacist 8a				
Pharmacist 7		+1.2		+1.2
Pharmacist 6				
Technician 7				
Technician 6				
Technician 5		+1.2		
Technician 4	+1.2			+1.2
ATO				
<b>ADU Workforce</b>				
AP Pharmacist 8a				
ADU Pharmacist Band 7			+1.2	
ADU Pharmacist Band 6				
Technician Band 5			+1.2	
Technician Band 4				
ATO Band 3	+1.2			

### Assumptions:

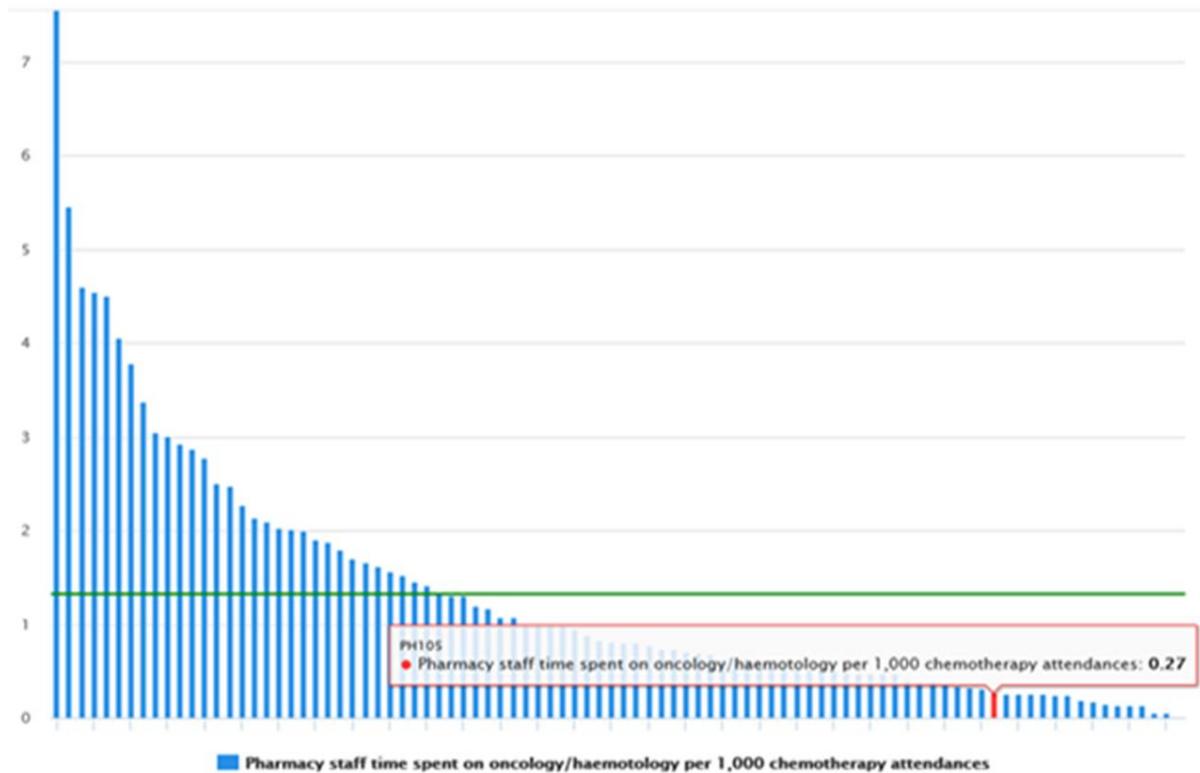
All of the above figures have been calculated on current workload and anticipated future growth. This calculation has included complexity of treatment, average number of items per patient treatment, calculated number of treatments per chair and chair use i.e. Supportive or chemotherapy.

This also includes pharmacist time allocated to cover BHH inpatient ward, expansion of BMT treatments, haematology clinics, clinical trials, Outpatient clinical screening, Kay Kendall, Richmond road surgery and production within ADU (which will all remain at BHH), all sites clinical screening of all day case prescriptions, blood checks, co-ordination of all prescriptions (inpatient/ outpatient/ day case) procurement of medicines, full dispensing and associated functions within site based pharmacy satellites.

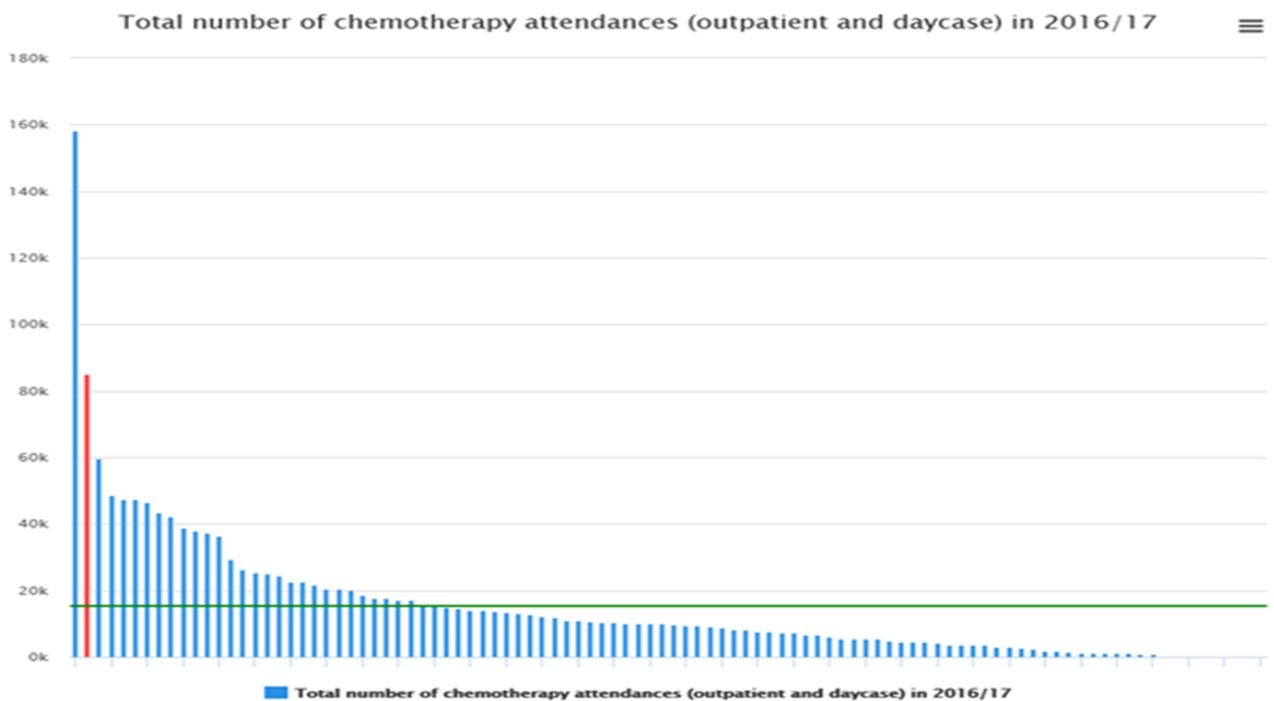
GHH day case patients have been forecasted to increase due to the change in usage of 3 chairs from supportive therapy to chemotherapy only in line with the opening of a dedicated supportive therapy unit.

With developments in treatment under constant review there will be an increasing amount of medication options available which will require pharmacy clinical input.

National benchmarking data as demonstrated in the following charts demonstrate the current shortfalls in pharmacy staffing when compared to other organisations:



Sample Mean	Sample median
1.32	0.81



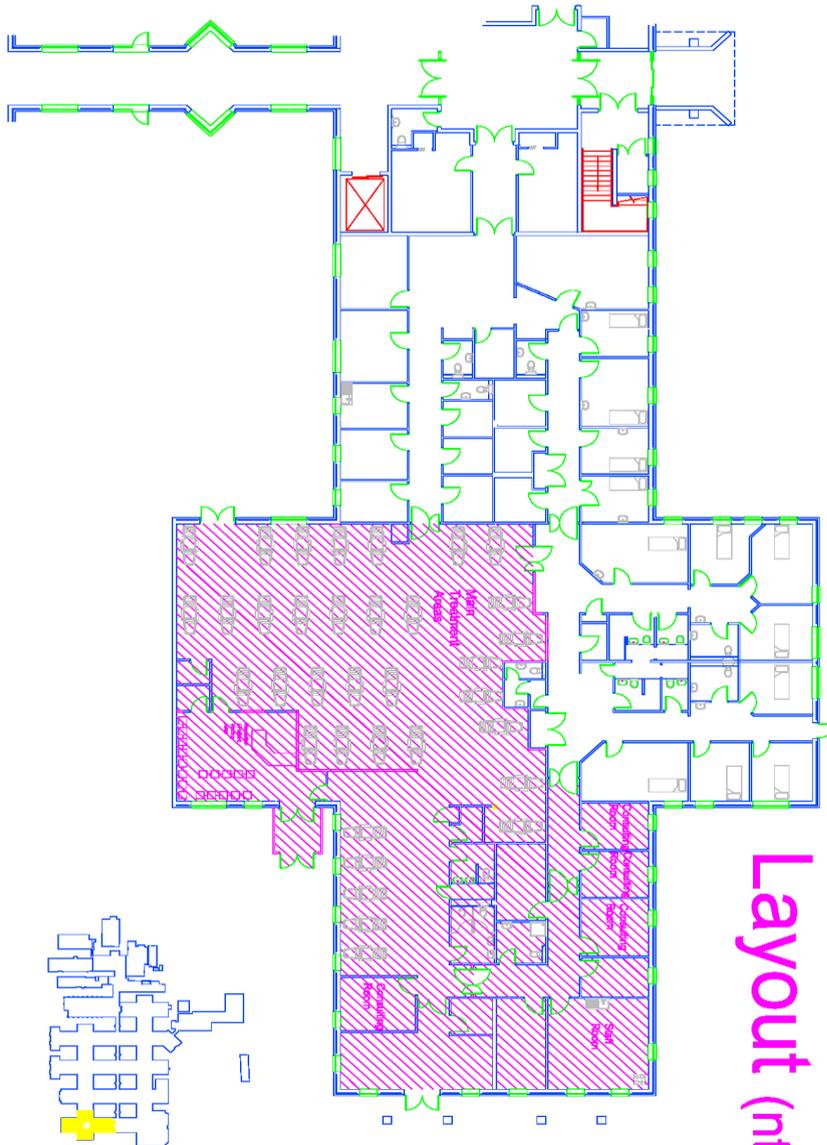
## APPENDIX I:

### Workforce Required to Support Chemotherapy Units at Heartlands and Solihull (excluding Pharmacy)

New Chemotherapy & Supportive Treatment Day Unit - 08.00 - 18.00 hours									
FIVE DAY WEEK 24 CHAIRS									
Shift	Band	No	Hours / shift	Shifts / week	Basic Hours	Allowance (%)	Total Hours	WTE REQ	Role
<b>Mon to Fri</b>									
0900-1700	Consultant/SG	1	8	5	40	25%	50	1.25	Medical Support
0830-1630	B7 Nurse	1	7.5	5	37.5	25%	46.875	1.25	B7 Nurse in Charge New DU and BH
0900-1700	B7 CNS	1	7.5	5	37.5	25%	46.875	1.25	B7 Chemo CNS
0800-1800	B6 Nurse	4	9.5	5	190	25%	237.5	6.33	B6 Chemo Nurse
0800-1800	B5Nurse	5	9.5	5	237.5	25%	296.88	7.92	B5 Chemo Nurse
0800-1600	B4 Navigator	1	7.5	5	37.5	25%	46.875	1.25	B4 Navigator
0800-1800	B3 HCA	1	9.5	5	47.5	25%	59.375	1.58	B3 Venesection HCA
0800-1800	B2 HCA	2	9.5	5	95	25%	118.75	3.17	B2 HCA
0830-1630	B2 Phlebotomy	1	7.5	5	37.5	25%	46.875	1.25	B2 Phlebotomy
0800-1600	B3 Admin	1	7.5	5	37.5	25%	46.875	1.25	B3 Admin DU & Reception
1000-1800	B3 Admin	1	7.5	5	37.5	25%	46.875	1.25	B3 Admin DU & Reception
								<b>27.75</b>	
REVISED WARD 19 DAY UNIT 0800-1800									
FIVE DAY WEEK		5 CHAIRS		Also supporting Clinics, Procedures and Stem Cell Service within legacy space					
Shift	Band	No	Hours / shift	Shifts / week	Basic Hours	Allowance (%)	Total Hours	WTE REQ	Role
<b>Mon to Fri</b>									
0900-1700	Consultant/SG	1	8	5	40	25%	50	1.25	Consultant/SG
0800-1800	B7 Nurse	0	0	0	0	25%	0	0.00	B7 Nurse (shared across service)
0900-1700	B7 CNS	2.8	7.5	5	105	25%	131.25	3.50	B7 Haem/Stem Cell CNS
0800-1800	B6 Nurse	3	9.5	5	142.5	25%	178.13	4.75	B6 Chemo & BMT Nurse
0800-1800	B5Nurse	1	9.5	5	47.5	25%	59.375	1.58	B5 Chemo Nurse
0800-1600	B4 Navigator	1	7.5	5	37.5	25%	46.875	1.25	B4 Navigator
0800-1800	B2 HCA	3	9.5	5	142.5	25%	178.13	4.75	B2 HCA
0830-1630	B2 Phlebotomy	2	7.5	5	75	25%	93.75	2.50	B2 Phlebotomy
0800-1800	B3 Admin	2	9.5	5	95	25%	118.75	3.17	B3 Admin - DU and Reception
								<b>22.75</b>	

An additional 1 WTE Band 6 Dietician will be required support both units due to increased activity.

# APPENDIX J: Bruce Burns Unit Solihull Hospital – Proposed Layout for Option 2



## Option Two Proposed Layout (nts.)

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**23 OCTOBER 2017**

<b>Title: CONVERSION OF WARD 2 AT HEARTLANDS TO A SHORT STAY MEDICAL WARD</b>					
<b>From:</b> Jonathan Brotherton, Director of Operations			<b>To:</b>		
<b>The Report is being provided for:</b>					
<b>Decision</b>		Discussion	Y	Assurance	Y
<b>Endorsement</b>		Y			
<b>Purpose:</b>					
To request funding from the winter contingency allocation to convert Ward 2 at Heartlands Hospital from a Gastro / Gen Med Ward to a Short Stay acute medical ward. This will be achieved by relocating Ward 18 (Diabetes) to Ward 2 and then moving the current Gastro Ward 2 to Ward 18					
<b>Key points/Summary:</b>					
<ul style="list-style-type: none"> <li>• Total number of patients presenting to BHH ED has increased by 21,000 over the past 5 years.</li> <li>• Bed modelling has identified that there is insufficient short stay medical capacity at Heartlands Hospital.</li> <li>• Increased medical input from acute physicians and the multidisciplinary team will provide more timely and appropriate assessment, diagnosis and treatment, enhancing the turnover of the ward through significantly reduced length of stay.</li> <li>• This change will improve and accelerate access to an appropriate setting for non-elective patients and overall provide a more effective use of resources.</li> </ul>					
<b>Recommendation(s):</b>					
<b>The Board is asked to consider the information set out in this report</b>					
The Board of Directors are requested to <b>APPROVE</b> the proposed changes to the Ward 2 establishment in order to realise the stated benefits. The additional cost to the organisation for Winter will be £292K					
<b>Assurance Implications:</b>					
Board Assurance Framework	N	BAF Risk Reference No.			
Performance KPIs year to date	Y	Resource/Assurance Implications (e.g. Financial/HR)		Y	
Information Exempt from Disclosure	N	If yes, reason why. Additional expenditure from winter budget allocation			
Identify any Equality & Diversity issues					
<b>Which Committees has this paper been to? CEAG</b>					

<b>Title:</b>	<b>BUSINESS CASE: CONVERSION OF WARD 2 AT HEARTLANDS TO A SHORT STAY MEDICAL WARD</b>
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<b>Support from other Divisions, discussed and agreed:</b>	Division 1	Name: Theresa Price Signed:
	Other Division: 4 & 5	Name: Andrew Clements, Stuart Dale Signed:

<b>Finance Comments/ Consideration:</b>	Agreed	Yes
	* See comments on attached sheet	
	Director of Operational Finance	Name: Andrew Foster Signed:

<b>Contracts/ Commissioning Considerations:</b>	Agreed	Yes Qualified*/No* (Delete as appropriate)
	* See comments on attached sheet	
	Director of Contracts & Income:	Name: Signed:

<b>Signed:</b>	<b>Date:</b> DD Month Year
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# HEART OF ENGLAND NHS FOUNDATION TRUST

## Board of Directors

September 2017

### Conversion of Heartlands Ward 2 to a Short Stay facility

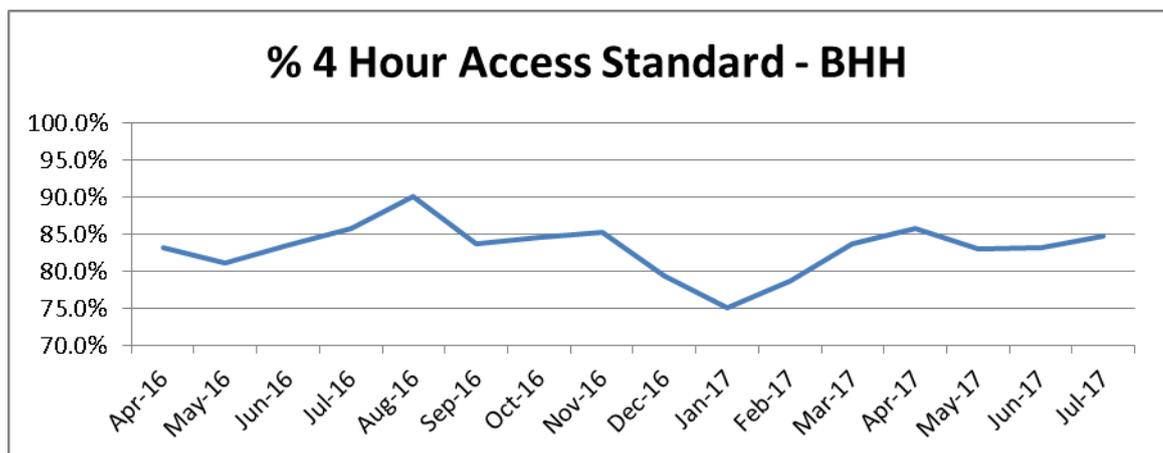
#### 1. Purpose

The purpose of this paper is to gain approval for the appropriate level of funding to convert Ward 2 at Heartlands Hospital from a Gastro / General Medicine Ward into a Short Stay unit.

#### 2. Strategic Context

Heartlands Hospital has not achieved the 4 hour emergency access standard for several years, with the last time the standard was achieved across a full week being July 2015.

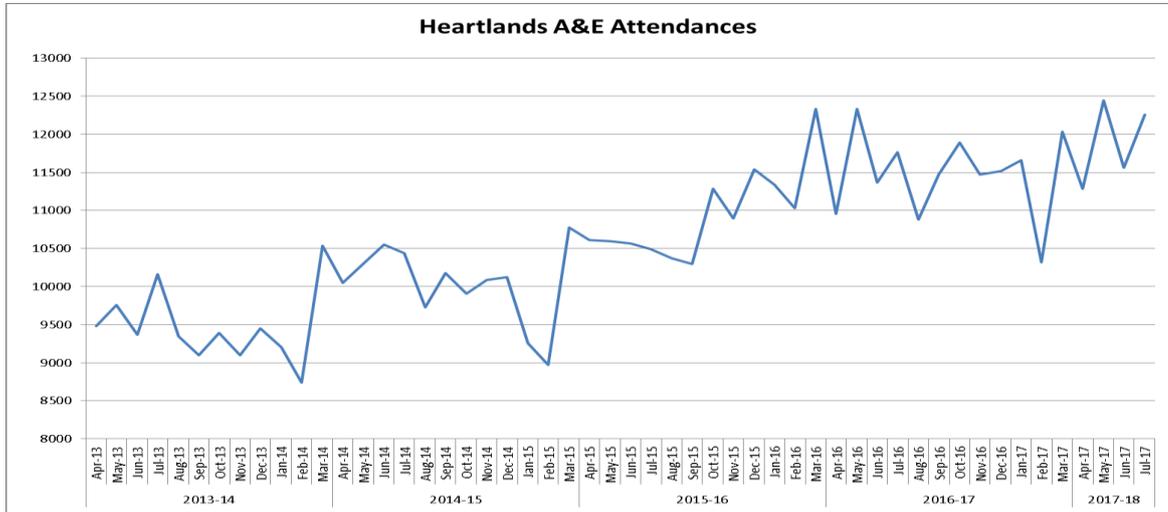
Site performance dipped through the last quarter of 2016 and performance has plateaued in recent months at approximately 84%.



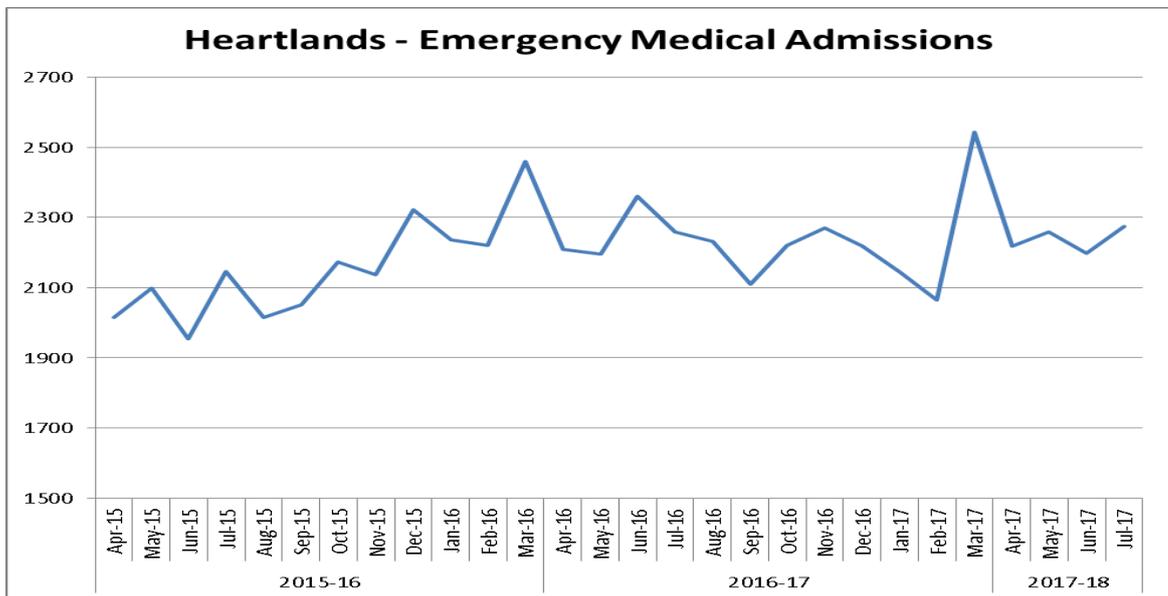
The over-riding reason for breaching the 4 hour standard has been identified as flow restrictions due to a lack of inpatient capacity, particularly for patients presenting with acute medical conditions. The lack of egress from the Emergency Department (ED) has restricted access to assessment space, leading to increased waits for patients waiting to be seen and consequently, sub-optimal care.

The volume of congestion issues can be tracked back to increasing ED attendances at the Heartlands site. The total number of attendances was 116,266 in 2012-13 and 137,637 in 2016-17, an increase of 21k over the period, equating to an extra 60

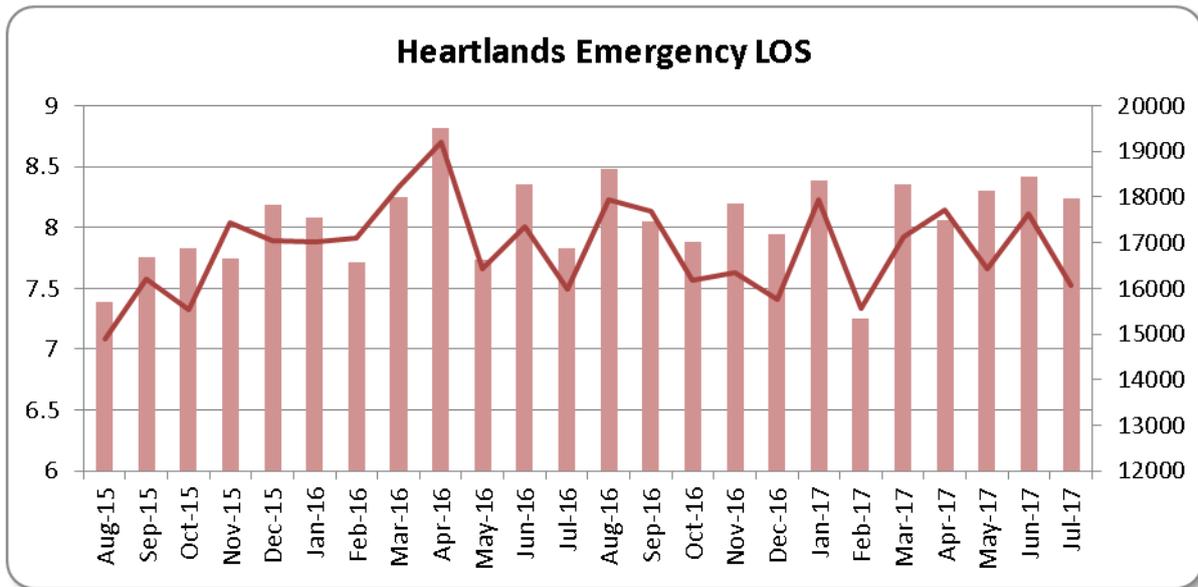
patients per day. A significant number of initiatives have been undertaken to manage demand including the complete redesign of the medical rota to provide a 7 day service; delivery of an increased ED footprint; the launch of GP streaming and most recently the relocation of AEC. Despite this the Trust has been unable to manage the increasing non elective-demand within the national access standard.



Non elective medical admissions have also increased in a similar proportion during this period. This has been reflected in high numbers of patients waiting admission from the emergency department at any time.



Average length of stay for medical emergency patients has also seen a small increase which has compounded the capacity issue. Average length of stay has risen from 6.95 days in 2014-15 to 7.25 days in 2016-17. In the upper quartile of NHS hospital performance, overall median length of stay for all-age medical emergency admissions is approximately 5 nights. This demonstrates there is an opportunity to reduce length of stay for this cohort of patients which would help reduce pressure at the front door.



A 'sense check' of the current medical front end configuration has been undertaken to verify whether the Site had an appropriate level of acute assessment and short stay beds. The model used was developed by the Emergency Care Intensive Support Team (ECIST) and is widely accepted as providing a reliable approximation of the appropriate level of front end capacity requirements.

The current Heartlands Short Stay capacity is 38 beds divided equally across Wards 7 & 22. Short stay principals are embedded on Ward 22 and an average length of stay of up to 72 hours is regularly achieved. Ward 7 is moving in a similar direction since the change from a flex area, with a current length of stay of 5 days. The recent bed modelling exercise has identified that on busy days a cohort of patients suitable for short stay by-pass Acute Medicine and are placed on Speciality Wards which often has the effect of increasing their length of stay. The output from the ECIST model indicated that the site would operate more effectively with 72 short stay beds.

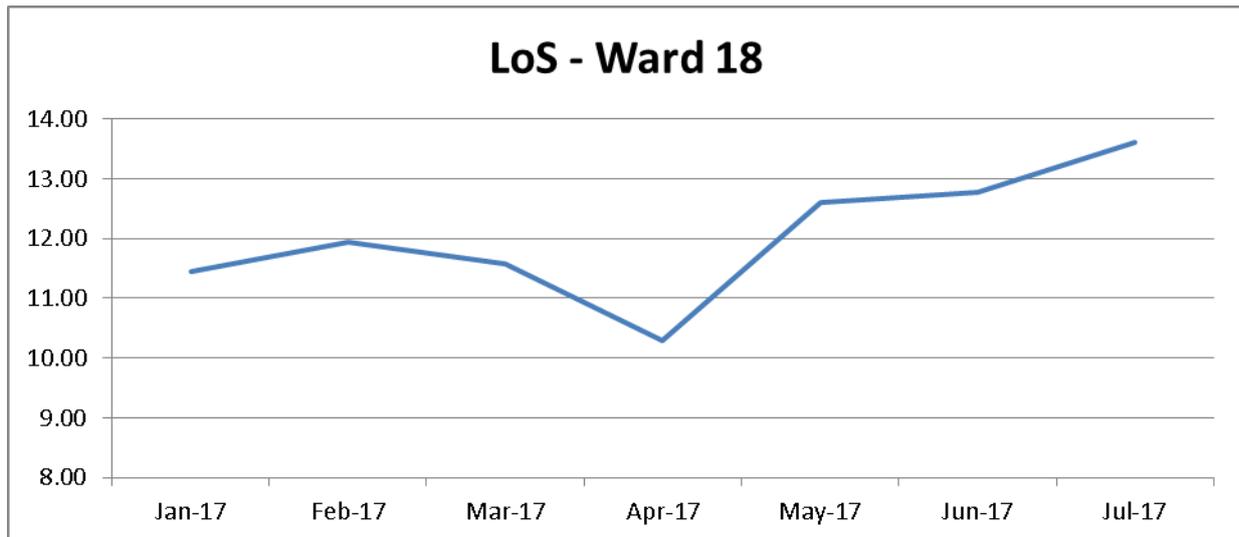
**Acute Medicine Current Performance & Finance** – please see appendix 1 for a detailed summary.

**Proposal**

Ward 2 becomes Short Stay and is managed by physicians with an interest in acute medicine, with a week-long commitment from each consultant to maintain consistency of medical plans. The expanded area will be managed in line with core short stay principals.

Gastroenterology moves to Ward 18 to manage the 25 beds previously managed by the Diabetes Team.

This could create up to 34 new short stay beds, discharging 12 patients a day when core principals are embedded, reducing length of stay to the required standard.



Operating Ward 2 as a short stay medical ward would require an amendment to the nursing establishment, additional medical PA's and increased input from supporting services such as therapies and pharmacy.

The implementation of the proposed new establishment and integration with the acute medical team in the model of care will provide a 7 day consultant presence on the ward. There will be a pool of Consultants working weekly shifts to ensure continuity of care for patients, which will help reduce length of stay. There will be intensive Consultant led ward rounds twice daily on weekdays, once daily at weekends. Ward rounds will include clinical and nursing teams, REACT / Therapists and the ward pharmacist. Clear, defined plans with anticipated patient discharge date will be reviewed throughout the day.

### Anticipated Benefits

Once the ward has the appropriate staffing in place and agreed operating protocols established with AMU and the Site Team, the ward would be expected to generate a minimum of 12 discharges a day. There will be a transition period as the new team evolves and short stay principals are embedded.

The increase to the regular discharge rate at the hospital will reduce the number of people waiting admission within the Emergency Department each day, improving access performance.

The current financial position of both the Division and the Trust is fully recognised. It is proposed that the additional funding to deliver the project is sourced from the winter contingency in the first instance. The project would be monitored from the outset, with a review of agreed key performance indicators during March 2018 undertaken to determine whether the project has delivered the identified benefits and therefore should continue. The approximate additional cost of this approach is £292k.

### 3. Option Appraisal

#### Option 1:

##### Do nothing – maintain current arrangement

Continuing with the existing model will not address the capacity issues at the Heartlands site. There is a potential risk to patient safety as the year on year growth in ED attendances is unlikely to plateau. This situation is likely to be exacerbated by the additional pressures associated with the next winter period. If greater patient flow is not created, national access standards and associated STF income will not be achieved.

#### Option 2:

##### Convert Ward 2 to a Short Stay facility

This would provide compliance with the acute bed modelling, increasing discharges by approximately 12 more each day once fully established. The increased volume of front end beds will also reduce the frequency with which patients are placed in an inappropriate speciality bed, reducing the consequential increase in length of stay across the Hospital. Integrating the ward with the Acute Medical Directorate will improve cross-cover arrangements and provide clear clinical leadership. These benefits will deliver a more stable and reliable acute response to demand and overall a more efficient use of scarce resources.

The preferred option is option 2 - Conversion of Ward 2 to Short Stay. The table below illustrates the total funding requirement for the conversion along with the impact on expenditure by staff group or non-pay items.

	WTE	Part Year £000's	Full Year £000's
<b>CAPITAL EXPENDITURE</b>			
<b>NON RECURRENT SET UP COSTS (REVENUE)</b>			
<b>REVENUE EXPENDITURE</b>			
<b>PAY</b>			
Consultant	<b>0.65</b>	(24)	(72)
SHO	<b>2.00</b>	(36)	(108)
Nurse Band 6	<b>1.00</b>	(14)	(42)
Nurse Band 5	<b>8.05</b>	(112)	(288)
Nurse Band 2	<b>0.84</b>	(6)	(20)
Band 6 OT	<b>1.50</b>	(19)	(57)
Band 4 OT	<b>1.50</b>	(13)	(40)
Band 7 Pharmacist	<b>0.60</b>	(9)	(27)

Band 5 Pharmacist	<b>1.00</b>	(10)	(31)
<b>Subtotal Pay</b>		<b>(243)</b>	<b>(685)</b>
<b>NON PAY</b>			
Pharmacy		(26)	(79)
General Non pay costs		(23)	(69)
<b>Subtotal Non Pay Costs</b>		<b>(49)</b>	<b>(148)</b>
<b>Net I&amp;E Impact Expenditure</b>		<b>(292)</b>	<b>(833)</b>

## Expenditure

The annual increase in expenditure (run-rate) for the proposed option 2 is (£833k). There is potential for a reduction in temporary staffing costs of £323k within Nursing if posts can be substantively recruited to. Due to the significant recruitment issues within emergency wards across the Trust it has been assumed that the ward will be staffed through temporary bank and agency nurses, particularly within the first year of the project, and so is costed using the current levels of bank and agency spend.

It is expected that the project could be live from December 2017, therefore the part year run-rate increase of (£292k) relates to the period December to March 2017/18. This conversion has been included within the winter plan submission.

The recurrent total cost relating to running Ward 2 as a short stay unit is £2,987k as detailed in Appendix 2.

The recurrent funding increase required for the change in use of Ward 2 is £851k and is detailed in Appendix 2.

#### 4. Key Risks associated with proposal

Risk	Mitigation	Risk Owner	Risk Score	Assurance / Monitoring
Unable to recruit to medical posts	The Ward will become part of the AMU directorate at BHH. Rotational posts across AMU and AEC will be offered.	Dr Balaji / Karen Hope	15	Via Divisional Meeting
Unable to recruit to Nursing Posts	Acute Med vacancy position continues to improve following recent recruitment campaigns. Rotational posts with AMU and AEC will be offered to attract candidates.	Julia Jackson / Karen Hope	10	Via Divisional Meeting
Projected LOS benefits not realised	Exemplar wards at BHH – 7 & 22. Staff will be rotated to ensure same approach / processes established to duplicate.	Karen Hope	10	LOS Group
Inappropriate patients on ward	Ordinarily patients will be transferred to W2 by the AMU co-ordinator. This process works effectively for the existing SS wards at BHH	Julia Jackson / Karen Hope	8	Daily Red / Green meeting. LOS Group

#### Exit Strategy

In the event that this proposal does not deliver the proposed benefits, a decision will need to be made as to the long term configuration of this area. The vacancy position for nursing, allied health professionals and medical staff across the Trust is such that any staff impacted by a reconfiguration could be easily absorbed into the funded establishment.

The key performance indicators used to judge the success of the ward configuration are proposed as:

Length of Stay: Reducing trajectory from 14 days (current) to 3 days over the trial period.

Nursing: Maintenance of Nursing and patient experience metrics.

**5. Agreement from key stakeholders**

Name	Role	Comments
Theresa Price	Head of Operations, Division 1	
Andrew Clements	Head of Operations, Division 4	
Stuart Dale	Head of Operations, Division 5	

**6. Summary and Conclusion**

The Heartlands site is unable to appropriately manage the level of non-elective admissions currently being experienced. Access standards are not being achieved and year on year increases in ED attendances are not sustainable. Bed Modelling has identified insufficient numbers of short stay medical beds to efficiently manage this cohort of patients. This Business Case proposes an expansion of appropriate staff to convert Ward 2 into a short stay ward, Ward 18 (Diabetes) will relocate to Ward 2 with the current Gastro Ward 2 moving to Ward 18.

This conversion will facilitate an additional 11 discharges a day once established, assisting in addressing the systemic issues currently being experienced on the Heartlands site.

**7. Recommendations**

To approve the increased establishment required to convert Ward 2 into a Short Stay medical establishment for Winter 2017 / 18 at an additional cost of £292K

To support the proposal to monitor and then review the project during March 2018 with a view to substantively funding the changes if there is a successful outcome.

## Appendix 1 - Acute Medicine Performance & Finance

Activity	2015/16 Target	2015/16 Actual	2015/16 Variance	2016/17 Target	2016/17 Actual	2016/17 Variance	2017/18 YTD Target	2017/18 YTD Actual	2017/18 YTD Variance
AMU Spells	27,586	26,438	(1,148)	26,241	26,568	327	9,011	8,201	(810)
Short Stay Assessment	18,661	14,453	(4,208)	14,193	14,999	806	4,833	5,367	534
AEC	3,956	8,723	4,767	7,919	9,937	2,018	3,366	3,962	596

Finance £'000	2015/16 Target	2015/16 Actual	2015/16 Variance	2016/17 Target	2016/17 Actual	2016/17 Variance	2017/18 YTD Target	2017/18 YTD Actual	2017/18 YTD Variance
AMU Spells	62,411	53,409	(9,002)	56,144	57,977	1,833	19,566	18,022	(1,543)
Short Stay Assessment	15,566	10,994	(4,573)	11,610	12,021	411	3,621	4,127	507
AEC	2,830	5,457	2,626	3,064	4,472	1,407	1,516	1,783	267
<b>TOTAL</b>	<b>80,807</b>	<b>69,860</b>	<b>(10,949)</b>	<b>70,818</b>	<b>74,470</b>	<b>3,651</b>	<b>24,703</b>	<b>23,932</b>	<b>(769)</b>

The above activity performance data illustrates the continued growth of emergency activity within medicine since 2015/16. Emergency spells within AMU have slowly increased at a rate of 0.5% from 2015/16 to 2016/17. This is coupled with the much quicker growth within Short stay and AEC activity, 4% and 14% respectively. This pattern is continuing in to 2017/18 with particularly high level of short stay and AEC activity being seen.

### Financial Expenditure Performance at Month 4 17/18.

Acute Medicine have shown considerable overspends for each of the last 3 years. Currently Acute Medicine are (£167k) overspent in July 2017 and (£777K) over spend year to date (YTD).

£000's	2015/16 Budget	2015/16 Actual	2015/16 Variance	2016/17 Budget	2016/17 Actual	2016/17 Variance	2017/18 YTD Budget	2017/18 YTD Actual	2017/18 YTD Variance
Income (non- contract)	(4)	(18)	14	(21)	(52)	31	(4)	(5)	1
Pay	19,245	24,394	(5,148)	23,654	24,658	(1,004)	7,767	8,164	(397)
Non Pay	5,964	6,236	(272)	4,269	5,130	(860)	1,069	1,451	(381)
<b>TOTAL</b>	<b>25,205</b>	<b>30,612</b>	<b>(5,406)</b>	<b>27,902</b>	<b>29,736</b>	<b>(1,833)</b>	<b>8,832</b>	<b>9,610</b>	<b>(777)</b>

The main overspends which drive the YTD Acute med position are;

#### **Nursing – (£549k)**

The service has considerable vacancies across all sites for which they are reliant on Agency staff and the use of an internal enhanced bank rate to fill vacant shifts. These both come with a considerable premium cost and is a large contributor to the monthly over spend.

There is also high usage of specialising staff across AMU & Short Stay for patients suffering

with mental health problems. Demand for Registered Mental Health Nurses is increasing adding more pressure to an already operationally and financially stretched service.

**Medics - £167k**

The level of vacancies within the Acute Medicine medical staffing service is resulting in a level of under spend each month. This is expected to continue as long as recruitment is difficult in this area.

**Current and Prior Year CIP Target – (£265k)**

As evidenced by the growing non-pay overspend over the last 3 years there has been poor performance against CIP within Acute Medicine. This has continued in to 2017/18 and is a key portion of the Directorate and Division overspend.

**Activity related expenditure – (£139k)**

In line with the growth in activity that has been seen in the directorate in to 2016/17 and 2017/18 the level of expenditure relating to clinical supplies, including pharmacy, pathology, radiology and MSSE has increased, causing a financial pressure within the directorate.

## Appendix 2- Ward 2 Additional Funding Required

Expected Costs	Ward 2 Short Stay - Proposed Total Cost @ Substantive rates		Funding Required
	WTE	£	
STAFF GROUP			
Consultant	2.00	222,800	72,410
SHO	7.00	379,596	108,456
Band 7	1.0	50,532	
Band 6	3.00	128,777	42,926
Band 5	29.20	1,000,719	201,856
Band 2	21.46	514,879	89,974
Ward Clerk	1.0	20,521	
Housekeeper	1.0	20,521	
Band 6 Occupational Therapist	1.5	57,075	57,075
Band 4 Occupational Therapist	1.5	39,581	39,581
Band 7 Pharmacist	0.6	27,261	27,261
Band 5 MMT Pharmacist	1.0	31,086	31,086
Drugs		278,503	122,503
Pathology		57,328	0
General Non Pay		157,832	57,881
<b>TOTAL</b>		<b>2,987,010</b>	<b>851,008</b>

### Appendix 3 Indicative Job Plan

Consultant x 2 (Intended to be rotated a week at a time from a pool of Consultants).

Indicative Consultant Job Plan						
Day/Time			Programmed Activity	DCC	SPA	Location
Monday	09:00	13:00	Ward Rounds	1		BHH
	15:00	17:00	Ward Rounds	0.5		BHH
Tuesday	09:00	13:00	Ward Rounds	1		BHH
	15:00	17:00	Ward Rounds	0.5		BHH
Wednesday	09:00	13:00	Ward Rounds	1		BHH
	13:00	17:00	CPE / Audit			BHH
Thursday	09:00	13:00	Ward Rounds	1		BHH
	15:00	17:00	Ward Rounds	0.5		BHH
Friday	09:00	13:00	Ward Rounds	1		BHH
	13:00	17:00	CPE / Audit		1	BHH
Evening/Weekends			On Call			
				1.5		BHH
No: of Programmed activities				8		

### Trust Grade

Indicative Trust Grade Job Plan						
Day/Time			Programmed Activity	DCC	SPA	Location
Monday	09:00	13:00	Ward Rounds	1		BHH
	13:00	17:00	Ward Rounds	1		BHH
Tuesday	09:00	13:00	Ward Rounds	1		BHH
	13:00	17:00	Ward Rounds	1		BHH
Wednesday	09:00	13:00	Ward Rounds	1		BHH
	13:00	17:00	Ward Rounds	1		BHH
Thursday	09:00	13:00	Ward Rounds	1		BHH
	13:00	17:00	Off	0		BHH
Friday	09:00	13:00	Ward Rounds	1		BHH
	13:00	17:00	CPE / Audit		1	BHH
Evening/Weekends			On Call	3		BHH
No: of Programmed activities				11	1	

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**23rd OCTOBER 2017**

<b>Title:</b> Annual Workforce Report					
<b>From:</b> Hazel Wyton, Director of Workforce			<b>To:</b> Board of Directors		
<b>The Report is being provided for:</b>					
Decision		Discussion		Assurance	Y
<b>Purpose:</b>					
The Board is asked to note the information contained in the report					
<b>Key points/Summary:</b>					
The report covers progress against the Trust's key workforce priorities in the period 2016/17 under the following themes:					
<ul style="list-style-type: none"> <li>• Workforce planning</li> <li>• Organisational change and transformation (including staff engagement)</li> <li>• Workforce governance</li> <li>• Operational HR</li> <li>• Resourcing (including medical workforce)</li> <li>• Education and training</li> </ul>					
<b>Recommendation(s):</b>					
The BoD Quality Committee is asked to consider the information set out in this report					
<b>Assurance Implications:</b>					
Board Assurance Framework	Y	BAF Risk Reference No.			
Performance KPIs year to date		Resource/Assurance Implications (e.g. Financial/HR)		Y	
Information Exempt from Disclosure	N	If yes, reason why.			
Identify any Equality & Diversity issues					
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>					
Board of Directors					

## **BOARD OF DIRECTORS – QUALITY COMMITTEE**

**DATE OF MEETING – OCTOBER 2017**

### **ANNUAL WORKFORCE REPORT (READ ONLY)**

The report covers the work undertaken in 2016/17 against the Trusts workforce priorities. It also looks ahead at the workforce priorities for 17/18.

The workforce directorate comprises HR and Education and training teams. Each of these functions have a strategic and operational role in helping the Trust deliver its workforce agenda.

Changes to structures within the Directorate have been made within this period to improve accountability and achieve more efficient working. These changes have been achieved with minimal impact on normal service delivery.

The Operational HR team has continued to work closely with divisional and corporate teams in supporting their workforce priorities and driving forward performance improvements. The team has successfully guided managers through a series of restructures and management of change projects, and managed complex employee relations issues, including doctors in difficulty. Heads of Operations and Divisional Directors have been particularly keen to develop and maintain the close working relationships they have with their HR Management teams.

Progress against the Trusts workforce priorities has been made in spite of the considerable pressures on front line staff, and the increasing demand on services. The Trust achieved improvements in its staff survey results and staff engagement metric, and has worked hard to improve staff communications, introducing new team brief arrangements. The trust has continued to build on its successful partnership working arrangements with staff side.

16/17 also saw increases in staff turnover and continued challenges in attracting and retaining staff including shortages in medical workforce supply at both junior and senior grades. New initiatives centred on international recruitment, and staff retention including a partnership with UHB have helped the Trust explore alternative talent pipelines, and which we plan to extend in 17/18, alongside improved exit management processes.

16/17 saw an expansion of our efforts to achieve greater workforce fairness and equality with the launch of new staff networks and an inclusion steering group. Improvements have been achieved in our performance against the workforce race equality standard, and we made a successful submission as part of the Stonewall workforce equality index. The links between inclusion, staff engagement and improved wellbeing will be further developed in 17/18.

The NHS generally has experienced a period of under supply of both clinical and non-clinical staff compounded by changes to Education funding which includes the removal of non-medical training bursaries. In response the Trust has successfully applied to be an employer-provider under the new Apprenticeship levy arrangements. We expect, in partnership with UHB and the STP to maximise access to the levy to help expand our talent pool for both clinical and non-clinical staff.

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Whilst our focus in 17/18 will of course be dependent on the progress of the case for change, the immediate priorities for workforce will continue to be on improving our capacity to attract and retain staff, maintain staff engagement, and reduce our medical agency costs.

#### **1 INTRODUCTION**

The report covers the key workforce priorities for the Trust and the contributions of the HR function, for the 12 month period April 16 to March 17.

It also looks ahead at the workforce priorities for the next 12 months, noting this period includes the proposal for the Trust to merge by acquisition with UHB.

The HR function has supported managers in delivering key areas of HR activity including workforce planning, staff retention, employee relations, organisational change, recruitment and selection and employee health and well-being.

The structure of the function combines HR business units aligned to operational and corporate teams, and specialist roles. Staff in these roles have in particular taken forward work on employee engagement, education and training, employee well-being, and inclusion.

Within the reporting period, HR has revised and streamlined its leadership structure to improve lines of accountability and responsibility and achieve efficiencies. This has ensured that HR resources have been targeted at key workforce issues, in response to Trust demand. Workforce governance arrangements have also been revised to allow strategic and operational workforce agendas to be progressed

Also within this period, the function successfully transferred its payroll team to UHB as part of the Trusts drive to achieve efficiency through a change in payroll provision. Payroll services to the Trust are now delivered through a service level agreement, managed between HR and Finance.

During 16/17, the Trust has continued to enjoy positive and productive relationships with its staff side partners and improved levels of staff satisfaction and engagement, including improvements in its staff survey results, across a range of domains, and FFT scores.

#### **2 WORKFORCE PRIORITIES**

The following areas were identified to support delivery of the Trusts workforce agenda:

- Workforce planning
- Organisational change and transformation (including staff engagement)
- Workforce governance
- Workforce (HR) operations
- Resourcing (including medical staffing)
- Education and training

## **BOARD OF DIRECTORS – QUALITY COMMITTEE**

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### **ANNUAL WORKFORCE REPORT (READ ONLY)**

#### **2.1 Workforce Planning**

An operational two year workforce plan and three year workforce forecast was prepared to meet NHSI reporting requirements and to help inform local Education commissioning decision making. Plans have been used by the Trust to help manage supply and demand and underpin recruitment strategies. Whilst these plans have helped shape recruitment activity, there has been an ongoing challenge in the Trust's ability to attract sufficient numbers of quality applicants for specific roles, particularly at Consultant level and training grades and in a range of specialities.

#### **2.2 Organisational change and transformation**

The last 12 months have seen further changes to team structures and working arrangements, to improve accountability and achieve more efficient working. These have included the implementation of a new Trust wide operational management structure, changes to corporate structures and the operationalisation of new job roles, including CNS, ACP's and nurse associates, reflecting changes to skill mix in support of improved clinical delivery.

Progress has also been made to devise and embed a joint approach with UHB to help respond to the new national apprenticeship levy and the creation of terms and conditions of employment which place both Trusts in the best position to attract new staff to trainee roles, and maximise our ability to drawdown from the levy. The Trust has successfully applied to be an apprenticeship 'employer – provider', which allows it to both train and employ apprentices.

During 16/17, HR and heads of profession have devised plans to tackle retention pressures within the organisation with a specific focus on improving the quality of the practice environment, employee reward, leadership and culture. This is supported by new exit management processes, to track staff reasons for leaving, which is a key Trust KPI.

Within the next 12 months implementation of a new retention strategy jointly led between Nursing, and HR is expected to support reductions in staff turnover and improved rates of attrition, staff engagement, and productivity.

#### **2.3 Workforce governance and compliance**

The strategic workforce group and the operational workforce committee have supported improved governance arrangements and oversight of performance, policies and practice across the Trust. Over the last 12 months, the Trust has successfully discharged its responsibilities for equality and diversity through delivery of the workforce race equality scheme (WRES), and EDS 2 and further enhanced staff engagement and leadership through the establishment of a Trust wide inclusion steering group, and staff networks covering LGBT, BAME and disability. A programme of HR policy review was also initiated supported by improved monitoring arrangements, enabling the Trust to align its policies to latest best

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practice, and improve support to managers. Policy reviews have been conducted in partnership with staff side.

Performance management has in this period been enhanced through the introduction of additional workforce KPI, covering employee relations processes, and recruitment.

#### **2.4 Operational HR**

The Operational HR team provides generalist support to operational and corporate teams including employee relations advice and support. The team has a central role in working with managers to deliver improvements across the range of workforce KPI, and lead the delivery of specific workforce initiatives. HR managers and their support staff are aligned to Divisional triumvirates and corporate functions and form part of an effective and valued corporate support function alongside Finance. They have forged strong working relationships with Heads of Operations and Divisional Directors as a result, which operational teams have been keen to develop and maintain.

A continued focus on workforce performance has helped deliver improvements in time to hire (recruit). This has enabled the Trust to revise its target for time to hire from 7 to 6 weeks, from April 17 and operational teams in particular, supported by the Recruitment team have responded positively, in many cases meeting and exceeding the target. This is a considerable performance improvement over 15/16 given some areas were taking over 12 weeks to complete the recruitment process.

The effective management of disciplinary and grievance cases has been further enhanced by the introduction of key performance targets in relation to length of investigations and arrangements for formal hearings, and progress has been achieved, including improved governance arrangements for managing doctors in difficulty, supported by joint working with UHB, through the Medical Director.

Sickness absence performance has fluctuated over the last months and whilst the overall Trust target of 4% was not achieved consistently, improvements were delivered in key hotspot areas, supported by a revised sickness management policy and improved health and well-being offers for staff, including confidential counselling support, basic health checks and fast track physiotherapy services. New and existing managers have been supported to help manage long and short term absence with a number of managers receiving absence management training in the last 12 months.

#### **2.5 Resourcing**

##### **Medical Workforce**

A key challenge for Medical Workforce in 2016/17 was managing the uncertainty created by the national contractual dispute with Doctors in Training and the implementation of the new contract. The 2016 contract has led to a major increase in workload for Medical Workforce and Education teams – new work schedules are required with pay circulated to the nearest

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15 minutes and Education opportunities clearly detailed and updated. Whilst all HEFT juniors are now appointed on the new contract continuing challenges have remained as a result of a shortage of medical and dental staff at both junior as well as senior levels in most specialties. A significant challenge for the Trust, as with other acute Trusts has been managing reductions in medical agency spend, and reducing reliance on agency locums. Whilst efforts have been partially assisted by the new NHSI controls and rate caps, the Trust has had limited success in being able to recruit substantively to some specialties, and therefore drive down agency costs. The Trust has considered but rejected proposals to adopt temporary recruitment premia preferring instead to explore alternative talent pipelines for doctors. These have included overseas recruitment programmes and new partnership arrangements with UHB (international fellows - IA). The IA programme led to the appointment of 4 Fellows, with plans to expand this to c 40 across both organisations in 17/18. Alongside these programmes, the Trust has also reviewed skill mix in some clinical teams and been successful in training and embedding new roles including ACP's and physician associates.

#### **Non-Medical Recruitment**

HR has continued to support line managers with their recruitment plans, and has helped deliver improvements in time to hire against the 7 week recruitment target (6 weeks from April 17), although maintaining performance continues to be challenging. Creative solutions to traditional attraction issues have led with some success to the increased use of social media platforms to promote vacancies and engagement with external agencies to attract overseas clinical applicants. The latter programme in conjunction with our partner Synergy has proved to be a success, with over 100 new nurse appointments achieved. This is spite of the uncertainties associated with Brexit.

#### **2.6 Education and training**

The Trust met the 2016/17 CCG KPI's for appraisal and mandatory training. As a result and to help stretch Trust performance we implemented an internal appraisal target of 90%. The Easy learning tool has transformed mandatory and appraisal reporting, given managers have direct access to individual and team compliance.

The Trust has worked collaboratively with University Hospitals Birmingham NHS Foundation Trust (UHB) to achieve employer-provider status on the register of approved apprenticeship training providers. This creates the opportunity to develop and grow our future workforce and to create new roles, as noted separately in the report.

In response to a reported shortfall in Education funding the Trust initiated a review of the Education service and within 16/17 remodelled its service provision (the outcomes of the service review, led by the new Head of Education, were then implemented successfully by September 2017). Service changes have resulted in c £1m+ savings.

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### **ANNUAL WORKFORCE REPORT (READ ONLY)**

#### **3 THEMES**

##### **3.1 WORKFORCE PLANNING**

The priorities for 2016/17 were to complete a refresh of the five year workforce plan (submitted to NHSI and HEE West Midlands in 2015) and to monitor performance against the plan in order to report progress, identify workforce risks, and influence recruitment planning.

###### **3.1.1 Staff Groups Shortages**

The trust has experienced shortages and difficulties recruiting to the following areas and occupational groups; Radiology (Radiologists, Sonographers and Radiographers), Allied Health Professionals at Band 6 and 7, Laboratory staff at Band 5 and Band 7/8a, Cardiac Physiologists, General Nurses at Band 5, Theatre Nurses and ODPs, Pharmacists and Medical staff in Emergency Department, Acute Medicine, Gastroenterology, Radiology, and Histopathology.

###### **3.1.2 Recruitment and Retention Challenges**

Voluntary Turnover reduced slightly from 8.90% in March 2015 to 8.59% in March 2016. However during 2016/17 turnover increased steadily, ending the year at 10.60%. Whilst there have been a range of reported reasons these notably have included the need for improved access to promotion opportunities, work life balance and relocation.

The staff groups with notable increases in voluntary turnover included; Administrative and Clerical, Maintenance, Pharmacists, Scientific and Technical and Senior Managers. Pharmacy turnover was triggered by concerns amongst some staff as to the fairness of the on call arrangements which have now been reviewed and addressed.

In response to generally rising turnover rates and also acknowledging the recruitment challenges faced, a Strategic Retention Group was established. The group which is co-chaired by the Deputy Chief Nurse and Deputy Director of Workforce includes members from key clinical groups, staff side, and HR. To support alignment of retention strategies the group is also supported by UHB staff. The outcomes from the work of the group will focus in 17/18 on implementing a new retention strategy based on a series of actions which focus on improving employee reward, leadership and culture and the professional practice environment.

###### **3.1.3 New Roles**

Advanced Clinical Practitioners - work continued on the development of Advanced Clinical Practitioner (ACP) role within the trust. As at 31st March 2017 there were 58.60 WTE ACPs in post a slight reduction from March 2016.

Apprentices - work was progressed in preparation for the introduction of the national Apprenticeship Levy and which came into effect on 6th April 2017. The Trust has worked

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collaboratively with University Hospitals Birmingham NHS Foundation Trust (UHB) to agree a joint apprenticeship strategy, and resourcing plan. A total of 105 apprenticeships have commenced since April 2016, as part of the pre levy work programme. The target for both Trusts in 17/18 and beyond is to recruit cohorts of between 200-250 new apprentices, although this will be subject to clarifying the currency of HEFT's status as a current 'employer – provider' post-merger, and the workforce planning requirements of both organisations.

Trainee Nursing Associates - the Trust has been the lead partner in the Birmingham and Solihull Partnership that forms one of the national pilot sites for the Nursing Associate programme. A total of 41 Nurse Associate Trainees commenced the training programme in April 2017, 79% of which were established trust employees working as HCAs. The HR and Nursing functions for the Trust led on the recruitment and engagement processes.

#### **3.1.4 Priorities for 2017/18**

- (i) Continue efforts to reduce reliance on the requirement for temporary staff and drive down medical locum agency costs in line with new NHSI targets, and finance recovery plans.
- (ii) Develop and implement a new pay structure and terms and conditions for apprenticeships as part of the Trusts response to new apprenticeship levy, in partnership with UHB.
- (iii) Continue to develop plans for the expansion of new roles within the workforce, in order to mitigate the impact of shortages within the junior medic and qualified nursing workforces.

The Trust continually reviews the actions and plans necessary to mitigate workforce risks through the Operational and Strategic Workforce Groups.

### **3.2 ORGANISATIONAL CHANGE & TRANSFORMATION (INCLUDING STAFF ENGAGEMENT)**

In support of the case for change significant cross Trust working has been undertaken as part of the preparatory work to inform and engage staff in the discussions regarding HEFT merger by acquisition, including engagement with staff side partners. This has also included the review of those similarities and differences in working arrangements and practices, between both organisations.

In 16/17, the trusts divisional management arrangements, and the following corporate teams were reviewed and restructured in line with the Trusts management of change policy, and supported by the HR function and staff side:

- Education and training team
- Governance
- Payroll reconfiguration and transfer to UHB
- Communications

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These changes are in addition to localised management of change projects involving for example, staff relocation, flexible working and changes to working hours/ patterns in response to service need, and which have been supported by HR.

#### **3.2.1 Priorities for 2017/18**

It is envisaged that these will largely centre on the transition arrangements if the Trust is merged by acquisition and will focus on a full programme of staff engagement and culture change and organisational development work, including:

Promoting the benefits and opportunities that will arise as a result of becoming one organisation

Engaging senior leaders and clinicians to ‘lead for the change’, seeking to understand and address concerns

Working in partnership with staff side representatives from both trusts, sharing information, promoting the benefits of becoming one organisation and responding to concerns

Implementing the ‘umbrella’ identity for the new organisation and local brands for individual hospitals

Delivering a seamless, consistent culture by embedding the new vision, purpose and values across the new organisation

### **3.3 WORKFORCE GOVERNANCE & COMPLIANCE**

#### **3.3.1 Equality, Diversity and Inclusion**

The Trust has published indicators of workforce equality, as part of the Workforce Race Equality Standard (WRES) since June 2015. This has allowed us to examine and begin to address areas of underperformance in relation to workforce equality and staff experience. Our latest staff survey results for equality and diversity have shown some improvement, although further work is required.

In 16/17 the Trust successfully launched 3 specific staff networks for LGBT, BAME and staff with a disability, and a staff and patient centered inclusion steering group. In addition, the Trust became a Stonewall Diversity Champion, and for the first time in 2016 submitted its application to join the Workplace Equality Index (WEI). The WEI has been used to assist the Trust in implementing its actions as part of the Equality Delivery System (EDS2) and equality action plans.

Our assessment against the WRES has highlighted the following areas:

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- White staff experience harassment, bullying or abuse from patients at the same level as BAME staff (24% White, 24% BAME), although harassment, bullying or abuse from colleagues is proportionately higher for BAME staff than White staff (27% BME, 22% White)
- 69% of BAME staff believe the Trust provides equal opportunities for career progression or promotion, compared to 86% of White staff (these figures are in line with the national average for acute trusts).

An area that the Trust has achieved success in 16/17 is in the monitoring of our workforce and improving the quality of data we hold. This has led to over 1700 staff updating their personal data, in 16/17. In 17/18 this will be supplemented by further drives to improve data quality in response to us meeting our obligations towards disabled staff through the workforce disability equality index (WDES). Trust performance in relation to equality and diversity is published annually as part of the WRES and the annual equality monitoring support.

Staff training programmes in support of the Trusts inclusion agenda have also been delivered in 2016/17 including equality and diversity and PREVENT both of which are mandatory. We have also devised new programmes to address unconscious bias and which will be launched in 2017/18.

#### **3.3.2 Priorities for 2017/18**

- i. Assessment against the requirements of the WDES and supporting action plans.
- ii. Participation in Stonewall's Diversity Champions programme and completion of the Stonewall's Workplace Equality Index to assess our progress from our 16/17 submission.
- iii. Further expansion of the Trusts staff networks and remit of the inclusion steering group to help continue to shape the Trusts inclusion and staff engagement agendas.
- iv. Work with operational divisions and corporate teams to respond to findings in the latest staff survey results and achieve further improvements in staff experience and engagement.
- v. Implementation of a transgender policy for Patients and staff
- vi. Ensure the Trust meets its new statutory requirements for reporting on gender pay gaps

#### **3.3.3 Staff Survey**

The Trust recognises and values its workforce, and regularly seeks staff feedback via quarterly and annual staff surveys. Staff survey results are published on the Trust intranet site and promoted through Trust wide staff communications.

This year, the Trust introduced new staff networks (Disability, BAME and LGBT) to provide further opportunities for staff to share their experience of working for the organisation, to

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promote inclusion, and to identify areas for further improvement. These new networks exist alongside our established staff side partnership and consultation forums (JNCC and JLNC).

Summary of performance – results from the NHS staff survey

The National Staff Survey ran from October to December 2016 and included as last year a full census of staff at the Trust. We achieved a 36% response rate (3619 respondents), an increase from a 29% response rate to the 2015 survey.

The results show that across the 32 key findings, the Trust improved in 23 findings, with no change on the remaining 9. We were particularly encouraged that we were able to achieve a significant improvement in our staff engagement score from 3.63 in 2015 to 3.73 in 2016.

The details of the staff survey results and corporate action plan are in **Appendix 1**.

#### 3.3.4 Priorities for 2017/18

The 2016 results reflect the positive changes seen in the Trust during 2015/16. This year, as part of our staff survey corporate action plan, we have been focusing on 2 key corporate priorities: improving the resources staff have to do their jobs, and staff health and wellbeing.

- i. Resources: We asked each of the divisions to talk to their teams and ensure essential equipment was prioritised and purchased, and encouraged staff to escalate via any concerns about lack of equipment.
- ii. Staff Wellbeing: During the last 6 months, we have been encouraging staff to take positive action on their wellbeing. 300 staff took part in a resilience workshop or training session, and we promoted a range of wellbeing initiatives through our staff communications, including a poster campaign to all wards and departments.
- iii. In addition, divisions developed local action plans, aligned to their local results.
- iv. We have continued to monitor staff engagement through the quarterly Staff Friends & Family test (FFT). The outcomes have continued to show positive signs that staff remain engaged and likely to recommend the Trust as a place to work and receive care.

#### 3.3.5 Health and Wellbeing

The Trust operates its own nurse led Occupational health from its Heartlands and Good Hope Hospital sites. The service also supports other NHS and non NHS organisations with their occupational health requirements through agreed service level arrangements. The service offers a range of occupational health transactional and broader well-being services to managers in support of the management of sickness absence, clearance of new starters and health screening.

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#### **On site health clinic**

In 16/17 Occupational health trialled and implemented new services offering basic health checks to all staff through on site health clinics. The health checks that we have been able to offer our staff has included blood pressure; waist/hip ratio; body fat analysis; BMI; and blood tests.

The long term objective is to offer an in house staff health service that could treat staff with existing / new conditions and also offer routine tests and health checks. The measurements recorded from these health checks can be stored on each staff member's occupational health records.

The Trust was able to meet its health and well-being CQUIN for 16/17 and successfully delivered its flu programme and achieved a 75% vaccination rate for front line staff. A series of well-being events across Trust sites have also been delivered in support of the CQUIN, including specific physiotherapy for staff with MSK problems, and access to confidential counselling. Both these services continue to be offered on a self-referral and management referral basis and continue to be the main positive health interventions available to support long and short term health conditions.

#### **3.3.6 Workforce Policies and Procedures**

A joint management and staff side Policy group was established in 2016/17 to review and update workforce policies and supporting procedures, in line with HR best practice. As a result, the majority of HR policies have now been updated, with some policies re-designated as supporting procedures.

- Flexible Working Policy
- Leavers Policy and Procedure
- Statutory Registration Policy
- Performance and Capability Policy
- Working Time Regulations Policy
- Equal Opportunities in Employment
- Organisational Change
- Sickness Absence Policy (inc Stress)
- Maternity, Paternity and Adoption, Shared Parental Leave and Ordinary Parental Leave Policy
- Special Leave Policy
- Dignity at Work Policy
- Grievance and Disputes Policy
- Statutory Mandatory Training Policy
- Disciplinary Policy
- Alcohol Drugs and Substance Misuse

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Procedures:

- Accessing Employee Data Procedure
- Disruption to travel Procedure
- Fixed Term Contract Procedure
- Healthy Skin Procedure
- Job evaluation procedure
- Latex Procedure
- On-Call Procedure
- Pay Progression Procedure
- Recovery of Overpayments Procedure
- Registration Authority Operation Procedure
- Travel and Miscellaneous Expenses Procedure

A Policy Monitoring Register is used to track review dates and policy monitoring reports to Operational Workforce Group and/or Trust Board. Regular joint working with Staff side colleagues has taken place in order to ensure the effective and timely review of policies and their application.

#### **3.7 Whistleblowing Cases**

There were no cases reported through HR in the period April 2016 – March 2017

#### **3.3.8 Pay and Reward, Terms and Conditions, Employment checks and Registration**

##### **Apprenticeship Levy and Trainee Nursing Associates**

Joint work with UHB has enabled us to devise a single employment package for new apprentices engaged as part of the Apprentice levy, which will be ready for implementation in 2017.

##### **Job evaluation**

Consistency in banding jobs has been maintained in 16/17 and the Trust has continued to enjoy a productive partnership with staff side, in maintaining the review and banding of Trust jobs. As the Trust and its services have further expanded, there have been increasing numbers of job evaluations undertaken. This has included in 16/17 a review and remodelling of our administrative workforce and the successful alignment of all new roles to new job families, supported by generic job descriptions.

##### **Immigration, Right to Work and Professional Registration**

The Trust currently employs a total of 191 staff with time limited right to live and work in the UK. The right to work status of those staff is monitored by the Employment Compliance Team who engage with the individuals a minimum of three months prior to the expiry of their existing leave to remain to ensure they retain the right to work in the UK. During 16/17, one member of staff, who had produced right to remain documentation for the Trust was subject

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to review by the Home Office, and their right to remain withdrawn. Their employment was terminated by the Trust.

Monitoring of statutory registration takes place through the Workforce Information Team for all staff requiring registration.

#### **Registration Authority**

The Workforce Information team hosts the trust's Registration Authority which manages the issue, maintenance and revocation of Smartcards. There are currently circa 3500 staff registered with a Smartcard, including a hosted arrangement for Marie Curie. Smart card access remains strictly controlled in line with Trust and NHS protocols.

#### **Workforce Reports**

The Workforce Information team produce a suite of regular reports to fulfil the requirements of Trust Board and Chief Executive Group. In addition regular reports, including workforce dashboards are produced for managers and operational HR colleagues. These include absence reports highlighting staff who have reached the trigger points identified in the Trust's Sickness Absence Policy and Employee Relations case reports from ESR. Production of a regular suite of reports has allowed managers access to timely workforce information and supported performance management processes.

#### **3.3.9 Priorities for 2017/18**

1. To meet the IG Toolkit requirements for Registration Authority requirements 303 and 304.
2. Workforce Directorate to meet the requirements of the Information Asset Owners Working Group and ensure assets reviews are undertaken and access controlled in line with agreed protocols.
3. To complete the transition to the new ESR portal by December 2017.

### **3.4 OPERATIONAL HR**

#### **3.4.1 Employee relations casework**

From May 2016 all live and future employee relations cases were recorded on ESR in order to improve reporting capability and to meet the requirements of the Workforce Race Equality Standard (WRES) and the proposed future Workforce Disability Equality Standard reports (WDES)

During 2016/17 there were a total of 332 cases, and which included 249 disciplinary cases (up to 15 cases managed under MHPS procedures), 22 Harassment cases and 26 employee grievances cases.

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Whilst efforts have been made to improve investigation timescales, this has continued to be a challenge for a range of factors, including management capacity to lead investigations, staff side availability, and case complexity. As a result new key performance indicators covering investigations, and hearing arrangements have been introduced to help achieve performance improvements, and which have started to deliver results, with many non MHPS cases completed in fewer than 10 -12 weeks since April 17.

Enhanced governance arrangements for doctors in difficulty cases have been introduced and have led to improved case management, and decision making. These have in addition been supplemented by new oversight arrangements between HEFT and UHB introduced by the Medical Director to support improved consistency in case management, timeframes and outcomes. Additional training for case managers through NCAS has also been delivered in 16/17 to help address concerns about case manager capacity.

#### 3.4.2 Performance management

There were 20 formal performance management cases in 2016/17. The Trust also operates performance notices as part of the initial informal stages of performance management to address issues of concern relating to teams and individual members of staff.

#### 3.4.3 Employment Tribunal Cases

There were 2 Employment Tribunal cases listed during 2016/17 (and carried forward unfinished into 17/18).

#### 3.4.4 Sickness absence management

As at 31st March 2017, the Trust recorded a moving annual average sickness absence rate of 4.40%, an increase from 4.35% in March 2016. HR Managers have continued to work in partnership with managers and staff side representatives to help manage absence levels ensure practice complies with policy.

There were 30 cases involving the termination of staff on the grounds of ill health / capability.

Long term absence has continued to be higher than short term sickness. In month long term sickness absence as at March 2017 was 2.98% and in month short term sickness absence was 1.27%. The top 5 reasons for sickness absence were recorded as follows, and reflect a broader NHS acute Trust pattern and trend:

Long & Short Term Sickness Absence Reasons
1. Anxiety/stress/depression/other psychiatric illnesses
2. Other musculoskeletal problems
3. Gastrointestinal problems
4. Cold, Cough, Flu – Influenza
5. Unknown causes / Not specified

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Staff groups with absence consistently above average have included Ancillary, Healthcare Assistants and Maintenance. In response to this, regular meetings have taken place across all divisions where both long term and short term cases are discussed to ensure managers are supported and are compliant with the sickness absence (incorporating stress) policy. Targeting particularly poor performing service areas (estates and facilities) has achieved significant results. Managers and staff have also been encouraged to utilise the free confidential support and counselling service (CIC) which is available to all staff to access 24/7.

An annual programme of people management training, including performance management, sickness absence management, disciplinary, grievance and Bullying and Harassment has been delivered in 16/17, led by the HR Operational team. . In addition to the annual programme of training, bespoke sickness absence management training has also been provided in hot-spot areas. All training has recently been updated to ensure it is both interactive and meaningful. In addition the trust's Sickness Absence policy was reviewed and re-launched in March 2017 as the sickness absence (incorporating stress) policy.

#### **3.4.5 Priorities for 2017/18:**

- Continue to drive improvements in KPI performance for disciplinary Investigations and Exit Interview questionnaires and implement robust actions plans for areas of non-compliance.
- Review implementation and effectiveness of new and revised HR policies and procedures, in particular Disciplinary, Sickness Absence, Grievance and Dignity at Work.
- Support corporate and operational areas with organisational change processes / management of change
- Review the delivery of the people management training to operational managers within divisions to include unconscious bias training (as part of the Trusts WRES commitment).
- Review capability of ESR module for employee relation cases, in particular analysing the equality data to address any areas of concern.

### **3.5 RESOURCING**

#### **3.5.1 Non-medical Recruitment**

In the period from 1st April 2016 to 31st March 2017, the Trust saw a 10.93% decrease in candidates commencing in new roles from the previous year, with 2,020 appointees. Of these, 744 were internal appointments and 1,276 external. The breakdown of these appointees is as follows:

- Nursing: There were 1,119 new nurse starters comprising 298 HCAs; 817 Bands 5 - 8 Nurses and 4 ACPs.
- All other staff groups not covered by medical and nursing: 901 new starters

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- 744 existing staff changed jobs

Whilst the overall number of candidates commencing in new roles within the Trust has decreased the level of recruitment activity has increased as the focus in 2016/2017 has changed from generalised recruitment campaigns to more targeted programmes. This has been achieved alongside renewed efforts to increase the pace at which the Trust is able to on board new staff.

The Recruitment Team is responsible for all non-medical posts within the Trust. The focus in 2016/17 has been to build on the good work started in 2015/16 in streamlining of processes and reducing the overall time to hire. The time to hire from the date of a request to recruit being received by the Recruitment Team to the candidate being fully cleared to commence has reduced to 7.62 weeks as an average for the year with the figure for March 2017 starters being 5.71 weeks which has been a significant achievement in the context of significantly increased recruitment activity.

Standard operating procedures are in place across all areas of recruitment ensuring consistency of processes and efficiency across the team, and improving the quality of the candidate recruitment experience.

One of the most significant steps forward for the Recruitment Team in 2016/17 was to embed the additional functionality provided by NHS Jobs 2, which has resulted in the greater automation of the recruitment processes and has underpinned the reduction in time to hire.

In response to demand, the Trust wide recruitment and selection training programme was revised and relaunched in support of consistent recruitment practice, with significant numbers of recruiting managers trained by the end of 2017.

#### **3.5.2 Medical Workforce**

One of the main challenges over the past twelve months has been the contractual dispute by Doctors in Training (DiT) and the implementation of the new 2016 contract of employment. The Medical Workforce Team worked closely with colleagues in Education and in Operational areas to identify, resolve and implement all key tasks within the 2016 contract requirements including rota compliance and distribution of work schedules. All DiT's within the Trust have been appointed to the new contract.

At HEFT the first doctors to transition were Foundation Year (FY) doctors in December 2016 and then a staged process was agreed for all others up to October 2017.

As part of the requirements of the contract a Guardian of Safe Working was required to provide assurance to the Board of the safe working arrangements and to oversee Exception Reporting Process. The Trust has continued to struggle to appoint a substantive Guardian, with the responsibilities of the post shared between the Director of Medical Education and Deputy Medical Director.

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A continuing challenge for the Trust has been the issue of medical workforce supply. This is a national issue and although the Government have recently announced 1500 more medical student placements (500 in 2018, 1000 in 2019) there will be an 8-10 year period before these doctors will be in a position to contribute to the service. The significant deficit in supply compared to demand will remain very challenging for at least 10 years and possibly longer if the planned 2018/19 increase does not meet ongoing demand. The workforce shortage is further constrained by immigration controls for non-EU applicants and the potential difficulties of Brexit. Within the Trust we have achieved some success with UHB in attracting training grade doctors as part of the international fellowship programme, and expect to expand the programme over the next 1-2 years, to help improve doctor supply and reduce vacancy gaps.

Particular areas of concern are Emergency Medicine, Trauma and Orthopaedics together with General Medical and Surgical subspecialties. Efforts to improve attraction for specific specialities has been undertaken including cross site working with UHB.

#### **3.5.3 Priorities for 2017/18**

- To continue to reduce the average time to hire figure to ensure ongoing compliance with performance targets
- To reduce the gaps between establishment and in-post figures across a number of staff groups particularly General Nursing and Medical Staff, through delivery of new approaches to candidate attraction and staff retention. To integrate the UHB International Fellowship Programme within HEFT ensuring that suitable posts are identified and any interim appointments are time limited to ensure the availability of posts for International Fellows

#### **3.6 EDUCATION**

Service Review - 2016/17 Service review streamlined the Education Service, bringing it in line with funded establishment saving c£1m+. The efficiency of the service has improved by focusing education and training on core delivery, including statutory, mandatory and contractual activity. Following the end of the Staffordshire Contract (June 2017) commissioning of education is directly with HEI's as part of Learning Beyond Registration Funding (LBR).

Corporate Induction – A joint project initiated by the Medical Director has enabled the Trust education team to review and revise its induction programme for Consultants. The new programme (delivered from June 2017) expanded the programme from 1 week to 4 and involves both theoretical and on the job learning, supported by mandatory training programmes and opportunities to shadow experienced colleagues before formally joining clinical teams.

Moodle – The Trusts on-line learning tool. The programme of learning available has been expanded significantly to extend the learning opportunities available for staff and reduce time

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in the classroom. Moodle links with Easy Learning to provide managers with direct access to records of on-line learning completed, supporting achievement of CQUINs, KPIs and profession specific/local training requirements.

Mandatory training programme – A review of the Trusts training portfolio was undertaken in line with the regional streamlining programme. From December the number of mandatory/statutory training programmes was reduced from 22 to 14, with role specific training introduced for designated staff groups based on new training needs analysis. In 2016/17 time spent in the classroom for mandatory training was reduced from a full day to half day due to Moodle providing flexible completion for mandatory subjects. The Trust met the 2016/17 CCG KPIs for appraisal and mandatory training.

Appraisal – following a successful pilot in 2016/17, appraisal completion has transformed from being paper based to electronic completion on Easy Learning. This has improved compliance by providing managers with direct access to appraisal performance supporting the achievement of CCG appraisal KPI.

Education Reform – In response to education funding reforms the Trust are members of the Birmingham & Solihull Local Workforce Action Board-Education Reform Group to develop a consistent contract/MOU to be used with all Higher Education Institutes (HEIs) across BSol providers. The group has worked to develop a collaborative approach to workforce planning to support the determination of student numbers.

Clinical Delivery – The education team comprises experienced nurse educators. To support the Trust during the difficult winter pressures in 2016 resources were diverted to ensure front line clinical services continued to be delivered. This was achieved with minimal impact on education service delivery.

#### **3.6.1 Priorities for 2017/18**

- Working collaboratively with colleagues at University Hospital Birmingham NHS Foundation Trust (HEFT) to finalise and embed a joint apprenticeship strategy
- Streamline the Education service provision bringing it in line with funded establishment and improving the efficiency and effectiveness of the service
- Developing procedural clinical skills and simulation education to ensure education and training remain fit for purpose by incorporating procedural, technology assisted and simulated practice in a supervised environment to support and achieve the required competence
- Working collaboratively with the Education Reform Group (LWAB) establishment of a consistent fit for purpose contractual framework for Higher Education Institutions (HEIs)
- Education facilities investment Good Hope Hospital Partnership Learning Centre (PLC) to create a more fit for purpose environment

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- Instigation of annual reports to Board with detailed information on Education and Training performance and development of a training strategic and tactical plan
- Maintaining the integrity of medical induction with particular regard to trainer training and support for trainees, GMC trainer approval and quality of internal teaching programmes aligned to best practice and national regulatory requirement
- Maintaining the acknowledged high-achieving, general, innovative performance of medical education
- Further develop the process of internal quality control monitoring of the training environment
- Develop a more transparent process for the use of education monies from HEE with particular regard to the LDA Tariff and Placement Fee
- Further develop the International Fellows Programme to address gaps in medical workforce in collaboration with UHB
- Assist with development of a more sustainable medical workforce to include consideration of Physicians Associates and Advanced Care Practitioners

#### Workforce Statistics at 31<sup>st</sup> March 2017

**Table 1 – Staff Group by WTE and Headcount**

<b>Staff Group</b>	<b>WTE</b>	<b>Headcount</b>
Administrative and Clerical	1605.25	1896
Ancillary	390.25	520
Healthcare Assistants	1192.76	1380
Junior Medics	474.26	485
Maintenance	93.00	94
Pharmacists	75.91	84
Allied Health Professionals	632.03	751
Professional and Technical	720.09	825
Qualified Nursing and Midwifery	3098.85	3554
Scientists	75.22	96
Senior Medics	545.21	590
Senior Managers	277.27	290
<b>Total</b>	<b>9180.10</b>	<b>10565</b>

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**Table 2 – Ethnic Origin by WTE and Headcount**

<b>Ethnic Origin</b>	<b>Headcount</b>	<b>%</b>
A White – British	5773	54.64%
B White – Irish	171	1.62%
C White – Any other White background	130	1.23%
C2 White Northern Irish	5	0.05%
C3 White Unspecified	402	3.81%
CA White English	392	3.71%
CB White Scottish	11	0.10%
CC White Welsh	10	0.09%
CE White Cypriot (nonspecific)	3	0.03%
CF White Greek	28	0.27%
CG White Greek Cypriot	3	0.03%
CH White Turkish	1	0.01%
CK White Italian	25	0.24%
CN White Gypsy/Romany	2	0.02%
CP White Polish	30	0.28%
CQ White ex-USSR	1	0.01%
CT White Bosnian	1	0.01%
CU White Croatian	2	0.02%
CV White Serbian	1	0.01%
CX White Mixed	12	0.11%
CY White Other European	84	0.80%
D Mixed – White & Black Caribbean	112	1.06%
E Mixed – White & Black African	13	0.12%
F Mixed – White & Asian	38	0.36%
G Mixed – Any other mixed background	43	0.41%
GA Mixed – Black & Asian	2	0.02%
GC Mixed – Black & White	4	0.04%
GD Mixed – Chinese & White	6	0.06%
GE Mixed – Asian & Chinese	2	0.02%
GF Mixed – Other/Unspecified	14	0.13%
H Asian or Asian British – Indian	692	6.55%
J Asian or Asian British – Pakistani	540	5.11%
K Asian or Asian British – Bangladeshi	63	0.60%
L Asian or Asian British – Any other Asian background	138	1.31%
LA Asian Mixed	4	0.04%
LB Asian Punjabi	5	0.05%
LC Asian Kashmiri	2	0.02%
LD Asian East African	2	0.02%
LE Asian Sri Lankan	12	0.11%
LH Asian British	35	0.33%
LJ Asian Caribbean	3	0.03%
LK Asian Unspecified	9	0.09%
M Black or Black British – Caribbean	405	3.83%
N Black or Black British – African	249	2.36%
P Black or Black British – Any other Black background	47	0.44%
PA Black Somali	8	0.08%

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<b>Table 2 cont</b>		
<b>Ethnic Origin</b>	<b>Headcount</b>	<b>%</b>
PB Black Mixed	1	0.01%
PC Black Nigerian	11	0.10%
PD Black British	44	0.42%
PE Black Unspecified	11	0.10%
R Chinese	46	0.44%
S Any Other Ethnic Group	99	0.94%
SC Filipino	148	1.40%
SD Malaysian	11	0.10%
SE Other Specified	71	0.67%
Undefined	4	0.04%
Z Not Stated	584	5.53%
<b>Grand Total</b>	<b>10565</b>	<b>100.00%</b>

**Table 3 – Disability Status by Headcount and Percentage of the Workforce**

<b>Disability</b>	<b>Headcount</b>	<b>%</b>
Yes	296	2.80%
No	8315	78.70%
Not Declared	1954	18.50%
<b>Total</b>	<b>10565</b>	<b>100.00%</b>

**Table 4 – Age Profile by Headcount and Percentage of the Workforce**

<b>Age</b>	<b>Headcount</b>	<b>%</b>
16-24	674	6.38%
25-29	1339	12.67%
30-34	1302	12.32%
35-39	1235	11.69%
40-44	1315	12.45%
45-49	1394	13.19%
50-54	1426	13.50%
55-59	1069	10.12%
60-64	582	5.51%
65+	229	2.17%
<b>Total</b>	<b>10565</b>	<b>100.00%</b>

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**Table 5 – Gender Profile by Headcount and Percentage of the Workforce**

<b>Gender</b>	<b>Headcount</b>	<b>%</b>
Female	8505	80.50%
Male	2060	19.50%
<b>Total</b>	<b>10565</b>	<b>100.00%</b>

**Table 6 – Sexual Orientation Profile by Headcount and Percentage of the Workforce**

<b>Sexual Orientation</b>	<b>Headcount</b>	<b>%</b>
Bisexual	40	0.38%
Gay	73	0.69%
Heterosexual	5793	54.83%
I do not wish to disclose my sexual orientation	4625	43.78%
Lesbian	34	0.32%
<b>Total</b>	<b>10565</b>	<b>100.00%</b>

**Table 7 – Religion and Belief Profile by Headcount and Percentage of the Workforce**

<b>Religion and Belief</b>	<b>Headcount</b>	<b>%</b>
Atheism	654	6.19%
Buddhism	12	0.11%
Christianity	3722	35.23%
Hinduism	110	1.04%
I do not wish to disclose my religion/belief	4792	45.36%
Islam	535	5.06%
Judaism	7	0.07%
Other	611	5.78%
Sikhism	122	1.15%
<b>Total</b>	<b>10565</b>	<b>100.00%</b>

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**Voluntary Turnover**

**Table 8 – Voluntary Turnover by Staff Group**

<b>Staff Group</b>	<b>WTE</b>	<b>Leavers WTE</b>	<b>Turnover</b>
A&C	1605.25	161.97	10.09%
Ancillary	390.25	19.92	5.10%
HCA's	1192.76	115.76	9.71%
Maintenance	93.00	14.60	15.70%
Pharmacists	75.91	19.40	25.56%
Allied Health Professionals	632.03	100.16	15.85%
Professional and Technical	720.09	89.18	12.38%
Qualified Nursing & Midwifery	3098.85	301.32	9.72%
Scientists	75.22	8.47	11.26%
Senior Medics	545.21	40.67	7.46%
Senior Managers	277.27	52.58	18.96%
<b>Total</b>	<b>8705.84</b>	<b>924.03</b>	<b>10.61%</b>

**Table 9 – Voluntary Turnover by Gender**

<b>Gender</b>	<b>Total</b>	<b>% of Leavers</b>	<b>% Turnover</b>
Female	702.37	76.01%	8.26%
Male	221.66	23.99%	10.76%
<b>Total</b>	<b>924.03</b>	<b>100.00%</b>	

**Table 10 – Leavers by Disability Status**

<b>Disabled</b>	<b>Total Leavers</b>	<b>% of all Leavers</b>
Yes	28.35	3.07%
No	782.60	84.69%
Not Declared	113.08	12.24%
<b>Total Leavers</b>	<b>924.03</b>	<b>100.00%</b>

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**Table 11 – Leavers by Ethnic Origin**

<b>Ethnic Origin</b>	<b>Total Leavers</b>	<b>% of all Leavers</b>
Any Other Ethnic Group	10.10	1.09%
Asian British	1.00	0.11%
Asian Kashmiri	0.92	0.10%
Asian Mixed	1.00	0.11%
Asian or Asian British - Any other Asian background	10.89	1.18%
Asian or Asian British - Bangladeshi	6.16	0.67%
Asian or Asian British - Indian	68.45	7.41%
Asian or Asian British - Pakistani	60.95	6.60%
Black British	3.83	0.41%
Black Nigerian	3.48	0.38%
Black or Black British - African	29.75	3.22%
Black or Black British - Any other Black background	5.80	0.63%
Black or Black British - Caribbean	31.88	3.45%
Black Somali	0.61	0.07%
Black Unspecified	2.46	0.27%
Chinese	2.03	0.22%
Filipino	10.61	1.15%
Mixed - Any other mixed background	6.92	0.75%
Mixed - Black & White	0.92	0.10%
Mixed - White & Asian	2.40	0.26%
Mixed - White & Black African	1.00	0.11%
Mixed - White & Black Caribbean	11.19	1.21%
Not Stated	49.02	5.30%
Other Specified	1.67	0.18%
White - Any other White background	18.00	1.95%
White - British	495.02	53.57%
White - Irish	8.80	0.95%
White Italian	5.63	0.61%
White Mixed	1.00	0.11%
White Other European	18.85	2.04%
White Polish	3.48	0.38%
White Scottish	1.00	0.11%
White Unspecified	21.41	2.32%
White Welsh	1.00	0.11%
White English	24.79	2.68%
White Greek	2.00	0.22%
<b>Total Leavers</b>	<b>924.03</b>	<b>100.00%</b>

\*Note: voluntary turnover excludes the following categories of leavers; junior medics, retirements, death in service, redundancy, staff transfer, end of fixed term contract and dismissals.

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Table 12

#### Sickness Comparator Data

##### Acute Sickness Comparator

	Jan 16	Feb- 16	Mar- 16	Apr- 16	May- 16	Jun- 16	Jul- 16	Aug- 16	Sep- 16	Oct- 16	Nov- 16	Dec- 16
Birmingham Children's Hospital NHS Foundation Trust	3.89%	3.79%	3.82%	3.56%	3.21%	3.20%	3.36%	3.03%	3.03%	3.54%	3.93%	4.36%
Birmingham Community Healthcare NHS Foundation Trust	5.81%	5.73%	5.36%	5.27%	5.01%	5.01%	5.18%	5.19%	5.16%	5.45%	5.59%	5.95%
Burton Hospitals NHS Foundation Trust	4.51%	4.12%	3.93%	3.82%	3.75%	3.88%	3.92%	3.86%	3.54%	4.02%	4.05%	4.09%
Dudley and Walsall Mental Health Partnership NHS Trust	4.78%	5.06%	4.43%	4.39%	4.84%	4.82%	5.30%	5.21%	5.04%	3.92%	3.72%	3.66%
George Eliot Hospital NHS Trust	4.01%	4.23%	4.08%	3.85%	3.66%	3.88%	4.05%	4.02%	3.87%	4.57%	4.64%	4.49%
Heart of England NHS Foundation Trust	4.78%	4.82%	4.44%	4.37%	3.99%	4.15%	4.21%	4.06%	4.35%	4.43%	4.29%	4.73%
Royal Wolverhampton NHS trust	5.16%	5.11%	4.90%	4.39%	4.14%	4.13%	4.28%	4.29%	4.22%	4.64%	4.84%	4.88%
Sandwell and West Birmingham Hospitals NHS Trust	5.24%	4.92%	4.81%	4.34%	4.23%	4.16%	4.11%	4.32%	4.17%	4.61%	4.82%	5.03%
Shrewsbury and Telford Hospital NHS Trust	4.56%	4.39%	4.35%	3.86%	3.45%	3.62%	3.97%	3.66%	3.78%	4.33%	4.34%	4.29%
South Warwickshire NHS Foundation Trust	4.20%	4.37%	4.18%	4.20%	3.83%	3.70%	3.78%	3.94%	4.20%	4.49%	4.87%	4.71%
University Hospitals Birmingham NHS Foundation Trust	4.45%	3.99%	3.86%	3.87%	3.83%	3.87%	3.82%	3.93%	4.17%	4.52%	4.45%	4.59%
University Hospitals Coventry and Warwickshire NHS Trust	4.78%	4.54%	4.26%	3.83%	3.79%	3.87%	3.73%	3.56%	3.69%	3.94%	4.39%	4.40%
University Hospitals of North Midlands NHS Trust	4.45%	4.31%	4.19%	4.07%	3.99%	4.16%	4.11%	4.11%	4.07%	4.42%	4.51%	4.81%
Worcestershire Acute Hospitals NHS Trust	4.70%	4.38%	4.08%	3.85%	4.04%	3.70%	4.14%	4.03%	3.92%	4.55%	4.79%	5.00%

Data from NHS Digital – latest data only published up to December 2016

## BOARD OF DIRECTORS – QUALITY COMMITTEE

DATE OF MEETING – OCTOBER 2017

### ANNUAL WORKFORCE REPORT (READ ONLY)

#### Staff Survey Summary of Results 2016

Response Rates by Division:

- Corporate Directorates – 56.2%
- Facilities – 37.7%
- Trust wide Education Services – 54.4%
- Trust wide Research Management – 61.5%
- Research & Innovation – 68.9%
- D1 Clinical Support Services - 36.9%
- D2 Women & Children's – 31.2%
- D3 Emergency Care – 24.9%
- D4 Medicine – 39.3%
- D5 Surgery – 28.1%

Number of Responses by Staff Group (2015 results in brackets):

- Adult / General Nurses – 664 (525)
- Other Registered Nurse – 284 (207)
- Nursing / Healthcare Assistants – 201 (229)
- Medical / Dental – 309 (216)
- Occupational Therapy – 47 (34)
- Physiotherapy – 115 (82)
- Radiology – 89 (55)
- Other Allied Health Professionals – 195 (135)
- General Management – 66 (58)
- Other Scientific and Technical – 238 (162)
- Admin & Clerical – 669 (466)
- Central Functions / Corporate Services – 168 (160)
- Maintenance / Ancillary – 168 (248)

#### Overview of Results

	2014	2015	2016
Highest 20%	1 finding	1 finding	3 findings
Above average (better than other trusts)	2 findings	0 findings	3 findings
Average	3 findings	7 findings	7 findings
Below average (worse than other trusts)	12 findings	12 findings	14 findings
Worst 20%	11 findings	12 findings	5 findings
	<b>29 findings</b>	<b>32 findings</b>	<b>32 findings</b>

## BOARD OF DIRECTORS – QUALITY COMMITTEE

DATE OF MEETING – OCTOBER 2017

### ANNUAL WORKFORCE REPORT (READ ONLY)

Comparison of HEFT results with other trusts in the West Midlands  
Based on no. of findings in top 20% or above average

- UHB – 22 findings
- Royal Wolverhampton – 10 findings
- Dudley Group of Hospitals – 7 findings
- Sandwell & West Birmingham – 9 findings
- Heart of England – 6 findings
- Worcester- 3 findings

Best 20% of acute Trusts nationally, including in the following key findings

- % witnessing potentially harmful errors, near misses or incidents in last month;
- % experiencing physical violence from patients, relatives or public in last 12 months;
- % experiencing harassment, bullying or abuse from patients, relatives or public in last 12 months;

	2015		2016		Trust improvement/Deterioration
Response Rate	Trust	National Average	Trust	National Average	
	29%	42%	36%	41%	Improved

#### 2016 Top 5 Ranking Scores

	2015		2016		Trust improvement/Deterioration
Top 5 Ranking scores	Trust	National Average	Trust	National Average	
KF28. % of staff witnessing potentially harmful errors, near misses or incidents in last month	29%	31%	26%	31%	Improved (lower score the better)
KF 22. % of staff experiencing physical violence from patients, relatives or the public in last 12 months	15%	15%	12%	15%	Improved (lower score the better)
KF 25. % of staff experiencing harassment, bullying or abuse from Patients, relatives or the public in last 12 months	28%	28%	25%	27%	Improved (lower score the better)
KF 11. % of staff appraised in last 12 months	85%	86%	90%	87%	Improved
KF 26. % of staff experiencing harassment, bullying or abuse from staff in last 12 months	27%	26%	24%	25%	Improved (lower score the better)

## BOARD OF DIRECTORS – QUALITY COMMITTEE

DATE OF MEETING – OCTOBER 2017

### ANNUAL WORKFORCE REPORT (READ ONLY)

#### 2016 Bottom 5 Ranking Scores

Bottom 5 Ranking scores	2015		2016		Trust improvement/Deterioration
	Trust	National Average	Trust	National Average	
KF 32. Effective use of patient / service user feedback	3.50	3.70	3.57	3.72	Improved
KF 30. Fairness & effectiveness of procedures for reporting errors, near misses & incidents	3.54	3.92	3.63	3.72	Improved
KF 1. Staff recommendation of the organisation as a place to work or receive treatment	3.47	3.76	3.59	3.76	Improved
KF 21. % believing the organisation provides equal opportunities for career progression / promotion	80%	87%	83%	87%	Improved
KF 9. Effective team working	3.64	3.73	3.70	3.75	Improved

## BOARD OF DIRECTORS – QUALITY COMMITTEE

DATE OF MEETING – OCTOBER 2017

### ANNUAL WORKFORCE REPORT (READ ONLY)

#### 2017 National Staff Survey Corporate Action Plan

Theme	Actions	Status
<b>Staff wellbeing</b>	<p>Deliver a Staff communications campaign to promote awareness of the wellbeing support that is available, including:</p> <ul style="list-style-type: none"> <li>a. Resilience ½ day workshop open to all staff – 240 spaces available in March &amp; April, with potential to run more later in the year.</li> <li>b. Confidential Care (CiC) advice line / access counselling services</li> <li>c. Stress &amp; Resilience sessions delivered by Occupational Health team</li> </ul>	<p><b>Complete</b> Campaign included in June team brief and posters being delivered to wards &amp; departments during July. Two additional Resilience workshops offered to priority areas (28<sup>th</sup> July 17).</p>
<b>Leadership behaviours</b>	Corporate support available for line managers to recognise and communicate success and showcase achievements	<b>In progress</b> Support offered – no requests to date
	Corporate support available for line managers on creating a safe environment for staff to speak up	<b>In progress</b> Support offered – no requests to date
<b>Resources</b>	Divisional teams to ensure essential equipment is prioritised and purchased (already underway – e.g. additional beds hired for GHH ED until flex beds came back into stock)	<b>In progress</b> All divisions asked to discuss essential equipment needs with their teams and purchase items as required.
	HR to produce a toolkit for divisions and line managers for discussing survey results within teams and generating local improvement actions	<b>Complete</b> Toolkit created and circulated to divisional teams and corporate areas
<b>Physical Violence from managers</b>	Include Zero tolerance message in CEO April team brief	<b>Complete</b>

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**23 OCTOBER 2017**

<b>Title:</b> Charitable Funds Annual Report and Accounts							
<b>From:</b> Julian Miller				<b>To:</b> Board of Directors			
<b>The Report is being provided for:</b>							
Decision	Y	Discussion	Y	Assurance	N	Endorsement	N
<b>Purpose:</b> To recommend the approval of the Annual Report and Accounts and the management representation letter for the Charity for the year ended March 2017 to the Board for approval.							
<b>Key points/Summary:</b> The Annual Report and Accounts of the Charity for the year ended 31 March 2017 require approval and signature							
<b>Recommendation(s):</b> To recommend the Annual Report and Accounts and management representation letter be approved by the Board of Directors for signature.							
<b>Assurance Implications:</b>							
Board Assurance Framework	N	BAF Risk Reference No.					
Performance KPIs year to date	N	Resource/Assurance Implications (e.g. Financial/HR)			N		
Information Exempt from Disclosure	N	If yes, reason why.					
Identify any Equality & Diversity issues							
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							
Audit Committee							

## **BOARD OF DIRECTORS**

**23 OCTOBER 2017**

### **1. SUMMARY**

The Annual Report and Accounts for the Heart of England NHS Foundation Trust Charity ('the Charity') has been completed by the Finance and Communications team and the audit has been completed. The report is required to be reviewed by the Board of Directors before the document is signed.

### **2. BACKGROUND**

Although the Charity ceased to exist from 1 April 2017, a final annual report and accounts must be prepared to be submitted to the Charity Commission. This report is the annual report and accounts for the year ended 31 March 2017.

An earlier draft of this annual report and accounts was presented to the Donated Funds Committee in April 2017 with some minor amend before being presented at Audit Committee.

KPMG have completed their audit, and require a management representation letter to be signed by the Trust prior to them releasing the audit opinion. The letter has been reviewed by the finance team.

### **3. RECOMMENDATIONS**

The Board of Directors is recommended to approve the Annual Report and Accounts and the management representation letter for signature.

Heart of England NHS Foundation Trust Charity

Annual Report and Financial Statements

2016-2017

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## Chair's Statement

It has been another challenging year for the NHS and for Heart of England NHS Foundation Trust. Therefore the contribution made by our Charity in supporting patients, families and staff by providing those added extras which cannot be provided by the NHS is invaluable.

Donors and fundraisers can specify a ward or department they wish to support, or can choose an individual hospital or HEFT Charity as whole.

I am very grateful for the imagination of our staff in coming up with ideas for funding and the efforts of our community and business partners in helping to raise the money which can make such a difference. There is an enormous well of appreciation for the work of the NHS and for its staff – the Charity's work helps us to build on this and to strengthen even further the relationships we have with the communities we serve. Most importantly, it provides huge benefits for our patients – thank you for your contribution.

Rt. Hon. Jacqui Smith  
Interim Chair – Heart of England NHS Foundation Trust

## Independent Committee Chairman's Statement

This year has again been a busy time for the Charity, competing with increasing demands for charitable gifts. The Charity has continued to provide invaluable support to the hospitals, funding over £1.8m for medical equipment and patient welfare. I recognise the enormous efforts of all the staff in the hospitals that have brought their ideas for improvements to the Charity and with its support turned them into a reality. Changes and challenges in the NHS provide the Charity with opportunities to innovate and help ensure that patients are getting the best care the hospitals' staff can provide.

Mr Paul Hensel  
Chairman – Donated Funds Committee

## **Our Vision**

Imagine a local hospital where all the doctors and nurses are trained in the very latest techniques and have the state-of-the-art equipment to match; where the non-medical needs of patients are treated with equal importance to their medical needs; where the comfort of the patients and their loved ones can be relied on to be as important as the medical care. Imagine if this local hospital was available to all who needed it.

This is the dream of the Heart of England NHS Foundation Trust Charity. Heart of England NHS Foundation Trust has the dedicated staff. It has the local hospitals. The Charity and its supporters are valued and needed to help make the dream a reality.

During the last 12 months Heart of England NHS Foundation Trust, in its role as corporate trustee of the hospital charity, has made the decision that the best way forward to deliver this vision is to merge into the University Hospitals Birmingham (UHB) Charity to form one hospital charity which will support some of the major hospitals in Birmingham.

This merger took place on 1 April 2017 and the UHB Charity number is 1165716. Next year's report will be under this charity number.

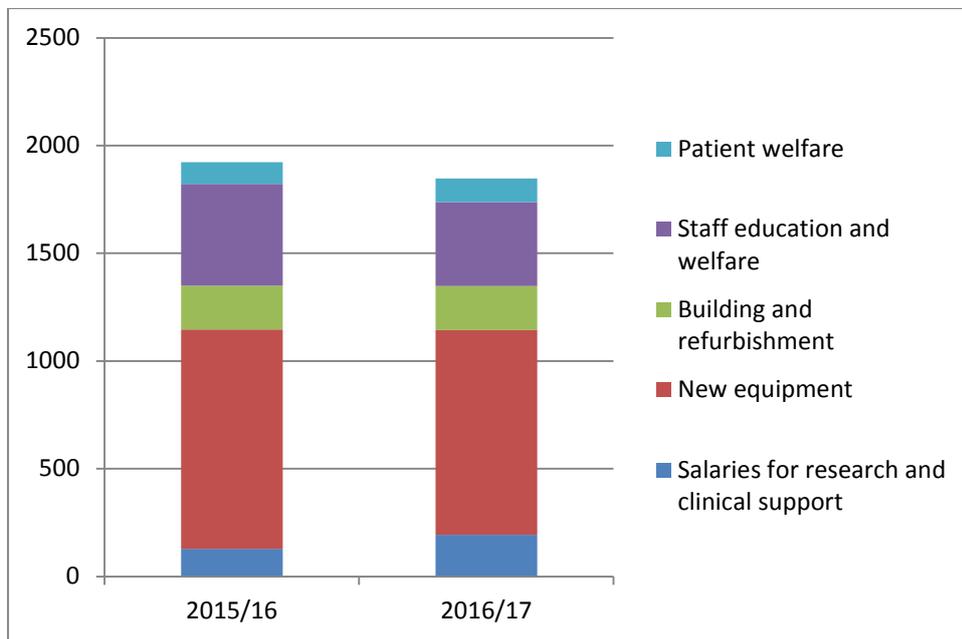
## **What We Have Funded**

The Charity has just over 300 funds covering every speciality as well as a general fund for each hospital. When we meet with fundraisers or donors we let them know they can raise money for any of these funds and the money will be allocated to the area they have chosen. We can then tell them exactly what their donation has purchased or contributed to and how it has benefited our patients.

The Charity provides funding in many different areas including research, equipment purchases, facilities and training. This expenditure helps to improve patients' care and experiences above and beyond what the core NHS funding allows. During the past year the Charity was delighted to be able to give over £1.8m of charitable support to the Trust for the benefit of our patients and staff.

The graph illustrates funds received and what the money was spent on over the last two years.

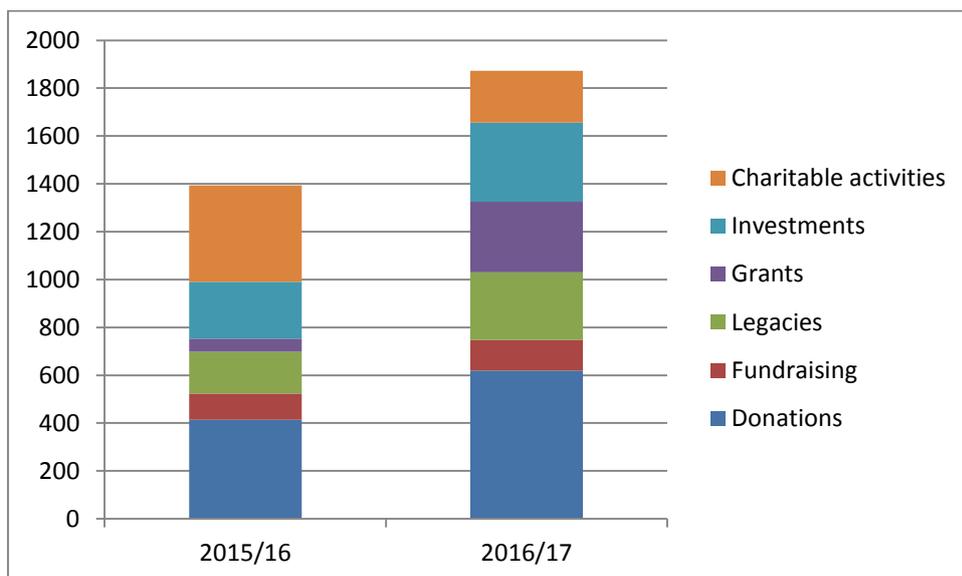
£'000



### How we are funded

Donations from generous individuals, companies, community groups, staff, patients and their families represent a vital source of income for the Charity. It is only with their support we can continue to fund the projects that benefit our patients. The total income of the Charity increased from £1,394k in 2015/16 to £1,871k in 2016/17 with the major sources of funding set out as below;

£'000



## Grant Making Policy

The Donated Funds Committee, which is responsible for the overall management of the Charity, on behalf of the Corporate Trustee, recognises that many donors have a personal connection with a specific part of the hospital. To accommodate their preference there are two types of funds available for making grants; restricted and unrestricted funds. A number of separately registered (restricted) funds exist which have a very specific purpose, and legally, spending must be for the purpose set out in the donation. These funds contain donations, legacies or income from charitable activities where a particular part or activity of the Trust has been nominated. Spending decisions are then delegated to Fund Managers / Advisers within the Trust who have particular knowledge of the different areas of the hospitals and what is needed to make a difference. Requests to spend the money are subject to internal review to ensure compliance with our Charity objectives and public benefit.

Unrestricted funds can either be designated, where a set area is indicated in the donation, or to the General Fund which contains donations and legacies where no particular preference has been expressed. The latter option gives maximum flexibility to respond to the changing needs of our hospitals and their patients and is used only with the approval of the relevant hospital manager or the Finance Director and is applied to projects where neither NHS funding is available nor a designated fund is available.

## Our Communities

The local community to which our Trust belongs to has always played a key part in our fundraising projects. We have built valuable relationships with local firms, schools, colleges, pubs and supermarkets and provided them with support to raise funds for their local hospitals.

### Children's ED receives toy and cash donations after flood damage



Young patients visiting the Children's Emergency Department at Heartlands Hospital were delighted after receiving a bumper donation of toys to replace the thousands of pounds worth of toys and equipment that were damaged during the floods earlier this year.

Staff in the Children's Emergency Department were left dismayed to see sofas, tables and chairs, a soft play area, toys, games, zimmer frames, books and electrical equipment such as a TV, DVD player, iPads, monitors and game consoles all irreparably damaged after the flash floods in June.

The department remained closed for a number of weeks while repairs and redecoration took place and paediatric patients were treated in another part of the Emergency Department.

£5,000 was kindly donated by Jaguar Land Rover, the same amount was donated by the Trust, Asda Small Heath donated toys and the Birmingham Vineyard Church donated £500. Sue and Eliot Wright from Topsham in Devon, whose daughter Katie works as a consultant in ED, also donated £500.

Charlotte Putt, healthcare play specialist, said: "We are so grateful for the generous donations which have meant that we can replace the toys and equipment that were damaged. We'd like to say a huge thank you to Jaguar Land Rover, Birmingham Vineyard Church, Sue and Eliot Wright, Asda Small Heath and the Trust for their kindness."

## Special donation in memory of a much loved dad



A family of an Acocks Green man visited the hospital ward which cared for him in his final days to hand over a special donation in his memory. Michael Green sadly passed away at Solihull Hospital, part of Heart of England NHS Foundation Trust, last May at the age of 81 after a long and courageous fight with Parkinson's disease. He was cared for at the end on Ward 20A and his family were keen to do something in his memory for the elderly care ward.

Michael was born in Galway in Ireland but had lived in Acocks Green for over 50 years with wife Peggy and they had four children and six grandchildren. His niece Fiona works as a matron at Solihull Hospital.

Michael's son Mike said the family were keen to give something back to the ward as a token of their appreciation for the care their dad received.

He said: "We raised about £1,200 at his funeral and decided to give it to the ward where he was treated. When we asked what they needed they said a comfortable chair for visitors would be really useful. When you are here for hours on end with your relative it is not ideal to have just a plastic chair to sit on".

Ward 20A senior sister Ann Bocock and charge nurse Ross Manuel took delivery of the chair from the family and thanked them for their kind gesture.

## Blues bring festive cheer to Heartlands children's ward



Poorly children at Heartlands got a fun Christmas surprise thanks to a visit from some of Birmingham City Football Club's star players.

First team captain Michael Morrison, defensive partner Ryan Shotton, midfielder David Davis and goalkeeper Adam Legzdins took time out of their busy pre-Christmas schedule to drop in and spread some Christmas cheer, giving out team goody bags to dozens of young patients and presenting staff with a £1,000 donation for play equipment.

"It's nice to give back your time," said centre half Shotton. "I have got a little daughter so I can appreciate being in hospital this time of year - it's never a place you want to be - around Christmas period you just want to be home with your family and your turkey dinner."

Christine Morrell, play specialist at Heartlands Hospital, said: "We were delighted to arrange a special visit from their footballing heroes for our young patients. Christmas can be a difficult time of year for children and families, especially those who have to stay in hospital over the festive period. It was wonderful to see so many smiles.

"Everyone had a great time and we would like to thank Michael, Ryan, David and Adam for taking the time to visit and for their kind donation."

## Ladies gym raises £1,700 for Ward 19



A ladies-only gym in Sutton Coldfield has presented a lifesaving cancer unit with a welcome donation of £1,700 after a year of fundraising for the cause.

Gym & Slim in Union Drive carried out various fundraising events during 2016 including a weight loss competition and raffles. However, its biggest fundraiser was a ladies night held at Walmley Golf Club including a three-course meal and entertainment, with a raffle and auction.

## Five women raise £4,071 for Heartlands wards



A fantastic £4,071 has been raised by five members of Sheldon Heath Club for Ward 6 and Ward 19 at Heartlands in memory of loved ones treated at the hospital.

Ann Marie Allbright, Gail Allbright, Tina Connolly, Sarah Holland and Natalie Stafford took on a variety of fundraising challenges to raise the impressive total. The money will be split evenly between Ward 6, a cardiology ward caring for patients with serious heart problems, and Ward 19, a specialist haematology ward treating patients for diseases such as leukaemia.

The donations were raised through Sheldon Heath Club by holding race nights, two organised walks from Heartlands to Sheldon Heath and an organised function night with a raffle and auction, all over one bank holiday weekend. Barclays Bank also pledged to match the funds raised on the night.

Tina Connolly said: "We wanted to raise money for Ward 6 and 19 as they are close to our hearts and wanted to give back to them for all the hard work that they do."

## Intrepid Lucy's donation help funds chemotherapy at home service



An intrepid Birmingham woman has handed over a cheque for over £6,000 to a cause close to her heart after completing a gruelling charity trek across the Great Wall of China.

Lucy Harborne, from Kings Heath, took on the challenge in memory of her uncle Mark who was treated on the Ward 19 blood cancer unit at Birmingham Heartlands Hospital but sadly died after a courageous five-year battle with the disease.

The 23-year-old and her family had nothing but praise for the treatment her uncle received and the staff on Ward 19 which is why she was so keen to take on such a challenge and in doing so raise a fantastic total of £6,311 to support the unit.

She said: "During the past five years Ward 19 supported Mark and my family huge amounts. He always went on about how great the nurses were and how they put up with his sense of humour. The doctors and nurses really kept his spirits high for a long time".

Dr Manos Nikolousis, clinical director on Ward 19, said: "The donation will go directly towards our Chemotherapy at home service which involves a specialist nurse going to the home of patients with

blood cancer conditions or reduced mobility to deliver chemotherapy directly at their address, without the need for them to come to the hospital.”

### **Thousands raised for Heartlands by singing group**



A group of 20 ladies raised £3,000 for the Trust charity through the singing of special holy hymns popular in the Sikh religion.

The Guru Nanak Nam group conduct a ‘Sukhmani Sahib’, which means jewels of happiness hymns. The hymns are taken from their holy scripture and the Guru Granth Sahib and take 90 minutes to read. The ladies are then invited to sing the holy hymns to friends and family and they donate money to the group.

This year they decided to donate to Heartlands and chose to split the £3,000 between the Ward 16 Children’s Ward, where they purchased a sofa for the adolescence room, Children’s A&E where they purchased toys for the patients after the June flood destroyed all the toys and to our Medical Day Hospital where they purchased two Dyson fans and an ophthalmoscope – this machine helps to see into the patients’ ears and eyes more clearly for diagnosis.

### **Ward 19 partners with bank to boost coffers**



Ward 19, the lifesaving cancer unit at Heartlands, was chosen as TSB’s new local charity partner for its branch in Sheldon. To kick start the partnership TSB donated over £1,000 to the unit, which specialises in treating all forms of blood cancer and chemotherapy and raising money for the benefit of their patient.

Amanda Barton, commercial customer service consultant at TSB’s Sheldon branch, said: “Ward 19 is a local cause that’s close to people’s hearts here in Sheldon and we are delighted to welcome them as our new local charity partner.

“We’re busy planning lots of fundraising activities for the coming months and can’t wait to build our partnership with them and support the vital work that they do for our local community.”

### **Charity serves up dementia friendly crockery**



A raft of new coloured dining crockery is set to benefit patients with dementia across Heartlands, Solihull and Good Hope Hospitals thanks to the Heart of England Foundation Trust (HEFT) Charity.

Research has shown that patients with dementia can experience difficulties with sight and perception and because of this they struggle to see food on white and pale plates. Jennifer Chatham, charity services manager for the HEFT Charity said: “Contrasting colours can help patients to distinguish between foods and rimmed plates can also help those with dexterity problems or who can no longer use a knife.

“After consulting with our dementia team, we have bought more than 600 pieces of crockery which will absolutely benefit the nutrition of our patients suffering with this debilitating illness. We are delighted to be able to support our patients in this way.”

The new crockery is just the latest in a number of projects and initiatives aimed at improving the care delivered by HEFT to patients with dementia as well as raising awareness of the condition itself.

### **Staff Engagement**

2016 saw a surge into staff involvement into fundraising appeals and initiatives, with teams of staff from all sites proactively organising fundraising events, supporting campaigns or even undertaking extreme challenges to make a difference on the daily experience of patients on their units.

### **Take steps walk raises over £1k**



Pulmonary rehab patients at Good Hope Hospital have helped raise over £1,000 for charity by taking on a sponsored walk.

The walk was held in the gym of the physiotherapy department following the rehab class and was held as part of the British Lung Foundation (BLF) Take Steps initiative which aimed to raise funds and awareness of the BLF and lung disease.

All in all the group of patients and staff walked a total of 36 miles during the challenge raising a grand total of £1,056.

### **A kidney transplant patient gives back to renal unit**



A member of staff at Heartlands who received a ‘new lease of life’ after a kidney transplant made a donation of her own to the unit that treated her. Carole Stanley who underwent a kidney transplant, raised £100 through a tuck shop she runs at the Medical Innovation Development Unit (MIDRU) at Heartlands Hospital, and decided she wanted the money to go the renal unit.

The waitlist coordinator had been managing the tuck shop, which was first started by her colleague Liz Adey, for five months and during this time they were able to raise £300 for charity.

They began the tuck shop with the purpose of raising money for non-profit charities chosen by members of staff at however this time they chose to raise money for somewhere more personal.

Carole received a kidney from her husband Richard last year after her kidney function fell to 15 per cent following renal failure.

After only 18 weeks of recovery time she was able to go back to work and she says the transplant has given her a new lease of life.

Carole said: "This transplant has changed my life and I will be forever grateful to Richard for giving me such a generous gift – one I wouldn't be able to have a normal Christmas without. I am also very grateful to my renal team who are like family too.

### **Dynamic dozen raise thousands for day unit**



A team of 12 members of the oncology team at Good Hope raised over £5,500 to help fund improvements to their day unit by taking on a triathlon challenge.

Three teams of four swam, cycled and ran as they completed the City of Birmingham Triathlon at Sutton Park and there was even an unexpected prize for one of the teams who won the female Olympic relay prize.

All the staff, most of whom had never taken on such an event before, had begun their training months prior to the big day as they set about the challenge of tackling the 1,500m open water swimming, 40k cycling and 10k running disciplines.

Clinical nurse specialist Rachel Powell, organiser and part of the prize-winning female Olympic relay team, said: "Everyone really embraced it and it was such a good day. I managed to hold it together the whole day but when I realised how much we had raised I burst into tears."

The plan is to use the money raised to create a more pleasant environment for patients with a cancer diagnosis while they wait to see an oncologist/haematologist or to have treatment in the day unit, based in the Sheldon Unit at Good Hope.

### **Our "Friends"**

The Friends of Solihull Hospital and the Friends of Good Hope Hospital are two fundraising groups that provide their hospitals with invaluable support in raising funds. These groups raise money exclusively for their respective hospitals and work closely with the Charity's fundraising team.

#### **Friends of Solihull**

Friends of Solihull Hospital is an independent registered charity that has been in existence for over 60 years. The Friends can count on 70 active volunteers and many other regular supporters. They raise

their funds by holding stalls in the hospital, organising charity events and running the afternoon trolley shop at Solihull Hospital.

All of the proceeds from their fundraising are used to purchase vital medical equipment for Solihull Hospital. 2016/17 has been a fantastic year for the Friends, who donated to the hospital over £140k worth of equipment.

### **FOSH Fete success**

The annual summer fete held by the Friends of Solihull Hospital once again proved a big success, raised thousands of pounds for the hospital and attracted record numbers.

More than £5,000 was raised from the event which was opened by the Mayor of Solihull, Councillor Michael Robinson, and saw a team of 60 volunteers helping on the day running stalls, serving up cream teas and organising the games, races and displays.

The attractions included music from the Birmingham Pipe and Drum band, dance presentations, a martial arts display and a dog training demonstration. Liz Steventon, chair of FOSH, said: "I would like to thank all the tireless volunteers and all the businesses in Touchwood and Mell Square for their generous donations, as well as Ruckleigh School who donated their PE equipment for the races.

"It was an incredible turnout, with 1,100 enthusiastic people from the local area. It's fantastic to see so many people give up their time and get involved. All proceeds from the FOSH fete go towards equipment for Solihull Hospital."



For additional information about upcoming events, initiatives and volunteering opportunities with the association, please contact Liz Steventon, Chairman of Friends of Solihull Hospital, at [liz@steventon.net](mailto:liz@steventon.net).

### **Friends of Good Hope Hospital**

**The Friends of Good Hope Hospital** is a fundraising group set up by volunteers from the local community to support patients, relatives and visitors at the Hospital. They raise funds for Good Hope Hospital with a range of activities including bric-à-brac stalls, car-boot sales, and coffee mornings, and are planning other events to raise funds for the benefit of patients.



For additional information about upcoming events, initiatives and volunteering opportunities with the association, please contact Tony Cannon, Chairman of Friends of Good Hope Hospital at [info@friendsofgoodhope.org](mailto:info@friendsofgoodhope.org)

### **Donations**

All our donors have very personal reasons for choosing to give money to our hospital charity. Many are grateful patients or relatives who want to give something back to benefit future patients. Whatever the reason, we are always grateful to our donors and work with them to make sure their money is used in the way they want it to be.

To make a donation to the Charity call 0121 371 4852 or visit our website at [www.heartofenglandcharity.org.uk](http://www.heartofenglandcharity.org.uk) where you can donate on-line to your chosen service, hospital or fund.

### **£200,000 donation improves care for prostate cancer patients**

Patients with prostate cancer are being diagnosed quicker and treated more effectively at Good Hope Hospital thanks to a £200,000 donation from the Sutton Coldfield Charitable Trust. The money has allowed the Urology team to purchase a Fusion Prostate Biopsy Machine to benefit patients and increase the early detection and treatment of prostate cancer.

Mr Vivek Wadhwa, was the consultant urological surgeon instrumental in securing the donation from the Sutton Coldfield Charitable Trust. He welcomed the Charitable Trust and members of the Sutton Coldfield Prostate Cancer Support Group to a thank-you event where the Sutton Coldfield Lord Mayor, Charlotte Hodivala, unveiled the plaque recognising the donation.

Mr Wadhwa said: "We are so grateful for this generous donation from the Sutton Coldfield Charitable Trust. This new machine will allow us to much more accurately target areas of concern when diagnosing prostate cancer."

Ernie Murray, Chief Executive of the Sutton Coldfield Charitable Trust, said: "The remit of the Sutton Coldfield Charitable Trust is to support the health and wellbeing of local residents. Good Hope Hospital excels in this area and it is reassuring to know that many more patients will now benefit from early detection of prostate cancer as a result of the purchase of this equipment."



### **Last kind wish grants donation to Neonatal Unit**



The Neonatal Unit at Heartlands received an £800 donation thanks to the generosity of Elaine Forrest who passed away in 2016. Elaine had asked for donations instead of flowers at her funeral and her husband David and sons, Darren and Daniel, delivered the cheque to the unit. The donation allowed the unit to buy a new ventilator.

This was a cause close to Elaine's heart as son Darren was cared for in the unit when he was born six weeks prematurely and her other son Daniel's own son was also born early and cared for there.

David Forrest said: "She knew how passionate and dedicated the staff on the Neonatal unit are, every day they go the extra mile and do wonderful work. She didn't want any flowers but she asked for donations because she wanted the money to go to something close to her heart, to a good cause. She would be happy now knowing that it will make a difference."

## **Legacies**

The Charity has again benefited from a considerable number of legacies this year covering a broad array of funds and departments totalling over £282k.

The majority of our benefactors left a legacy in their will to their local hospital rather than a specific service and these funds are held in the specified Hospital General Fund to be spent where we think the need is greatest for our patients.

It can be a sensitive subject to discuss but if you are considering leaving a gift in your will we are here to offer advice and will always respect your wishes.

If you would like to discuss leaving a gift in your will please contact Mike Hammond on 0121 371 4852 or email [mike.hammond@uhb.nhs.uk](mailto:mike.hammond@uhb.nhs.uk)

## **Patients at Good Hope to benefit from anonymous donation**

Hundreds of patients are set to benefit from a significant anonymous donation to Good Hope Hospital worth tens of thousands of pounds.

The £56,900 funding was awarded to the Heart of England Foundation Trust Charity with a remit that it be invested into equipment to benefit patients at Good Hope.

The funds will be allocated to improve care for the elderly as well as patients of all ages visiting the physiotherapy and endoscopy units at the hospital. Equipment purchased will include a diathermy machine for the endoscopy unit which delivers a high-frequency electric current to generate deep heat in body tissues and help reduce pain for patients.

Other equipment purchased with the donation includes a state-of-the-art lifting chair, wheelchair, dumbbells, pedal exercisers and much more for the therapy team and equipment such as a bladder scanner and portable pulse oximeters (which read oxygen levels) for Ward 10.

## **Corporate Fundraising**

Corporate Fundraising has played a large part in our 2016/17 campaign and support from corporate partners has been an important contributor in our fundraising results.

## **Thousands raised from quiz night**



Patients on a lifesaving cancer unit at Heartlands are set to benefit thanks to a quiz night held by a city-based property company which raised £7,000 for the cause.

Hortons' Estate Limited made Ward 19 at Heartlands Hospital its chosen charity for 2016 and as part of their fundraising drive held a quiz night at Penny Blacks in the Mailbox.

In total 28 teams from businesses and organisations across the region took part in the European-themed quiz, including a team made up of staff from Ward 19, and raised a fantastic amount for the unit which treats patients with haematological cancers, including serious illnesses like leukaemia.

## **Forward Look**

During the last twelve months Heart of England NHS Foundation Trust, in its role as corporate trustee of the hospital charity, has made the decision that the best way forward to deliver its vision and purpose is to merge into the University Hospitals Birmingham (UHB) Charity to form one hospital charity which will support some of the major hospitals in Birmingham. This merger took place on 1 April 2017 and the UHB Charity number is 1165716. Next year's report will be under this charity number.

**Website:** [www.heartofenglandcharity.org.uk](http://www.heartofenglandcharity.org.uk)

# Governance

## **Our Trustee**

Heart of England NHS Foundation Trust has been the Corporate Trustee of the Charity during 2016/17 and is governed by the law applicable to trusts, principally the Trustee Act 2000 and also the law applicable to charities which is governed by the Charities Act 2011. The directors of the Corporate Trustee who were in office during 2016/17 can be found in the Trust's Annual Report and Accounts.

The Board has devolved responsibility for the on-going management of the charity to the Donated Funds Committee, which administers the funds on behalf of the Corporate Trustee. Under Charity Law neither Members of the Board nor members of the Donated Funds Committee are individual Trustees but represent the Corporate Trustee. Those serving on the Donated Funds Committee during 2016/17 were:

### **Mr Paul Hensel (Chairman)**

Paul was appointed as a Non-Executive Director to the Trust in August 2005 and served until July 2013. He was the non-executive lead for IT issues drawing on his 35 years' experience in the development and provision of IT systems and has remained a member of the Donated Funds Committee after his tenure as Non-Executive Director ended to provide support during the transition of the Charity to greater independence. He is also a Non-Executive Director of the John Taylor Hospice.

### **Rt. Hon. Jacqui Smith – Interim Chair**

Jacqui was appointed Interim Chair of the Trust Board on 1 December 2015, at which time she became a member of the Committee. Jacqui is also Chair of University Hospitals Birmingham NHS Foundation Trust and Birmingham Health Partners. Previously, she was elected MP for Redditch in 1997, serving for 13 years, and was appointed the first female Home Secretary in 2007.

### **Mr Albert Fletcher - Deputy Lead Governor**

Albert is the Trust Governor for Erdington and has a background working in Personnel and Employee Relations. He spent 25 years as the Chair of a school governing body and 30 years as a Justice of the Peace.

### **Mrs Angeline Jones – Chief Financial Controller**

Angeline, a Chartered Accountant, was appointed Chief Financial Controller of the Trust in April 2005 and has been an advisor to the Committee since then. In September 2014 she joined the Committee.

### **Ms Fiona Alexander**

Fiona is Interim Director of Communications and joined the Trust in November 2015 following 10 years in the same role at University Hospitals Birmingham NHS Foundation Trust. She has a dual role across both trusts. Before joining the NHS she spent 20 years in the media.

### **Mr David Burbridge**

David joined University Hospitals Birmingham NHS Foundation Trust as Director of Corporate Affairs in May 2007, following two periods of secondment to the Trust as Foundation Secretary. He became Interim Director of Corporate Affairs at HEFT in November 2015 and has a dual role across both trusts.

A qualified lawyer since 1999, he has worked with law firms based in Birmingham, London, Oxford and High Wycombe, specialising in corporate and company law. Prior to qualifying as a solicitor, David worked in the HM Customs & Excise National Investigation Service, investigating major drug smuggling and serious VAT fraud.

During the year four clinical division representatives also joined the Committee:

#### **Mr Alan Jones - Consultant Chemical Pathologist**

Alan joined the Trust as a Consultant in 1989, became Clinical Director of Laboratory Medicine in 1999, and Associate Medical Director for Clinical Support Services in 2011. He subsequently was appointed Director Division 1. His clinical interests are in Metabolic Medicine and Toxicology.

#### **Stuart Dale – Head of Operations, Division 5**

Stuart joined the Trust in 2001 as part of the Service Development Unit, undertaking the commissioning of services. He became Finance Manager for the Surgery Directorate in 2006 and in 2009, transferred to become General Manager for Trauma and Orthopaedics. Subsequently he was appointed as Group Manager for Theatres in 2012 and then to Head of Operations for Division 5 in 2016. His interests are in operational management and service delivery and improvement.

#### **Ann Edgar – Head Nurse Division 4**

Ann joined the Trust in 1990 as a Staff Nurse, became a Matron in 2007 and Associate Head Nurse in 2014. She was subsequently appointed as Divisional Head Nurse for Division 4 in 2016. This covers medicine and community. She is passionate about nursing and getting it right for Dementia Care and frailty.

#### **Richard Steyn – Deputy Medical Director**

Richard joined the Trust as a Consultant Thoracic Surgeon in 1999, became Associate Medical Director for Surgery in 2012. He was subsequently appointed as Divisional Director for Division 5 in 2016 and in 2017, Deputy Medical Director for the Trust. Richard is also an Honorary Professor at University of Warwick and is Chair of Charitable Company Directors at West Midlands Central Accident Resuscitation and Emergency Care Team.

#### **Donated Funds Committee**

The Donated Funds Committee is normally assisted in its deliberations by the Charitable Funds Manager and the Fundraising Manager. The Committee, on behalf of the Corporate Trustee, is responsible for the overall management of the Charity. Under those powers, the Committee is required to:

- Control, manage and monitor the use of the Charity's resources for the public benefit, having regard for guidance issued by the Charity Commission;
- Provide support, guidance and encouragement for all its income raising activities whilst managing and monitoring the receipt of all income;
- Ensure that best practice is followed in the conduct of all its affairs, fulfilling all of its legal responsibilities;
- Ensure that the Investment Policy approved by the Corporate Trustee is adhered to and that performance is continually reviewed whilst being aware of ethical considerations; and
- Keep the Corporate Trustee fully informed on the activity, performance of and risks to the Charity. The Donated Funds Committee confirms that it has complied with the duty in section 4 of the Charities Act 2011 to have due regard for the Charity Commission's general guidance on public benefit in planning the budget for each year and in setting or reviewing the guidelines for fund holders, who are authorised to spend charitable funds.

## How We Manage the Charity

The Charity was registered in accordance with the Act on 27 January 1996 (number: 1052330) and was established using the model Declaration of Trust. Charitable funds are held and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990. These funds are held on trust by the Corporate Trustee.

## Reserves Policy

The Trustee reviews the level of reserves required on an annual basis in line with the guidance issued by the Charity Commission. It recognises the need to ensure that the reserves held enable financial stability, are adequate to meet working capital requirements and can safeguard the Charity's current commitments against fluctuations in income levels. It has been the Trustee's policy to maintain the total funds year-on-year whilst allowing individual fund-holders to spend their available resources in accordance with the existing rules and procedures. In order to monitor the activity, the detailed income and expenditure is reviewed on a quarterly basis against an approved plan.

## Looking After Our Investments

The Donated Funds Committee endeavours to ensure that donations are spent effectively and efficiently for the Trust and its patients. This means that there will be time between receiving donations and spending them when they can be invested to further increase their value and earn extra income for the Charity.

The Donated Funds Committee appoints an independent advisor to perform a retrospective review of the investments and provide advice on amending the Investment Policy.

The management of the investments is performed by Investec Wealth & Investment. The Investment Manager's objective is to generate income of 3% per year and make short term asset allocation to add value whilst not knowingly investing in companies whose business is based directly on tobacco and/or tobacco-related products.

## The Cost of Governance

All charities have to spend some of their income on making sure things are carried out appropriately and that the organisation is effective and efficient.

Governance costs are now classified as support costs and have therefore been apportioned between fundraising activities and charitable activities in line with the Financial Reporting Standard (FRS 102) issued on July 2014.

Support costs total £99k for 2016 / 2017 (£103k 2015 / 2016)

## Our Advisors

The Charity uses a number of advisors to help run its activities;

### Banker

The Royal Bank of Scotland Plc  
79/83 Colmore Row  
Birmingham  
B3 2AP

### Independent Auditor

KPMG LLP  
One Snowhill  
Snowhill Queensway  
Birmingham  
B4 6GH

### **Investment Fund Manager**

Investec Wealth & Investment  
2 Gresham Street  
London  
EC2V 7QP

### **Solicitor**

DAC Beachcroft LLP  
Portwall Place  
Portwall Lane  
Bristol  
BS1 6NB

### **Risk Management**

The major risks to which the Charity is exposed have been identified and considered. The most significant risks identified were fluctuations in the value of investments due to volatility in world equity markets, the impact of a recession on levels of voluntary income and the value of legacies. These would imply a fall in the level of income and a lower capacity to generate reserves. In addition, reputational risks due to inappropriate or untimely use of funds were identified. These risks have been carefully considered and procedures have been put in place to ensure that over-spending does not occur and internal controls and reviews are in place for all expenditure requests. All funds hold sufficient balances so as not to prejudice the activity and support of the Charity.

The Charity continues to support and participate in the activities of the Association of NHS Charities. This Association is supported by almost all of the larger NHS charitable organisations and ensures that the Charity is kept informed and fully updated on all current and developing issues and knowledge shared with similar organisations.

Contact Details

**The Principal address of the Charity and Finance Office is:**  
**Heart of England NHS Foundation Trust**  
**1st Floor East Wing – Devon House**  
**Birmingham Heartlands Hospital**  
**Bordesley Green East**  
**Birmingham**  
**B9 5SS**

**Approved by the Trust Board on behalf of the Corporate Trustee**

**23 October 2017**

## **Statement of trustees' responsibilities**

The trustees are responsible for preparing the Trustees' Report and the financial statements in accordance with applicable law and regulations.

The law applicable to charities in England and Wales requires the trustees to prepare financial statements for each financial year. Under that law the trustees have prepared the financial statements in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards and applicable law). Under that law the trustees must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of the affairs of the charity and of the incoming resources and application of resources of the charity for that period. In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP;
- make judgments and estimates that are reasonable and prudent
- state whether applicable UK Accounting Standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charitable company will continue in business.

The trustees are responsible for keeping accounting records that are sufficient to show and explain the charity's transactions and disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provision of the Trust deed. They are also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustees are responsible for the maintenance and integrity of the charity and financial information included on the Charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

On behalf of the Trustee

Chair

**23 October 2017**

***Independent auditor's report to the trustee of Heart of England NHS Foundation Trust General Charitable Fund***

**To be provided by KPMG once audit completed (3 pages)**





## **Foreword to the Accounts**

The Corporate Trustee presents the Financial Statements for the year ended 31 March 2017 for Heart of England NHS Foundation Trust General Charitable Fund (“the Charity”).

The Financial Statements for the year ended 31 March 2017 have been prepared for the Corporate Trustee in accordance with the Charities Act 2011 chapter 25 and the Charities (Accounts & Reports) Regulations 2008. The Corporate Trustee for the year under review was Heart of England NHS Foundation Trust (“The Trust”). The Charity’s Financial Statements include all the separately established funds for which the patients, their carers, the staff of the Trust and the communities served by the Trust are the sole beneficiaries.

## Statement of Financial Activities for the year ended 31 March 2017

	Note	Unrestricted Funds £000	Restricted Funds £000	2016/17 Total Funds £000	2015/16 Total Funds £000
<b>Income from:</b>					
- Donations		612	0	612	414
- Legacies		282	0	282	174
- Grants		296	0	296	55
	1	1,190	0	1,190	643
- Fundraising Events		126	0	126	110
- Investments	8.3	216	0	216	237
		1,532	0	1,532	990
- Charitable activities.	2	339	0	339	404
<b>Total income</b>		<b>1,871</b>	<b>0</b>	<b>1,871</b>	<b>1,394</b>
<b>Expenditure on:</b>					
<i>Raising Funds</i>					
- Fundraising activities		32	0	32	118
- Investment Management Costs		51	0	51	43
<b>Total Costs of Raising Funds</b>		<b>83</b>	<b>0</b>	<b>83</b>	<b>161</b>
<i>Charitable activities:</i>					
- Salaries for Research & Clinical Support		203	0	203	128
- Purchase of New Equipment		958	0	958	1,018
- New Building and Refurbishment		204	0	204	204
- Staff Education and Welfare		389	0	389	472
- Patient Education and Welfare		111	0	111	101
<b>Total Charitable Activities</b>	4	<b>1,865</b>	<b>0</b>	<b>1,865</b>	<b>1,923</b>
<b>Total expenditure</b>		<b>1,948</b>	<b>0</b>	<b>1,948</b>	<b>2,084</b>
Net gains / (losses) on investments	8.1	963	0	963	(366)
<b>Net income/ (expenditure)</b>		<b>886</b>	<b>0</b>	<b>886</b>	<b>(1,056)</b>
Transfers	12	0	0	0	0
<b>Net outgoing resources before other recognised gains and losses</b>		<b>886</b>	<b>0</b>	<b>886</b>	<b>(1,056)</b>
<b>Net movement in funds</b>		<b>886</b>	<b>0</b>	<b>886</b>	<b>(1,056)</b>
Reconciliation of funds					
Fund balances brought forward at 1 April		5,685	1,695	7,380	8,436
<b>Fund balances carried forward at 31 March</b>	13	<b>6,571</b>	<b>1,695</b>	<b>8,266</b>	<b>7,380</b>

**Balance Sheet as at 31 March 2017**

	Note	Unrestricted Funds £000	Restricted Funds £000	Total at 31 March 2017 £000	Total at 31 March 2016 £000
<b>Fixed assets</b>					
Investments	8	6,386	1,695	<b>8,081</b>	7,660
<b>Total fixed assets</b>		<b>6,386</b>	<b>1,695</b>	<b>8,081</b>	<b>7,660</b>
<b>Current assets</b>					
Debtors	9.1	181	0	<b>181</b>	89
Cash at bank and in hand	9.2	304	0	<b>304</b>	149
<b>Total current assets</b>		<b>485</b>	<b>0</b>	<b>485</b>	<b>238</b>
Creditors: Amounts falling due within one year	10	300	0	<b>300</b>	518
<b>Total current liabilities</b>		<b>300</b>	<b>0</b>	<b>300</b>	<b>518</b>
<b>Net current assets</b>		<b>185</b>	<b>0</b>	<b>185</b>	<b>(280)</b>
<b>Total assets less current liabilities</b>		<b>6,571</b>	<b>1,695</b>	<b>8,266</b>	<b>7,380</b>
<b>The Funds of the Charity</b>					
Restricted income funds	13.1	0	1,695	<b>1,695</b>	1,698
Unrestricted income funds	13.2	6,571	0	<b>6,571</b>	5,682
<b>Total charity funds</b>		<b>6,571</b>	<b>1,695</b>	<b>8,266</b>	<b>7,380</b>

The accounting policies and notes on pages 28 to 40 form part of these financial statements.  
The financial statements were approved by the board and signed on its behalf by:

Chair

**Statement of Cash Flows for the year ended 31 March 2017**

	Total Funds 31 March 2017 £000	Total Funds 31 March 2016 £000
<b>Cash Flows from operating activities:</b>	<b>(603)</b>	<b>(728)</b>
<b>Net cash provided by ( used in) operating activities</b>		
<b>Cash Flows from investing activities</b>		
Dividends and interest.	216	237
Proceeds from sale of investments	1,106	862
Purchase of investments	<u>(564)</u>	<u>(792)</u>
<b>Net cash provided by ( used in ) investing activities</b>	<b>758</b>	<b>307</b>
<b>Change in cash and cash equivalents in the reporting period</b>	<b>155</b>	<b>(421)</b>
<b>Cash and cash equivalents at the beginning of the reporting period.</b>	<b>149</b>	<b>570</b>
<b>Cash and cash equivalents at the end of the reporting period.</b>	<b><u>304</u></b>	<b><u>149</u></b>

**Reconciliation of Net income / (expenditure) to net cash flow from operating activities**

	31 March 2017 £000	31 March 2016 £000
<b>Net income / Expenditure for the year as per the Statement of Financial Activities</b>	<b><u>886</u></b>	<b><u>(1,056)</u></b>
<b>Adjustments for:-</b>		
Depreciation charges	0	0
(Gains)/ losses on investments	(963)	366
Dividends and interest	(216)	(237)
Loss / (profit) on the sale of fixed assets	0	0
(Increase)/ decrease in stocks	0	0
(Increase)/ decrease in debtors	(92)	(52)
Increase/ (decrease) in creditors	(218)	251
<b>Net cash provided by (used in) operating activities</b>	<b><u>(603)</u></b>	<b><u>(728)</u></b>

## ACCOUNTING POLICIES

### 1. Accounting Policies

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at market value.

The Accounts (Financial Statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland ( FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland ( FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The Charity transferred to University Hospitals Birmingham (UHB) Charity on 1 April 2017.

### 2. Reconciliation with previous generally accepted accounting practice.

In preparing these accounts, the trustees have considered where any restatement of comparatives was required to comply with FRS 102 and the Charities SORP FRS 102. No restatement was required.

### 3. Funds Structure.

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified as a *restricted income fund* where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

Those funds which are not restricted income funds are *unrestricted income funds* which are sub analysed between *designated (earmarked) funds* where the donor has made known their non-binding wishes or where members of the Corporate Trustee,

at their discretion, have created a specific fund for a specific purpose, and *wholly unrestricted funds* which are wholly at the Trustee's unfettered discretion.

The major funds held in each of these categories are disclosed in note 13.2.

Transfers between funds are approved from time to time normally following a request from an individual fund holder. These will be sanctioned only after full consideration to ensure that the donor's wishes are not compromised and that the transfer will result in the funds being committed more quickly for the purpose for which they were given.

All of the unrestricted income funds are now regarded as designated funds following the approval of the Corporate Trustee with the exception of the General Purposes Fund to ensure that expenditure is in accordance with donor's wishes and all new funds when approved are on that basis.

#### **4. Incoming Resources**

All incoming resources, with the exception of legacies, are included in the Statement of Financial Activities when the Charity is legally entitled to the income and the amount can be quantified with reasonable accuracy.

Incoming resources from legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

Legacies which have been notified but not recognised as incoming resources, where material, have not been included in the Statement of Financial Activities (SOFA) but are disclosed in note 14 to the financial statements with an estimate of the amount receivable. Donations, grants and fundraising income are included in the Statement of

Financial Activities upon receipt of the income or an invoice raised, whichever is sooner. Investment income is accounted for on an accrual basis.

Gifts in kind are either;

i Assets given for distribution by the charity are included in the SOFA only when distributed.

ii Donated services and facilities are included in the SOFA where the benefit to the charity is reasonably quantifiable and measurable.

In both cases, the amount at which gifts in kind are recognized is either a reasonable estimate of their value or the actual amount realized.

## **5. Resources Expended**

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category. The categories are selected to reflect those areas where the Charity provides or is willing to provide greatest support to the Trust. The Charity supports these activities by means of grants either by paying for goods and services directly or reimbursing the actual expenditure where the Trust has made the payment such as for salary costs. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

## **6. Irrecoverable VAT**

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

## **7. Allocation of Overhead Support Costs**

Support costs are those costs which do not relate directly to a single activity. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis.

## **8. Fixed Asset Investments**

Investments are a form of basic financial instrument. Fixed asset investments are initially recognised at their transaction value and are subsequently measured at their fair value (market value) as at the balance sheet date. The statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year. Quoted stocks and shares are included in the Balance Sheet at the current market value quoted by the investment analyst, excluding dividend.

## **9. Debtors**

Debtors are amounts owed to the charity.

They are measured on the basis of their recoverable amount.

## **10. Cash and cash Equivalents**

Cash balances that are surplus to immediate requirements are invested on the money market to obtain better returns than in the high interest account with the Charity's bankers for an appropriate period.

## **11. Creditors**

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

Amounts which are owed in more than a year are shown as long term creditors.

## **12. Realised Gains and Losses**

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and purchase price.

Unrealised gains and losses are calculated as the difference between the market value at the year end and the opening market value (or purchase price if later).

## **13. Pension Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme. Employers 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.

## **14. Pooling Scheme**

The Charity does not operate a pooling scheme because the Charity operates as a single registered Charity containing a number of unrestricted and restricted funds in furtherance of its charitable objectives.

## **15. Cash Flow Statement**

Cash Flow statement as prepared under the requirements of FRS 102.

**1 Income from donations, legacies and grants.**

	<b>Unrestricted Funds £000</b>	<b>Restricted Funds £000</b>	<b>Total 2016/17 £000</b>	<b>Total 2015/16 £000</b>
Donations from individuals	266	0	<b>266</b>	132
Donations from companies	346	0	<b>346</b>	282
Legacies	282	0	<b>282</b>	174
Grants	296	0	<b>296</b>	55
	<b>1,190</b>	<b>0</b>	<b>1,190</b>	<b>643</b>

**2 Income from charitable activities.**

The income was derived from fees for the provision of training and education and totalled £168,000 (2015/16: £245,000).

Additionally support was received from Commercial organisations and individuals who derive some benefit from the support provided. This amounted to £70,000 (2015/16: £60,000). Other items which are not regarded as donations amounted to £101,000 (2015/16: £99,000).

Fundraising Income includes income from events which do not take place under the direction of the Charity's fundraising team, but by volunteers.

**3 Support Costs and Overheads****3.1 Analysis of Expenditure :**

	<b>Unrestricted Funds £000</b>	<b>Restricted Funds £000</b>	<b>Total 2016/17 £000</b>	<b>Total 2015/16 £000</b>
Financial administration	42	0	<b>42</b>	21
Salaries and related costs	36	0	<b>36</b>	59
External audit	15	0	<b>15</b>	15
Internal Audit	6	0	<b>6</b>	4
Stationery	0	0	<b>0</b>	2
Review of Investments	0	0	<b>0</b>	2
	<b>99</b>	<b>0</b>	<b>99</b>	<b>103</b>

**3.2 Governance Costs**

Previously these have been separately analysed on the face of the Statement of Financial Activity. Governance costs are now classed as support costs and have therefore been apportioned between fundraising activities and charitable activities. There is no effect on the total expenditure for 2015/6 or 2016/7

**4 Charitable Activities**

The Charity did not undertake any direct charitable activities during the year. Grants were approved in favour of beneficiaries and the Charity either incurred expenditure with third parties in pursuance of those grants or reimbursed expenditure incurred by beneficiaries.

Support costs attributable to charitable expenditure which amount to 5.7% (2015/16: 5.7%) of direct expenditure have been allocated proportionately to total spend. This apportionment policy is considered appropriate to the Charity by avoiding a disproportionate apportionment to high

	<b>Grant Funded Activity £000</b>	<b>Support Costs £000</b>	<b>Total 2016/17 £000</b>	<b>Total 2015/16 £000</b>
Salaries	193	10	<b>203</b>	128
Purchase of New Equipment	907	51	<b>958</b>	1,018
Building and Refurbishment	193	11	<b>204</b>	204
Staff Education and Welfare	368	21	<b>389</b>	472
Patient Education and Welfare	105	6	<b>111</b>	101
	<b>1,766</b>	<b>99</b>	<b>1,865</b>	<b>1,923</b>

**5 Grants**

The Charity does not make grants to individuals. The total cost of making grants is disclosed in the Statement of Financial Activities as 'Total Charitable Activities'. The beneficiary of the above grants is Heart of England NHS Foundation Trust to support activities that are not wholly funded by the NHS.

**6 Analysis of Staff Costs**

	<b>Total 2016/17 £000</b>	<b>Total 2015/16 £000</b>
Salaries and wages	<b>29</b>	28
Social security costs	<b>2</b>	2
Other pension costs	<b>4</b>	4
	<b>35</b>	<b>34</b>
Average monthly full time equivalent employees in the year:	<b>1</b>	<b>1</b>

No employees had emoluments in excess of £60,000 (2015/16: nil).

The employee is employed by Heart of England NHS Foundation Trust and spends 100% of his/her time on the administrative work of the Charity. The actual total cost is charged to the Charity. 2016/2017 salaries cost unchanged from 2015/2016. The employer's contributions made to the NHS Pension Scheme in 2015/16 were £4k (2015/16: £4k). The employee is covered by the provisions of the NHS Pensions 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.

**6.1 Agency Costs**

Included in the Accounts for 2016/2017 Agency Costs of £26k relating to support (2015/2016: £37k).

**7 Auditor's Remuneration**

The auditor's remuneration of £14,833 including VAT (2015/16: £15,360) related solely to statutory audit work. The Charity did not commission any additional work from the auditor.

**8 Fixed Asset Investments****8.1 Movements during the year**

	<b>31 March 2017 £000</b>	31 March 2016 £000
Market value at 1 April	<b>7,660</b>	8,096
Less: Disposals at selling price	<b>(847)</b>	(862)
Less: Movement in Capital Investment cash balance	<b>(259)</b>	
Add: Acquisitions at cost	<b>564</b>	792
Net gain on revaluation	<b>963</b>	(366)
Market value at 31 March	<b>8,081</b>	7,660
Historic cost at 31 March	<b>6,788</b>	7,561

**8.2 Market value**

	<b>31 March 2017 Total Cost £000</b>	31 March 2016 Total Held in UK £000	31 March 2016 Total Held in UK £000
UK Equities	2,758	<b>3,165</b>	2,793
Overseas Equities	1,307	<b>2,091</b>	1,708
Fixed Interest	1,537	<b>1,626</b>	1,476
Alternative Investments	633	<b>583</b>	706
Property	531	<b>594</b>	696
Cash held as part of the Investment Portfolio	22	<b>22</b>	281
	<b>6,788</b>	<b>8,081</b>	7,660

The Charity has holdings in Equities, fixed interest, property, alternative investment funds and overseas investments, which are intended to provide a balanced portfolio and minimise risk. These provide a return of income above cash deposit interest rates and invest in a wide spread of investments. There were no individual material investments of more than 5% value in the portfolio.

**8.3 Activities for generating funds:**

<b>Investment income</b>	<b>Held in UK £000</b>	<b>2016/17 Total £000</b>	2015/16 Total £000
Fixed Asset Investments	216	<b>216</b>	237
Cash held in High Interest Bearing Account	0	<b>0</b>	0
	<b>216</b>	<b>216</b>	237

HEART OF ENGLAND NHS FOUNDATION TRUST GENERAL CHARITABLE FUND

9	Analysis of Current Assets	31 March 2017 Total £000	31 March 2016 Total £000
9.1	Debtors		
	Other debtors	181	89
	<b>Total debtors all falling due within one year</b>	<b>181</b>	<b>89</b>
9.2	Analysis of cash and cash equivalents.		
		31 March 2017 £000	31 March 2016 £000
	Cash at bank and in hand	304	149
	<b>Total cash and cash equivalents.</b>	<b>304</b>	<b>149</b>
	The deposit is held in RBS		
10	Creditors: amounts falling due within one year	31 March 2017 £000	31 March 2016 £000
	Creditors - due to Heart of England NHS Foundation Trust	250	212
	Other creditors.	28	109
	Accruals	22	197
	<b>Total creditors all falling due within one year</b>	<b>300</b>	<b>518</b>

11	Commitments	Charitable Salary Obligations £000	31 March 2017 Total £000	31 March 2016 Total £000
11.1	Movements During the Year			
	Commitments at the start of the year	37	37	37
	Decrease in commitments in the year	(37)	(37)	(37)
	Commitments outstanding at the end of the year	<u>0</u>	<u>0</u>	<u>0</u>
11.2	Timing of Commitments			
	Commitments payable within one year	0	0	0
	Commitments outstanding at the end of the year	<u>0</u>	<u>0</u>	<u>0</u>

## 12 Transfers

There were no transfers between restricted and unrestricted funds during the year ( 2015/16 : £0k). There were transfers between unrestricted funds during the year of £141k (2015/16: £127k) , of which a total of £125k (2015/2016: £52k) exceeded £10k individually.

These 4 ( 2015/2016: 3) transfers related to the transfer of:-

GHH Haematology Fund	to	GHH Chemotherapy Fund
Diversity and Equality Fund	to	Medical Retina Fund
Special Activities	to	Gwendoline Starkey Memorial Fund
Medical Retina Fund	to	Diversity and Equality Fund

## 13 Analysis of Charitable Funds

### 13.1 Restricted Income Funds

	Balance 31 March 2016 £000	Incoming Resources £000	Resources Expended £000	Transfers £000	Gains and (Losses) £000	Balance 31 March 2017 £000
Hollier Charity - GHH	1,681	(1)	0	0	0	1,680
Specialised Equipment - GHH	5	0	0	0	0	5
Post Grad Medical Centre - GHH	12	1	(3)	0	0	10
	<u>1,698</u>	<u>0</u>	<u>(3)</u>	<u>0</u>	<u>0</u>	<u>1,695</u>

### Nature and purpose of Accounts - restricted

NAME OF FUND	DESCRIPTION OF NATURE AND PURPOSE OF FUND
Hollier Charity - GHH	Post Graduate Medical Centre, to fund lecture room and for the training and education of Junior doctors.
Specialised Equipment - GHH	Purchase of specialised equipment
Post Graduate Medical Centre - GHH	Development and maintenance of the centre and the advancement of education and training medical staff.

## 13.2 Unrestricted Income Funds

	Balance 31 March 2016 £000	Incoming Resources £000	Resources Expended £000	Transfers £000	Gains and Losses £000	Balance 31 March 2017 £000
LEUKAEMIA AND CANCER FUND	362	35	(12)	0	0	385
GHH GENERAL PURPOSE FUND	444	29	(122)	0	0	351
SOLIHULL GENERAL MANAGEMENT	233	19	(17)	0	0	235
WARD 19 CHARITY FUND	161	132	(76)	0	0	217
RENAL UNIT	162	16	(19)	0	0	159
BACTERIOLOGY	121	39	(42)	0	0	118
THE EDUCATION FUND	94	19	1	0	0	114
HEARTLANDS WARD 19	111	34	(34)	0	0	111
CANCER RESEARCH	92	0	0	0	0	92
RHEUMATOLOGY	92	1	(6)	0	0	87
PATIENT PROPERTY FUND	74	5	(0)	0	0	78
RESUSCITATION TRAINING	41	103	(70)	0	0	74
IMMUNOLOGY	67	3	(5)	0	0	65
NEW MATERNITY SCAN FUND	45	36	(26)	0	0	55
RHEUMATOLOGY RESEARCH FUND	50			0	0	50
MATERNITY UNIT	87	20	(57)	0	0	50
Other Unrestricted Funds	2,642	1,380	(1,460)	0	0	2,562
	<b>4,878</b>	<b>1,871</b>	<b>(1,945)</b>	<b>0</b>	<b>0</b>	<b>4,803</b>

Reconciliation of unapportioned gains on revaluation of investments:

	Restricted Fund £000	Unrestricted Fund £000	Total Fund £000
Funds balances at 31 March 2017	1,695	4,803	6,498
Unapportioned revaluation on Investments	0	1,768	1,768
Fundraising cost	0	0	0
Dividend Accrual		0	0
Fund Balances per SOFA at 31 March 2017	<b>1,695</b>	<b>6,571</b>	<b>8,266</b>

There are a further 288 (2015/16: 276) funds with balances of less than £50,000 as detailed over page:

**13.2 Unrestricted Income Funds (continued)**

	<b>31 March 2017</b>	31 March 2016
£40,000 to £49,999	<b>8</b>	11
£30,000 to £39,999	<b>11</b>	9
£20,000 to £29,999	<b>13</b>	15
£10,000 to £19,999	<b>43</b>	31
under £10,000	<b>213</b>	210

The Trustee sets a closing balance of £50,000 or above as the threshold for reporting material designated (D) and wholly unrestricted (U) funds. In the interests of accountability and transparency a summary of all these funds is available upon written request.

All unrestricted funds may be used for any charitable purpose or purposes relating to the National Health Service. The Trustee is the ultimate parent and controlling party.

**13.3 Nature and purpose of Accounts - unrestricted**

All of the unrestricted and designated funds are available for any charitable purpose relating to the NHS but are wholly or mainly for the stated purpose contained in the funds title. The designated funds relate to other wards and clinical departments within Heart of England NHS Foundation Trust for which donors have indicated their non-binding wishes when making their generous gifts. Where a legacy has been received a separately identified fund is normally set up to ensure that the terms of the legacy are respected.

NAME OF FUND	DESCRIPTION OF NATURE AND PURPOSE OF FUND
D Leukaemia and Cancer Fund	Treatment, care and training
U Good Hope General Purpose	General purposes at Good Hope Hospital
U Solihull General Purpose	General purpose at Solihull Hospital
D Ward 19 Charity Fund	Fundraising fund for treatment, care and training
D Renal Unit	Treatment, care and training
D Bacteriology	Study of germs
D Faculty Of Education	Training & education
D Heartlands Ward 19	Treatment, care and training
D Cancer Research	Research into Cancer
D Rheumatology	For the benefit of rheumatology
D Patient Property Fund	Patient welfare and amenities
D Resuscitation Training	Training & education
D Immunology	Treatment, care and training
D New Maternity Scan Fund	Treatment, care and training
D Rheumatology Research Fund	Research into Rheumatology
D Maternity Unit	Treatment, care and training

**14 Material Legacies**

There are no material outstanding legacies (2015/16: nil) that have been included in the Statement of Financial Activities.

**15 Post Balance Sheet Event**

The Charity transferred to University Hospitals Birmingham (UHB) Charity on 1 April 2017.

**16 Related Party Transactions**

During the financial year none of the members of the Corporate Trustee or members of the key management staff or parties related to them were beneficiaries from the Charity.

The Charity has made revenue and capital payments to Heart of England NHS Foundation Trust which is the Corporate Trustee.

During the financial year the Charity made payments to the Heart of England NHS Foundation Trust to reimburse it for payments made on behalf of the Charity. These amounted to £1,352,931 (2015/16: £1,231,511). The Charity owed the Trust £61,010 at 31 March 2017 (31 March 2016: £212,157).

The total turnover (operating income) of Heart of England NHS Foundation Trust amounted to £709,137,000 for 2016/17 (2015/16: £672,411,000).

Neither the Corporate Trustee or any member of its Board received honoraria, emoluments or expenses from the Charity in the year and the Trustee has not purchased trustee indemnity insurance.

Birmingham Heartlands Hospital  
Bordesley Green East  
Birmingham  
B9 5SS

Andrew Bostock  
Partner  
KPMG LLP  
One Snowhill  
Snowhill Queensway  
Birmingham  
B4 6GH

23 October 2017

Dear Andrew,

This representation letter is provided in connection with your audit of the financial statements of Heart of England NHS Foundation Trust General Charitable Fund (“the Charity”), for the year ended 31 March 2017, for the purpose of expressing an opinion:

- i. as to whether these financial statements give a true and fair view of the state of the Charity’s affairs as at 31 March 2017 and of its surplus or deficit for the financial year then ended;
- ii. whether the financial statements have been properly prepared in accordance with UK Generally Accepted Accounting Practice (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and
- iii. whether the financial statements have been prepared in accordance with the Charities Act 2011.

These financial statements comprise the Balance Sheet, the Statement of Financial Activities, the Cash Flow Statement, and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Trustee confirms that the Charity is exempt from the requirement to also prepare consolidated financial statements.

The Trustee confirms that the representations they make in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Trustee confirms that, to the best of their knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing themselves:

### **Financial statements**

1. The Trustee has fulfilled their responsibilities, as set out in the terms of the audit engagement dated, for the preparation of financial statements that:
  - i. give a true and fair view of the state of the Charity's affairs as at the end of its financial year and of its surplus or deficit for that financial year;
  - ii. have been properly prepared in accordance with UK Generally Accepted Accounting Practice ("UK GAAP") (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and
  - iii. have been prepared in accordance with the Charities Act 2011.

The financial statements have been prepared on a going concern basis.

The Trustee confirms that the Charity meets the definition of a qualifying entity and meets the criteria for applying the disclosure exemptions with Financial Reporting Standard 102.

2. Measurement methods and significant assumptions used by the Trustee in making accounting estimates, including those measured at fair value are reasonable.
3. All events subsequent to the date of the financial statements and for which section 32 of FRS 102 requires adjustment or disclosure have been adjusted or disclosed.

### **Information provided**

4. The Trustee has provided you with:
  - access to all information of which they are aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
  - additional information that you have requested from the Trustee for the purpose of the audit; and
  - unrestricted access to persons within the Charity from whom you determined it necessary to obtain audit evidence.
5. All transactions have been recorded in the accounting records and are reflected in the financial statements.

6. The Trustee confirms the following:

- i) The Trustee has disclosed to you the results of their assessment of the risk that the financial statements may be materially misstated as a result of fraud.

Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

ii) The Trustee has disclosed to you all information in relation to:

- a) Fraud or suspected fraud that it is aware of and that affects the Charity and involves:
- management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements; and
- b) allegations of fraud, or suspected fraud, affecting the Charity's financial statements communicated by employees, former employees, analysts, regulators or others.

In respect of the above, the Trustee acknowledges their responsibility for such internal control as they determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Trustee acknowledges their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

7. The Trustee has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
8. The Trustee has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with section 21 of FRS 102 all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.
9. The Trustee has disclosed to you the identity of the Charity's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with section 33 of FRS 102.

The Trustee confirms that the Charity, including all assets and liabilities transferred to University Hospitals Birmingham Charity on 1 April 2017.

10. The Trustees confirms that all charity activity income disclosed within the financial statements was undertaken for the charitable purposes of the charity and therefore appropriate to recognise within the financial statements, notably in regards to research and education related income.

This letter was tabled and agreed at the meeting of the Trustee on 23 October 2017.

Yours sincerely,

**Dame Julie Moore**  
**Interim Chief Executive,**  
**for and on behalf of the Board of Heart of England NHS Foundation Trust**

## **Appendix to the Trustees' Representation Letter of Heart of England NHS Foundation Trust General Charitable Fund: Definitions**

### **Financial Statements**

A complete set of financial statements comprises:

- a Balance Sheet as at the end of the period;
- a Statement of Financial Activities for the period;
- a Cash Flow Statement for the period; and
- notes, comprising a summary of significant accounting policies and other explanatory information.

### **Material Matters**

Certain representations in this letter are described as being limited to matters that are material.

FRS 102 states that:

Omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or combination of both, could be the determining factor.

### **Fraud**

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

### **Error**

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

- a) was available when financial statements for those periods were authorised for issue; and

- b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

## **Management**

For the purposes of this letter, references to “management” should be read as “management and, where appropriate, those charged with governance”.

## **Qualifying Entity**

A member of a group where the parent of that group prepares publicly available consolidated financial statements which are intended to give a true and fair view (of the assets, liabilities, financial position and profit or loss) and that member is included in the consolidation by means of full consolidation.

## **Related Party and Related Party Transaction**

### **Related party:**

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in FRS 102 as the “reporting entity”).

- a) A person or a close member of that person’s family is related to a reporting entity if that person:
  - i. has control or joint control over the reporting entity;
  - ii. has significant influence over the reporting entity; or
  - iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.
  
- b) An entity is related to a reporting entity if any of the following conditions apply:
  - i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
  - ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
  - iii. Both entities are joint ventures of the same third party.
  - iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
  - v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
  - vi. The entity is controlled, or jointly controlled by a person identified in (a).

- vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).
- viii. The entity, or any member of a group of which is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity.

**Related party transaction:**

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

# Heart of England NHS Foundation Trust General Charitable Fund

Audit highlights  
memorandum and  
management letter  
for the year ended 31  
March 2017

August 2017



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Our objective is to use our knowledge of the Heart of England NHS Foundation Trust General Charitable Fund, gained during our routine audit work, to make useful comments and suggestions for you to consider. However, you will appreciate that our routine audit work is designed to enable us to form opinions on the Heart of England NHS Foundation Trust General Charitable Fund's financial statements and it should not be relied upon to disclose all irregularities that may exist, nor to disclose errors that are not material to the financial statements and contributions.

This report is made solely to the Trustee of the Heart of England NHS Foundation Trust General Charitable Fund, in accordance with the terms of our engagement. It has been released to the Trustee on the basis that this report shall not be copied, referred to or disclosed, in whole (save for the Trustee's own internal purposes) or in part, without our prior written consent. Matters coming to our attention during our audit work have been considered so that we might state to the Trustee those matters we are required to state to the Trustee in this 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 Charity and its Trustee, for our work referable to this report, for this report, or for the opinions we have formed.

Please note that that this report is confidential between the Trustee and this firm. Any disclosure of this report beyond what is permitted above will prejudice this firm's commercial interests. A request for our consent to any such wider disclosure may result in our agreement to these disclosure restrictions being lifted in part. If the Trustee receive a request for disclosure of this report under the Freedom of Information Act 2000, having regard to these actionable disclosure restrictions you must let us know and you must not make a disclosure in response to any such request without our prior written consent.



# Summary

The purpose of this memorandum is to set out the significant issues that came to our attention during the course of the audit of Heart of England NHS Foundation Trust General Charitable Fund for the year ended 31 March 2017.

<b>Audit conclusions</b>	
✓	We propose an unqualified audit opinion on the financial statements, containing an emphasis of matter paragraph which explains the transfer of the Charity to University Hospitals Birmingham Charity on 1 April 2017.
<b>Accounting matters</b>	
✓	<p>As at 1 April 2017 the Charity transferred all assets and liabilities to University Hospitals Birmingham Charity. We obtained the legal transfer documentation and worked with the Finance team to ensure the appropriateness of the going concern wording within the accounts to reflect the transfer. We also requested that the accounts disclose the transfer as a Post Balance Sheet Event within Note 15.</p> <p>As part of our testing of revenue we noted items of income, notably charitable activities income, where it was difficult to verify whether the activity was undertaken for the charitable purposes of the charity, or a normal Trust operation, particularly in regards to research and education activities. To some degree this is indicative of the strong connection between the Charity and Education and Research departments within the Trust. Whilst ultimately we were able to satisfy ourselves that income recognition was appropriate, we have raised a recommendation to support increased clarity between Trust and Charity income going forward.</p> <p>There are two audit adjustments identified during the course of the audit, both of which have been corrected. These are set out within Appendix 2. There are no uncorrected audit adjustments.</p> <p>There were no other accounting issues which arose during the course of our audit.</p>
✓	The financial statements adopted appropriate accounting policies and are in accordance with disclosure requirements of relevant charities legislation, UK GAAP (FRS 102) and the Statement of Recommended Practice.
<b>Auditing matters</b>	
✓	We have successfully completed those procedures as set out on page 11 of our External Audit Plan presented to the Trust's Audit Committee on 24 October 2017.
✓	<p>Whilst no significant audit issues arose during the course of our audit, there have been some staffing issues related to the Charity during the year including staff sickness for key individuals which did impact on the audit. However, Trust staff worked to support the audit and we had good co-operation throughout the audit process.</p> <p>There are a number of presentational updates required to the draft accounts presented for audit.</p>

# Summary

The purpose of this memorandum is to set out the significant issues that came to our attention during the course of the audit of Heart of England NHS Foundation Trust General Charitable Fund for the year ended 31 March 2017.

<b>Auditing matters (cont.)</b>	
✓	At the date of writing this report, we had the following audit areas outstanding; <ul style="list-style-type: none"><li>— final Partner review;</li><li>— finalisation procedures; and</li><li>— receipt of Management Representation Letter.</li></ul>
<b>Systems and controls</b>	
✓	We have made 2 recommendations in regards to controls, both of which are considered medium priority. These are set out in Appendix 3.
✓	We identified no major weaknesses in the financial systems or controls in the current year. Our control recommendations are set out in Appendix 3.
<b>Regulatory and tax matters</b>	
✓	No significant regulatory or tax matters came to our attention during the course of our normal audit work.

# Audit approach and findings

We highlight significant findings in respect of the risks and other areas of focus for our audit identified in our discussion with you at the audit planning and strategy stage. We have dealt with them as set out in the right hand column.

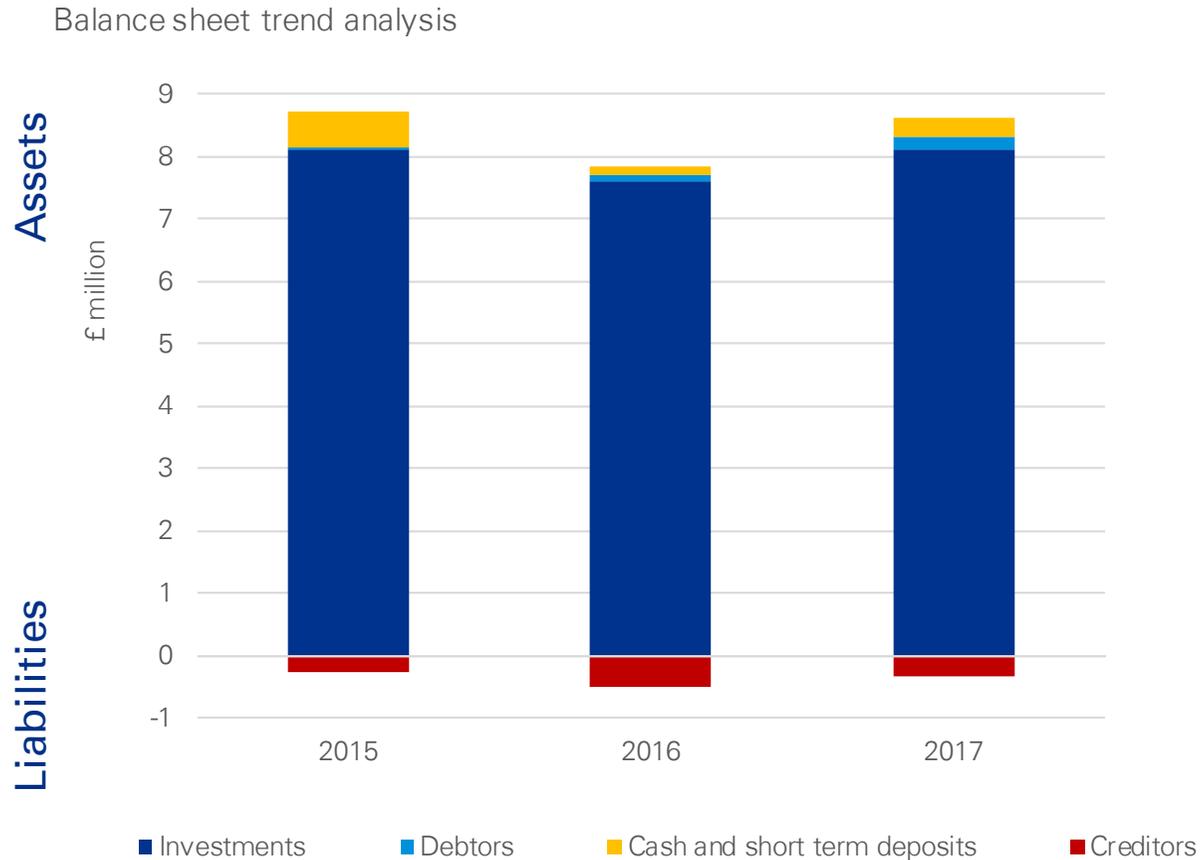
Significant risks	Audit area	Proposed work	Our findings from the audit
Significant risk area required by ISA's <b>Fraud Risk from Revenue Recognition</b>	Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk.	We will review the terms of legacies and corresponding treatment to ensure the completeness and restriction of the revenue.  We consider the restricted or unrestricted nature of funding as well as the period of recognition in line with recognition criteria in accordance with SORP FRS 102.	There were no issues arising in regards to revenue recognition. We have however raised a recommendation in regards to increasing clarity in regards to Trust and Charity income, notably related to Education and Research activities.
Significant risk area required by ISA's <b>Fraud risk from management override of controls</b>	Professional standards require us to communicate the fraud risk from management override of controls as significant. This is because management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.  We have not identified any specific additional risks of management override relating to this audit	We have considered management override of controls as a significant fraud risk. We have not identified any specific risk factors that increase the risk of management override.  We will carry out specific testing over journals, judgements & estimates, and any significant or unusual transactions.	There were no issues arising from our audit work in regards to the fraud risk from management override of controls.

# Audit approach and findings (cont.)

Other area of audit focus	Audit area	Proposed work	Our findings from the audit
Other area of audit focus	<p><b>Going concern disclosures</b></p>	<p>In light of the transfer of the Charity to the University Hospitals Birmingham Charity, the Charity's accounts will need to contain appropriate disclosures, including disclosing the transfer as a Post Balance Sheet Event.</p>	<p>We will work with the Charity to ensure that going concern and post balance sheet event disclosures are appropriate.</p> <p>We obtained the underlying legal transfer documentation and worked with the Finance team to ensure the appropriateness of the going concern wording within the accounts to reflect the transfer. We also requested that the accounts disclose the transfer as a Post Balance Sheet Event in Note 15.</p> <p>We are satisfied that these disclosures are appropriate.</p>

# Summary of financial performance - assets and liabilities

The Charity's asset base has remained broadly constant over the three year period, as the Charity continues to support the Trust through charitable activity spend. There is a strong investment position.





# Appendices

1. Mandatory communications
2. Summary of audit differences
3. Control observations raised in current year
4. Auditor independence

# Mandatory communications

We set out below details of the required communications to the Trustee.

<b>Other information in documents containing audited financial statements</b>	Our responsibility for other information in the Charity's Annual Report and Financial Statements does not extend beyond the financial information identified in our auditors' report. We have no obligation to perform any procedures to corroborate other information contained in those documents. However, prior to approval and signing we will continue to read the other information included in the Annual Report, and confirm that the information given, and the manner of its presentation, is materially consistent, with the financial statements.
<b>Disagreement with management</b>	There have been no disagreements with management on financial accounting and reporting matters that, if not satisfactorily resolved, would have caused a modification of our auditor's report on the financial statements.
<b>Consultation with other accountants</b>	To the best of our knowledge, management has not consulted with or obtained opinions, written or verbal, from other independent accountants during the past year that were subject to the requirements of Statement 1.213 of the Institute of Chartered Accountants in England and Wales Guide of Professional Ethics.
<b>Difficulties encountered in performing the audit</b>	<p>There have been some staffing issues related to the Charity during the year including staff sickness for key individuals which did impact on the audit. However, Trust staff worked to support the audit and we had good co-operation throughout the audit process.</p> <p>As part of our testing of revenue we noted items of income, notably charitable activities income, where it was difficult to verify whether the activity was undertaken for the charitable purposes of the charity, or a normal Trust operation, particularly in regards to research and education activities. To some degree this is indicative of the strong connection between the Charity and Education and Research departments within the Trust. Whilst ultimately we were able to satisfy ourselves that income recognition was appropriate, we have raised a recommendation to support increased clarity between Trust and Charity income going forward.</p>
<b>Material written communications</b>	<p>In accordance with the communication requirements of International Standard on Auditing (UK and Ireland) 260, we provide the following written communications to the Trustee for their meeting on the 23 October 2017.</p> <ul style="list-style-type: none"> <li>— Report to Those Charged with Governance – This is the main body of this report; and</li> <li>— KPMG Independence communication – Appendix 4 to this report.</li> </ul>
<b>Management Representations</b>	<p>In accordance with ISA 580 <i>Written representations</i>, we request written representations from Those Charged with Governance. Written representations are necessary information we require in connection with the audit.</p> <p>The draft written representations will be provided within the papers for the meeting on 23 October 2017.</p>
<b>Audit misstatements</b>	<p>Under the requirements of ISA 260 <i>Communication of audit matters with those charged with governance</i>, we are required to report any adjusted audit misstatements arising from our work. These have been reported in Appendix 2 and have been adjusted for in the accounts.</p> <p>We are also required to report any unadjusted audit misstatements, other than those that are 'clearly trivial' (if there are any) to the Trustee. There are no uncorrected misstatements.</p>

# Summary of audit differences

## Summary of corrected audit differences

Under UK auditing standards (ISA UK and Ireland 260) we are required to provide the Audit Committee with a summary of corrected audit differences identified during the course of our audit. The adjustments below have been included in the financial statements for Heart of England NHS Foundation Trust Charity for the year ended 31 March 2017. Audit differences over £5,000 are shown.

Corrected audit differences				
£	Statement of financial activities		Balance sheet	
	Dr	Cr	Dr	Cr
<b><u>Incorrect offset against income</u></b>				
Salaries for research and clinical support	£9,000			
Charitable Activities Income		£9,000		
<b><u>Incorrect offset against creditors</u></b>				
Debtors	£146,548			
Creditors		£146,548		

## Summary of uncorrected audit differences

Under UK auditing standards (ISA UK and Ireland 260) we are required to provide the Audit Committee with a summary of uncorrected audit differences identified during the course of our audit. There are no uncorrected audit differences.

# Control observations raised in current year

## Management Report

All issues raised in the report have been discussed with management and we have included their responses where appropriate.

<b>1</b>	Grade A – These are particularly significant matters for the organisation, such as those relating to factors critical to the successful running of the scheme and regulatory environment. We have identified no grade A observations in the current year.
<b>2</b>	Grade B – These include observations on non-critical control systems, one-off items subsequently corrected, improvements to the efficiency of effectiveness of controls and matters that could be significant in the future. We have identified two grade B observations in the current year.
<b>3</b>	Grade C – These are less significant than those graded A and B but we nevertheless consider that they merit attention by Management. We have raised no grade C observations in the current year.

Grade	Observation	Recommendation	Management's response
<b>2</b>	<p><b>Donations in suspense</b></p> <p>Our sampling testing of donations included testing one donation for £56,900 from 30/12/2016 which was donated to specifically support the Trust in purchasing new equipment (equipment items specified by the donor).</p> <p>At the time of our audit the donation was on a suspense code and the equipment yet to be purchased.</p> <p>There is a risk that the donor's instruction associated with the donation might not be completed following the transfer to UHB charity.</p>	As part of the transfer of funds to UHB Charity, all suspense accounts should be reviewed and supporting documentation provided to UHB Charity so that donations can be spent in line with donors wishes	The Financial Accountant will contact the accountant at UHB looking after the charity and advise her that this specific item needs to be moved to a specific account to ensure it is spent in line with the wishes of the donor. All other suspense accounts will be reviewed prior to final handover to identify any other items that require explanation and movement.

# Control observations raised in current year (cont)

## Management Report

All issues raised in the report have been discussed with management and we have included their responses where appropriate.

Grade	Observation	Recommendation	Management's response
2	<p><b>Charitable Activities</b></p> <p>The Trust recognised £330k of income from charitable activities. As per the Charity's SORP, income should be recognised when:</p> <ul style="list-style-type: none"> <li>— control over the rights or other access to the economic benefit has passed to the charity;</li> <li>— it is more likely than not that the economic benefits associated with the transaction or gift will flow to the charity; and</li> <li>— the monetary value or amount of the income can be measured reliably and the costs incurred for the transaction and the costs to complete the transaction can be measured reliably.</li> </ul> <p>We tested a sample of 25 items of charitable activities income which we were satisfied met the above criteria, however as per the charity SORP, for income to be recorded as charitable activities, the activities must be undertaken for the charitable purposes of the charity.</p> <p>There were items of income which we tested, where there was a degree of judgement in determining whether the activity was undertaken for the charitable purposes of the Charity and a not a Trust activity, notably for research and education activity. To some extent this is a reflection of the strong connection between the Charity and Research and Education departments within the Trust. It is important however, that appropriate supporting documentation is retained to support the recognition of the income within the Charity's accounts.</p>	<p>Where the Trust undertakes charitable activities, clear documentation should be retained to support that the activity is being undertaken for the charitable purposes of the Charity and not a Trust activity. This is to support recognising such income within the Charity's accounts.</p>	<p>Some of the support for documentation that would ordinarily be available was not due to two key members of staff who processed income receipts being off on long term sick. This recommendation will be passed on to the accountant at UHB so they can check their existing procedures would comply with this recommendation.</p>

# Auditor independence

**We confirm the independence of KPMG.**

## **Assessment of our objectivity and independence as auditor of Heart of England NHS Foundation Trust Charity**

Professional ethical standards require us to provide to you at the conclusion of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence and addresses:

- General procedures to safeguard independence and objectivity;
- Independence and objectivity considerations relating to other matters.

### **General procedures to safeguard independence and objectivity**

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP Partners and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the FRC Ethical Standard. As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values
- Communications
- Internal accountability
- Risk management
- Independent reviews.

We are satisfied that our general procedures support our independence and objectivity

# Auditor independence (cont.)

**We confirm the independence of KPMG.**

## **Summary of fees**

Our fee is £12,361 (exclusive of VAT) as per our External Audit Plan 2016/17 presented to the Audit Committee in October 2016. We have provided no other services to the Charity in year and therefore there are no non-audit fees which we need to disclose.

## **Independence and objectivity considerations relating to other matters**

There are no other matters that, in our professional judgement, bear on our independence which need to be disclosed to the Board of Directors.

## **Confirmation of audit independence**

We confirm that as of the date of this report, in our professional judgement, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the Partner and audit staff is not impaired.

This report is intended solely for the information of the Trustee and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so.



**The contacts at KPMG in connection with this report are:**

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[kpmg.com/app](https://kpmg.com/app)



The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavour to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act on such information without appropriate professional advice after a thorough examination of the particular situation.

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**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**Monday 23<sup>rd</sup> October 2017**

<b>Title: Quality Account Update for Quarter 2, 2017/18 (July – September 2017)</b>							
<b>From:</b> Dr David Rosser, Interim Executive Medical Director  Samantha Baker, Quality Development Support Manager; Mariola Smallman, Head of Quality Management; Mark Garrick, Director of Medical Directors' Services.						<b>To:</b> Board of Directors	
<b>The Report is being provided for:</b>							
Decision	N	Discussion	Y	Assurance	Y	Endorsement	Y
<b>Purpose:</b> To provide an update on the Quality Account for Quarter 2, 2017/18 (July – September 2017).  To receive and note the contents of this report.							
<b>Key points/Summary:</b> The Board of Directors will consider: <ul style="list-style-type: none"> <li>• Trust Quality Improvement Priorities 2017/18;</li> <li>• Mortality (SHMI, HSMR and Crude Mortality);</li> <li>• Patient safety indicators;</li> <li>• Clinical effectiveness indicators.</li> </ul>							
<b>Recommendation(s):</b> The Board is asked to consider the information set out in this report, discuss the contents and approve the actions identified.							
<b>Assurance Implications:</b>							
Board Assurance Framework	Y/N	BAF Risk Reference No.					
Performance KPIs year to date	Y	Resource/Assurance Implications (e.g. Financial/HR)		Y			
Information Exempt from Disclosure	N	If yes, reason why.					
Identify any Equality & Diversity issues							
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							
N/A							

**HEART OF ENGLAND NHS FOUNDATION TRUST  
BOARD OF DIRECTORS  
Monday 23<sup>rd</sup> October 2017**

**QUALITY ACCOUNT UPDATE REPORT FOR QUARTER 2, 2017/18  
PRESENTED BY EXECUTIVE MEDICAL DIRECTOR**

**1. Introduction**

The aim of this paper is to present the Trust's Quality Account Update for Quarter 2, 2017/18.

The Board of Directors is asked to approve the contents of this report and Appendix A.

**2. Quarter 2, 2017/18 Quality Account Update**

2.1 The Quality Account Update report for Quarter 2, 2017/18 (July to September 2017) is shown in Appendix A. The latest available data is included in the report. There has been a delay in receiving data for certain indicators from the national team; these indicators will be updated as soon as the data becomes available.

2.2 Performance for Quality Improvement Priorities:

- Reducing delays and omissions in medication for Parkinson's Disease - Overall performance has continued to improve across the three hospital sites.
- Screening for sepsis – performance is similar to the previous quarter for both inpatients and emergency patients.
- Percentage of acute inpatients receiving antibiotics within one hour of being diagnosed with sepsis continues to improve. Performance for Emergency patients remains variable.
- There is no update for the implementation of the Surgical Site Infection bundle.
- There has been one MRSA bacteraemia apportioned to HEFT this quarter. The number of CDI cases has increased since Quarter 1 is currently below trajectory.

**3. Recommendations**

The Board of Directors is asked to:

- **Approve** the Quarter 2, 2017/18 Quality Account report for external publication (Appendix A).

## Appendix A

### Quality Account Update for Quarter 2, 2017/18 (July – September 2017)

#### Contents

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# Quality Account Update for Quarter 2, 2017/18 (July – September 2017)

## Introduction

The Trust published its eighth Quality Account Report in June 2017 as part of the Annual Report and Accounts. The report contained an overview of the quality initiatives undertaken in 2016/17, performance data for selected metrics and set out four priorities for improvement during 2017/18:

- Priority 1:** Reduce avoidable harm to patients from omission and delay in receiving Parkinson's disease medication
- Priority 2:** Improve early recognition of sepsis and reduce hospital acquired sepsis
- Priority 3:** Reducing surgical site infection after major surgery
- Priority 4:** Improve infection rates for Clostridium Difficile (C Diff) and MRSA

This report provides an update on the progress made for the period July to September 2017 towards meeting these priorities and updated performance data for the selected metrics. This update report should be read alongside the Trust's Quality Account Report for 2016/17.

## Quality Improvement Priorities

### Priority 1: Reduce avoidable harm to patients from omission and delay in receiving Parkinson's disease medication

#### Background

Since June 2015 the Trust has focused on reducing the number of omitted and delayed doses of Parkinson's disease (PD) medication.

PD medications are time critical. If medications are delayed or omitted, patients rapidly deteriorate in terms of their ability to move, speak and swallow. When this happens, patients are at risk of falls, pressure ulcers, aspiration pneumonia and neuroleptic malignant syndrome. This can be fatal. There is also evidence showing that PD patients in whom medication has been delayed or missed have an increased length of stay (Martinez-Ramirez et al, Movement disorders 2015). The importance of timely PD medication in hospital is recognised nationally in the Parkinson's UK "Get it on time" campaign.

Baseline data (2015) at HEFT showed 14,000 delayed doses and 3,500 missed doses of PD medication annually across the three Trust sites. The data also identified that only 53% of inpatients were receiving their PD medication within 30 minutes of the prescribed time.

This data, combined with several clinical incidents, formed the impetus for the development of a Quality Improvement (QI) team to address this issue. The Trust aim is for 90% of PD medication to be administered within 30 minutes.

#### Performance

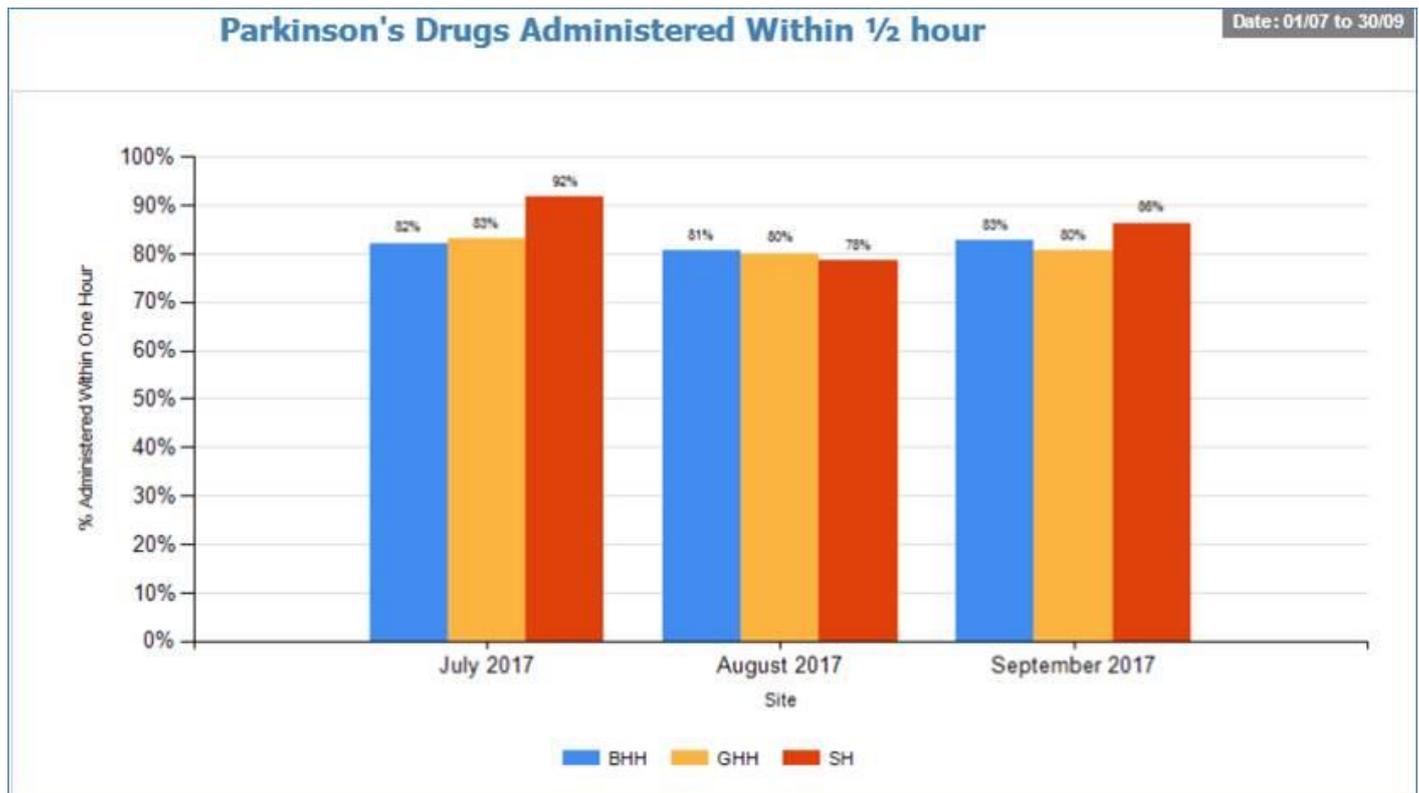
Overall performance has continued to improve across the three hospital sites and is 82% for Quarter 2, 2017/18. This is an improvement on the same period during 2016/17 and 2015/16 – see Table 1 below for detail.

It is expected that performance will continue to improve as the nurse responder bleep system is more widely utilised across all wards. In addition, the stocks of emergency PD medication have increased and have been added to the pharmacy out of hours cupboard to support timely administration.

Table 1 – Performance by Quarter, including previous Quarter 2's for comparison

			2017/18	
	2015/16 Q2	2016/17 Q2	Q1	Q2
Overall Trust % (Target 90% PD medication administered within 30 minutes)	58%	75%	81%	82%
Total doses prescribed	10320	9012	12784	12613
Total doses administered within 30 minutes	5967	6734	10344	10346
Total doses administered late	3467	1897	1969	1780
Total doses non-administered (omitted)	886	381	471	487

## Graph – Quarter 2, 2017/18, Parkinson's Disease medication performance by hospital site



### Initiatives to be implemented in 2017/18

- A review of Trust-wide reasons for omissions and delays in the administration of Parkinson's disease medication is currently being undertaken by the PD Quality Improvement team. This will identify and target any specific areas that require further improvement.
- An audit of omissions and delays in Parkinson medication has been undertaken in ED BHH (non-Electronic Prescribing area). Following this a PD sticker has been developed which is currently being trialled. The aim of the sticker is to prompt staff to think and act on Parkinson's medication at the time of triage.

### How progress will be monitored, measured and reported

- Progress will continue to be measured at ward, speciality, divisional and Trust levels via the live electronic medication dashboard which links directly to the Trust Electronic Prescribing (EP) system.
- Ward and divisional performance continues to be monitored via the Nursing and Midwifery Care Quality Dashboard and is reported monthly to the Chief Executive's Group (CEG) by the Deputy Chief Nurse.
- The PD Quality Improvement team continue to meet regularly to monitor progress and report to the Safer Medicines Practice Group (SMPG) and Sign up to Safety workstream lead.
- Progress is publicly reported in the quarterly quality report updates.

## Priority 2: Improve early recognition of sepsis and reduce hospital acquired sepsis

### Background

Sepsis is defined as “life threatening organ dysfunction caused by a dysregulated response to infection”. It is a syndrome, described by a set of clinical criteria and not truly a diagnosis in and of itself. This makes recognising it complicated. Previous definitions were based on the systemic inflammatory response (SIRS) criteria. In 2016 these were replaced as they were felt to be insufficiently sensitive. The NICE guidance published that year defined sepsis using broader clinical criteria. An audit at Birmingham Heartlands Hospital (BHH) indicated that these new standards have the potential to increase the proportion of medical admissions classed as septic by 50% (i.e., to one third of the medical take).

The Trust has had well publicised clinical pathways for sepsis management in place for several years. These have been updated and now take account of the NICE guidance changes. We have taken this opportunity to launch a number of other changes which are detailed below. This is with the aim of improving:

- Reliable recognition and screening of sepsis;
- Timely and reliable escalation and sepsis treatment;
- Reviewing and de-escalating antibiotics where possible.

### Performance

#### Indicator 2a Timely identification of sepsis

*(September's audit result were not available at the time of writing)*

Emergency departments			
	Patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening	Patient NEEDED sepsis screening according to the local protocol	%
Apr-17	12	26	46.2%
May-17	13	34	38.2%
Jun-17	28	41	68.3%
Quarter 1	53	101	52.5%
Jul-17	9	24	37.5%
Aug-17	29	51	56.9%
Sep-17			
Quarter 2	38	75	50.7%

Acute inpatient departments			
	Patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening	Patient NEEDED sepsis screening according to the local protocol	%
Apr-17	44	55	80.0%
May-17	36	38	94.7%
Jun-17	30	31	96.8%
Quarter 1	110	124	88.7%
Jul-17	46	52	88.5%
Aug-17	34	38	89.5%
Sep-17			
Quarter 2	80	90	88.9%

**Indicator 2b: Percentage of patients diagnosed with sepsis who received antibiotics within 1 hour**

**Results by Quarter:**

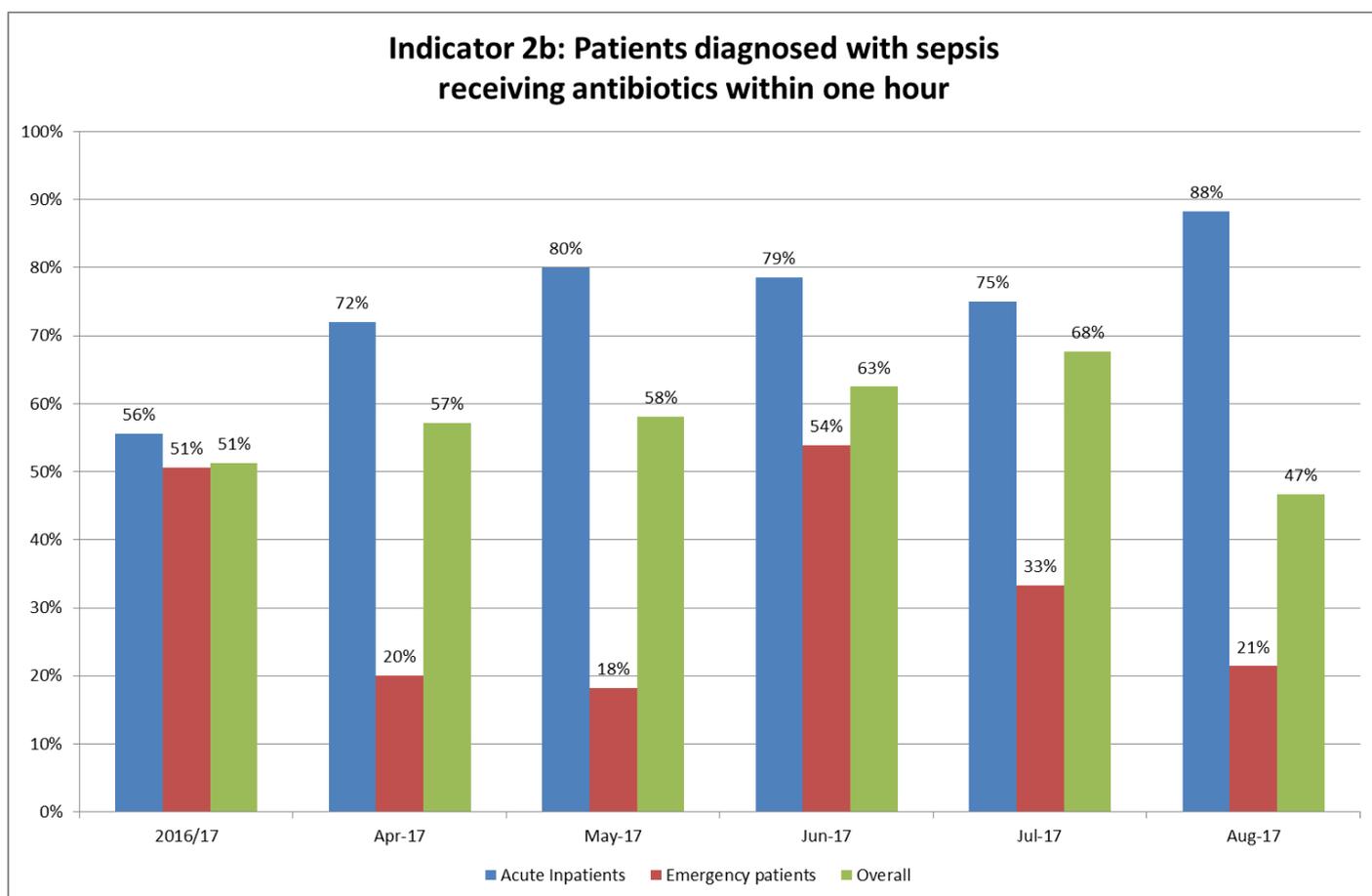
	2016/17	2017/18				
		Q1	Q2	Q3	Q4	YTD
Acute Inpatients	56%	76%	80%			78%
Emergency patients	51%	38%	24%			32%
Overall	51%	59%	56%			58%

**Notes :**

*2016/17 data relates to Quarter 2 data only*

*2017/18 Quarter 2 data is July & August 2017 only*

**Results by month:**



*Note - 2016/17 data relates to Quarter 2 data only.*

## Initiatives to be implemented 2017/18

- Following the dissemination of the new sepsis pathway the nursing metric audits were updated to include the sepsis screening element of the pathway.
- A sepsis and deteriorating patient 'Lesson of the Month' is planned for October 2017.
- Learning from the 'Lesson of the Month' will be shared with the junior doctors at the Risky Business forums.
- The 2017 edition of the junior doctor's memory bank will include information on sepsis and the new sepsis pathway.

### Admitting areas and inpatient wards

- The relaunched adult Modified Early Warning Score (MEWS) chart with new sepsis screening check boxes and new adult sepsis screening tool are both now in use.
- Rolling training is delivered to all new nurses at Trust induction via the new Acute Illness Management (AIM) course and to junior doctor risky business forums.
- The Divisional leads have been made aware of the changes to sepsis management and the requirements of the sepsis CQUIN.
- Rather than limit the Trust to the minimum CQUIN requirement, the sepsis team have identified those factors which we feel will most improve the clinical care of patients with sepsis and will include these in CQUIN data collection. This includes whether blood cultures were taken, the time band of antibiotic administration if beyond 1 hour, and whether patients fell into the sickest group. This will enable us to understand the potential clinical impact of improvement work, beyond CQUIN achievement.

### Paediatrics

- Sepsis teaching sessions have been delivered to 108 of the paediatric staff (total 120); this includes qualified nurses (hospital and community based), health care assistants (HCA) and nursery nurses. Plans are underway to train all new starters as they arrive and training dates have been set to capture the remaining staff members. In July 2017 drop in sessions were increased to facilitate wider teaching.
- Doctors are attending ward based scenario sessions and Birmingham Children's Hospital is delivering RAPT training at the Good Hope Hospital (GHH) site for the multidisciplinary team.
- Sepsis scenarios continue to be included on the paediatric recognition and management of the deteriorating child study day which occurs monthly.
- A paediatric sepsis tool has been developed and piloted and is currently with the printing team; the patient safety team will assist with trust wide communication about the launch of the new form. Staff within paediatrics will receive face to face communication about the new form.
- The new version of the Paediatric Early Warning Score (PEWS) is now in place; this includes a prompt box on the right hand side to remind staff to consider sepsis. The introduction of a carer/nurse concern box allows staff to record parental concerns regarding subtle signs of deterioration.
- The patient safety team will support the paediatric directorate with communication and raising awareness with the revised PEWS and new sepsis pathway.
- The training programme to support the launch will include the lessons learned from serious incidents.

### Maternity

- SSI prevention to be included as a MATNEOQI project.
- A new maternity sepsis tool and the updated MEOWS chart will be launched by the end of 2017 with support of midwifery trainers.

- Updated Caesarean section leaflet now in use to including correct information about pre-operative hair removal and advice to patients about post-operative wound care.
- Education and training on sepsis and the new pathway provided to new doctors at Trust induction.
- Results of surgical site infection (SSI) audit from Infection Control expected.

### **How will progress be monitored, measured and reported**

The national sepsis CQUIN promotes timely identification and treatment for sepsis in both admitting areas (e.g., ED, AMU) and inpatient areas. This is monitored by the Trust's Performance team. The CQUIN has 3 key elements for audit and ultimately we need to achieve 90% in each area.

- The percentage of patients who meet the criteria for sepsis screening and are screened for sepsis using the Trust recognised screening tool.
- The percentage of patients defined as septic who receive their IV antibiotics within 1 hour.
- The percentage of patients having a documented antibiotic review within 24-72hrs by a senior decision maker.

In previous years CQUIN audit data and sepsis improvement work was conducted by a dedicated sepsis nurse and associated team. Following organisational changes this responsibility has transferred to the individual divisions. It is worth noting that meetings have taken place between the sepsis groups at HEFT and our University Hospitals Birmingham partners. There are differences in how the organisations have defined sepsis screening and how the cohorts for audit are identified. It is unlikely that this will change in the short term and will limit the extent to which audit data can be compared.

## Priority 3: Reducing surgical site infection after major surgery

### Background

Surgical Site Infections (SSI) comprise up to 20% of all of healthcare-associated infections. At least 5% of patients undergoing a surgical procedure develop a SSI and they represent the second most common hospital acquired infection (after UTI). SSI's range in severity from a spontaneously limited wound discharge within a few days of an operation to a life-threatening postoperative complication. Most surgical site infections are caused by contamination of an incision with microorganisms from the patient's own body during surgery and NICE states that the majority of SSI's are preventable.<sup>1</sup> SSI can severely affect the patient's experience after surgery and quality of life; they are costly and are associated with considerable morbidity, extended hospital stays and increased rates of readmission.

A care bundle is a small set of evidence-based practices that can be delivered together to improve patient outcomes. Based on NICE and WHO guidelines<sup>2</sup>, a SSI Bundle was established and introduced to Theatre 1 and 3 at BHH for a trial period in 2016. 170 patients undergoing major abdominal surgery were evaluated and a dedicated, independent nurse evaluated the patients for SSI. The overall SSI rate at 30 days was 29% and 28% in the standard group and the bundle group respectively. However, surgical readmissions within 30 days were 6% in the bundle group compared to 20% in the standard care group. This suggests that the trialled bundle needs to be used 7 times to prevent one readmission. A revised bundle has been developed and will be introduced with additional efforts made to ensure compliance.

### Performance

No performance data is available for Q1 or Q2, 2017/18, and there are no updates to report for this quality priority.

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<sup>1</sup> <https://www.nice.org.uk/guidance/cg74/chapter/introduction>

<sup>2</sup> <http://www.who.int/gpsc/ssi-prevention-guidelines/en/>

## Priority 4: Improve infection rates for Clostridium Difficile (C Diff) and MRSA

### Performance

#### MRSA Bacteraemia

The national objective for all Trusts in England in 2017/18 is to have zero avoidable MRSA bacteraemia. During Quarter 2, 2017/18, there was one avoidable MRSA bacteraemia apportioned to HEFT.

All MRSA bacteraemias are subject to a post infection review (PIR) by the Trust in conjunction with the Clinical Commissioning Group (CCG). MRSA bacteraemias are then apportioned to HEFT, the CCG or a third party organisation, based on where the main lapses in care occurred.

The table below shows the Trust-apportioned cases reported to Public Health England for the past three financial years:

Time Period	2015/16	2016/17	2017/18 Q1	2017/18 Q2
HEFT Apportioned	4	7	0	1
Agreed trajectory	0	0	0	

#### Clostridium Difficile Infection (CDI)

The Trust's annual agreed trajectory is a total of 64 cases during 2017/18. Each case is also reviewed to see whether there were any lapses in care; a lapse in care means that correct processes were not fully adhered to, therefore the Trust did not do everything it could to try to prevent a CDI. During Quarter 2, 2017/18 HEFT reported 21 cases in total, of which 3<sup>3</sup> had lapses in care. The Trust uses a post infection review (PIR) tool with the local CCG to identify whether there were any lapses in care which the Trust can learn from.

The table below shows the total Trust-apportioned cases reported to Public Health England for the past three financial years:

Time Period	2015/16	2016/17	2017/18 Q1	2017/18 Q2
Lapses in care	14	18	4	3*
Trust-apportioned cases	61	76	10	21
Agreed trajectory	64	64	64	

<sup>3</sup> \* At the time of reporting, the cases for September 2017 had not been reviewed for potential lapses in care

## **Initiatives being implemented in 2017/18**

A robust action plan has been developed to tackle Trust-apportioned MRSA bacteraemias and CDI:

- Strict attention to hand hygiene and the correct and appropriate use of PPE (Personal Protective Equipment). Ensuring all staff are compliant in performing hand hygiene and adhere to PPE policy.
- Ensuring all relevant staff understand the correct procedure for screening patients for MRSA before admission, on admission and the screening of long stay patients.
- Ensuring the optimal management of all patients with MRSA colonisation and infection, including decolonisation treatment, prophylaxis during procedures, and treatment of established infections.
- Ensure appropriate antimicrobial use including use of Octenisan hair and body wash.
- Optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance through prudent antimicrobial prescribing and stewardship.
- Careful attention to the care and documentation of any devices, ensuring all procedures are being followed as per Trust policy.
- Ensure all relevant staff are performing infection prevention and control audits and acting on the results.
- Providing and maintaining a clean environment throughout the Trust including the implementation of the deep cleaning programme.
- Ensure all staff are aware of their responsibility for preventing and controlling infection through mandatory training attendance.
- Ensure post infection review investigations are completed and lessons learned are fed back throughout the Trust.
- Continuation of the reviews by the infection prevention and control team of any area reporting two or more cases of CDI.

## **How progress will be monitored, measured and reported**

- The number of cases of MRSA bacteraemia and CDI will be submitted monthly to Public Health England and measured against the 2017/18 trajectories.
- Performance will be monitored via the clinical dashboard. Performance data will be discussed at divisional quality and safety meetings, the nursing and midwifery quality meetings and the Trust Infection Prevention Committee (TIPC) meetings.
- Any death where an MRSA bacteraemia or CDI is recorded on part one of the death certificate and any outbreaks of CDI and MRSA will continue to be reported as serious incidents (SIs) to Birmingham CrossCity Clinical Commissioning Group (CCG).
- Post infection review (PIR) and root cause analysis will continue to be undertaken for all MRSA bacteraemia and CDI cases.
- Progress against the Trust infection prevention and control annual programme of work will be monitored by the infection prevention and control strategic management group and reported to the Board of Directors via the infection prevention and control quarterly and annual reports. Progress will also be shared with Commissioners.

## Mortality

The Trust continues to monitor mortality as close to real-time as possible with senior managers receiving daily emails detailing mortality information and on a longer term comparative basis via the Trust's Clinical Quality Monitoring Group. Any anomalies or unexpected deaths are promptly investigated with thorough clinical engagement.

The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.

### Summary Hospital-level Mortality Indicator (SHMI)

The NHS Digital first published data for the Summary Hospital-level Mortality Indicator (SHMI) in October 2011. This is the national hospital mortality indicator which replaced previous measures such as the Hospital Standardised Mortality Ratio (HSMR). The SHMI is a ratio of observed deaths in a trust over a period time divided by the expected number based on the characteristics of the patients treated by the trust. A key difference between the SHMI and previous measures is that it includes deaths which occur within 30 days of discharge, including those which occur outside hospital.

The SHMI should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care<sup>4</sup>. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model but may still be within the control limits. A SHMI above the control limits should be used as a trigger for further investigation.

The Trust's latest SHMI is 96.72 for the period April 2016 – February 2017 which is within tolerance. The latest SHMI value for the Trust, which is available on the HSCIC website, is 96.58 for the period July 2015 – June 2016. This is within tolerance. The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio (HSMR) which was superseded by the SHMI but it is included here for completeness. HEFT's HSMR value is 96.31 for the period February 2017 – March 2017 as calculated by Health Informatics. The validity and appropriateness of the HSMR methodology used to calculate the expected range has however been the subject of much national debate and is largely discredited<sup>5</sup>. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

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<sup>4</sup> Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. *BMJ Open*. 31 January 2013.

<sup>5</sup> Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black, N. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review. *BMJ Quality & Safety*. Online First. 7 July 2012.

<sup>3</sup> Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. *The Lancet*. 3 April 2004.

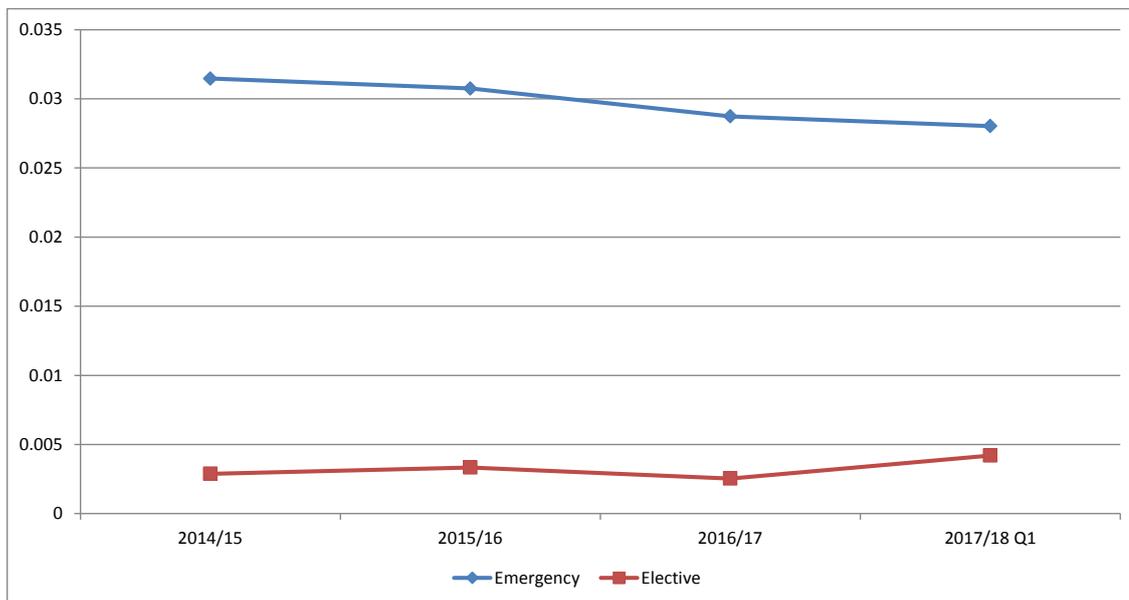
## Crude Mortality

Quarter 2 data was not available at the time of reporting. The report will be updated when it becomes available.

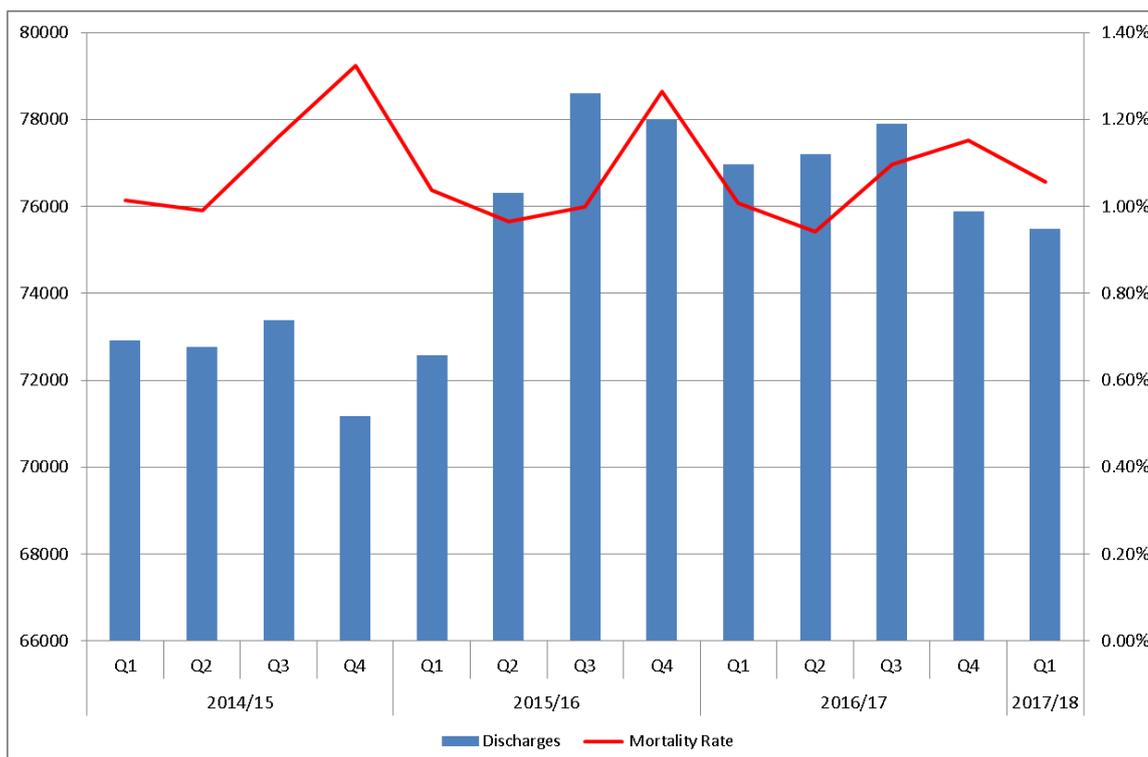
The first graph shows the Trust's crude mortality rates for emergency and non-emergency (planned) patients. The second graph below shows the Trust's overall crude mortality rate against activity (patient discharges) by quarter for the past two calendar years. The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period. The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.

The Trust's overall crude mortality rate for Quarter 1, 2017/18 was 1.06%, this was a slight increase on Quarter 1, 2016/17 (1.01%) and Quarter 1, 2015/16 (1.04%).

### Emergency and Non-emergency Mortality Graph



### Overall Crude Mortality Graph



## Selected Metrics

### Patient safety indicators

Quarter 2 data not yet available for all indicators.

Indicators marked with a \* are Q1 only.

Indicator	Data source	2015/16	2016/17	2017/18 Q1-Q2	Peer Group Average (where available)
<b>1a. Patients with MRSA infection/ 100,000 bed days</b> (includes all bed days from all specialties)  <i>Lower rate indicates better performance</i>	Trust MRSA data reported to PHE, HES data (bed days)	0.9	1.9	0.0*	<b>0.58</b> April 2016 – March 2017 Acute trusts in West Midlands
<b>1b. Patients with MRSA infection/ 100,000 bed days</b> (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics)  <i>Lower rate indicates better performance</i>	Trust MRSA data reported to PHE, HES data (bed days)	0.4	0.4	0.0*	<b>0.64</b> April 2016 – March 2017 Acute trusts in West Midlands
<b>2a. Patients with C. difficile infection /100,000 bed days</b> (includes all bed days from all specialties)  <i>Lower rate indicates better performance</i>	Trust CDI data reported to PHE, HES data (bed days)	13.5	16.0	7.7*	<b>13.77</b> April 2016 – March 2017 Acute trusts in West Midlands
<b>2b. Patients with C. difficile infection /100,000 bed days</b> (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics)  <i>Lower rate indicates better performance</i>	Trust CDI data reported to PHE, HES data (bed days)	5.9	6.8	8.4*	<b>15.27</b> April 2016 – March 2017 Acute trusts in West Midlands

Indicator	Data source	2015/16	2016/17	2017/18 Q1-Q2	Peer Group Average (where available)
<b>3a. Patient safety incidents (reporting rate per 1000 bed days)</b> <i>Higher rate indicates better reporting</i>	Provisional Datix and Trust admissions data (not validated)	34 <sup>7</sup>	34 <sup>8</sup>	47.73*	<b>59.1</b> October 2016 – March 2017 Acute (non-specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
<b>3b. Never Events</b> <i>Lower number indicates better performance</i>	Datix	6	2	4	<i>Not available</i>
<b>4a. Percentage of patient safety incidents which are no harm incidents</b> <i>Higher % indicates better performance</i>	Provisional Datix	73% <sup>9</sup>	75% <sup>10</sup>	Data being validated	<b>89.4%</b> October 2016 – March 2017 Acute (non-specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
<b>4b. Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death</b> <i>Lower % indicates better performance</i>	Provisional Datix	0.65% <sup>11</sup>	0.6 <sup>12</sup>	0.9%	<b>0.38%</b> October 2016 – March 2017 Acute (non-specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

<sup>7</sup> NRLS data

<sup>8</sup> NRLS data April – September 2016

<sup>9</sup> NRLS data

<sup>10</sup> NRLS data April – September 2016

<sup>11</sup> NRLS data

<sup>12</sup> NRLS data April – September 2016

Indicator	Data source	2015/16	2016/17	2017/18 Q1-Q2	Peer Group Average (where available)
<b>4c. Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)</b>  <b>Higher number indicates better reporting culture</b>	Provisional Datix	15,449 <sup>13</sup>	7,899 <sup>14</sup>	9,610	<b>10,963</b> (6 months) October 2016 – March 2017 Acute (non-specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

**Clinical effectiveness indicators**  
(Quarter 2 data not yet available)

Indicator	Data Source	2015/16	2016/17	2017/18 Q1	Peer Group Average (where available)
<b>5a. Emergency readmissions within 28 days (%)</b> (Medical and surgical specialties - elective and emergency admissions aged >15) % <i>Lower % indicates better performance</i>	HED data	7.63%	7.90%	7.92%	England: <b>7.40%</b>
<b>5b. Emergency readmissions within 28 days (%)</b> (all specialties) <i>Lower % indicates better performance</i>	HED data	7.99%	8.23%	8.19%	England: <b>7.54%</b>
<b>5c. Emergency readmissions within 28 days of discharge (%)</b> <i>Lower % indicates better performance</i>	PMS 2	15.15%	15.09%	15.09%	<i>Not available</i> This is the information used in the Trust's LOS Board reporting. Latest Position YTD (April – August 2017): <b>14.92%</b>

<sup>13</sup> NRLS Data

<sup>14</sup> NRLS data April – September 2016

Indicator	Data Source	2015/16	2016/17	2017/18 Q1	Peer Group Average (where available)
<b>6. Falls (incidents reported as % of patient episodes)</b> <i>Lower % indicates better performance</i>	Datix and Trust admission data	0.98%	1.23%	1.23%	<i>Not available</i>
<b>7. Stroke in-hospital mortality</b> <i>Lower % indicates better performance</i>	SSNAP data	11.64%	11.04%	13.25%	<i>Not available</i>

#### Notes on patient safety & clinical effectiveness indicators

The data shown is subject to standard national definitions where appropriate.

**1a, 1b, 2a, 2b:** Receipt of HES data from the national team always happens two to three months later; these indicators will be updated in the next quarterly report.

**3a:** The NHS England definition of a bed day (“KH03”). For further information, please see this link:  
<http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/>

**4c:** The number of incidents shown only includes those classed as patient safety incidents and reported to the National Reporting and Learning System.

**5a, 5b, 5c:** Readmissions data is available 28 days after the end of the quarter and will be updated in the next quarterly report.

**5c:** This indicator only includes patients readmitted as emergencies to the Trust within 28 days of discharge and excludes cancer patients. The data source is the PMS 2 system. The data for previous years has been updated to include readmissions from 0 to 27 days and exclude readmissions on day 28 in line with the national methodology. Any changes in previously reported data are due to long-stay patients being discharged after the previous years’ data was analysed.

**6, 7:** The majority of the data is due to be validated for September and will be available towards the end of the month. This will be updated in the next quarterly report.

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**MONDAY 23<sup>rd</sup> OCTOBER 2017**

<b>Title: AMENDMENTS TO PRE AUTHORISED BUSINESS CASES</b>							
<b>From:</b> Jonathan Brotherton				<b>To:</b> Board of Directors			
<b>The Report is being provided for:</b>							
Decision	Y	Discussion	N	Assurance	N	Endorsement	N
<b>Purpose:</b>							
To gain Board of Directors approval for:							
<ul style="list-style-type: none"> <li>• The conversion of a 12 month Locum ENT Consultant to a WTE substantive post</li> <li>• The appointment of a replacement Urology Consultant</li> </ul>							
<b>Key points/Summary:</b>							
<ul style="list-style-type: none"> <li>• Maintain patient safety</li> <li>• Deliver National Key Performance Indicators (KPIs)</li> <li>• Deliver 31/62 Cancer and RTT targets.</li> <li>• Reduce reliance on locum capacity.</li> <li>• Repatriation of Radical Prostate Surgery to HEFT</li> </ul>							
<b>Recommendation(s):</b>							
<b>The Board is asked to consider the information set out in this report</b>							
<b>Assurance Implications:</b>							
Board Assurance Framework	N	BAF Risk Reference No.					
Performance KPIs year to date	N	Resource/Assurance Implications (e.g. Financial/HR)			N		
Information Exempt from Disclosure	Y	If yes, reason why.					
Identify any Equality & Diversity issues							
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							
Chief Executives Group							

# HEART OF ENGLAND NHS FOUNDATION TRUST

## BOARD OF DIRECTORS

MONDAY 23<sup>rd</sup> OCTOBER 2017

### 1. Purpose

To gain Board of Directors approval for:-

- The conversion of a 12 month Locum ENT Consultant to a WTE substantive post
- The appointment of a replacement Urology Consultant

### 2. ENT Business Case

At the Chief Executives Group meeting on 20<sup>th</sup> December 2016 a business case was approved to:-

- Establish 1.4 WTE new ENT Consultant posts
- Replace 0.6 WTE established ENT Consultant post
- Recruit 1 Fixed Term 12 month Locum Consultant post
- Establishment of 5.4 WTE other related posts in Divisions 1 & 5
- £4k of set up costs for 2 new consultants

Following approval of the Business Case the Directorate have tried to appoint to the fixed term locum position on 3 separate occasions without success.

On 12<sup>th</sup> September 2017 the Directorate conducted interviews to appoint to the 2 WTE Consultant posts which consisted of the 1.4 WTE new posts and the 0.6 WTE established post. At interview there were three candidates who were considered suitable for appointment.

Given the history with the failure to appoint to the 12 month locum consultant post the Division seek approval to convert the 12 month fixed term locum post to a WTE post in order to appoint all three of the applicants interviewed on 12<sup>th</sup> September.

The risk to converting the locum post to a permanent this appointment is minimal as the Division have been made aware that two WTE Consultants have been interviewed for positions at a neighbouring Trust. Whilst those two Consultants have not formally resigned from the Trust it is thought highly likely that they will resign their positions over the coming weeks.

Over the past three years the new referral demand has increased by a steady 3.8%. Over the same 3 year period, activity within the department has grown by 3.7% without the recruitment of any additional consultant posts to support this on a substantive basis. The Business case approved in December stated that the Directorate would re-run the capacity and demand model in 6 to 12 months time following the appointments of the posts outlined in the business case. Given that the implementation of the business case has been delayed the Directorate propose to re-run the capacity and demand model in June 2018. However,

demand for ENT services has continued to grow at around 3-4% in the previous 6 months with no foreseeable change.

### **3. Urology Business Case**

At the Chief Executives Group meeting on 28<sup>th</sup> February 2017 a business case was approved to recruit:-

- 1.0 WTE replacement Consultant Urology Surgeon.
- 2.24 WTE related support service posts within Division 1 to fund 1 Outpatient clinic and 2 Theatre sessions

Following approval of the Business Case the Directorate held interviews on 18<sup>th</sup> August. Just prior to the interview process the Clinical Director confirmed that he would be retiring from the Trust. At interview there were two candidates who were considered suitable for appointment. At that time approval was sought from the Medical Director regarding the appointment of both candidates.

### **4. Recommendations**

The Board of Directors is requested to:

**APPROVE** the contents of this business case.

**HEART OF ENGLAND NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS**

**23rd October 2017**

<b>Title:</b> Replacement of three Consultant Anaesthetists							
<b>From:</b> Jonathan Brotherton, Director of Operations				<b>To:</b> Board of Directors			
<b>The Report is being provided for:</b>							
Decision	N	Discussion	N	Assurance	N	Endorsement	Y
<b>Purpose:</b> To gain Board of Directors approval for: <ul style="list-style-type: none"> <li>The replacement of 1.0 WTE Consultant Anaesthetist with interest in Intensive Care Medicine.</li> <li>The replacement of 2.0 WTE Consultant Anaesthetists</li> </ul>							
<b>Key points/Summary:</b> <ul style="list-style-type: none"> <li>Fully funded posts to be replaced</li> <li>Maintain patient safety</li> <li>Maximize utilisation of capacity</li> <li>Deliver RTT targets</li> <li>Maintain service resilience</li> </ul>							
<b>Recommendation(s):</b> The Board of Directors is requested to:  <b>Approve</b> the appointment of three replacement Consultant Anaesthetists.							
<b>Assurance Implications:</b>							
Board Assurance Framework	Y/N	BAF Risk Reference No.					
Performance KPIs year to date	Y/N	Resource/Assurance Implications (e.g. Financial/HR)			Y/N		
Information Exempt from Disclosure	Y/N	If yes, reason why.					
Identify any Equality & Diversity issues							
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							
<ul style="list-style-type: none"> <li>Division 1 CSS Board – Approved August 2017</li> <li>Division 1 Operations Group – Approved September 2017</li> <li>Chief Executives Group – Approved September 2017</li> </ul>							

## **1. SUMMARY**

These replacement posts are essential to the delivery of both Anaesthetic and Critical Care medical services. The current post holders have handed in their resignations with the intention to retire in November 2017, December 2017 and May 2018 respectively. There are currently no other Consultant vacancies in either Anaesthetics or Critical Care that have not already been recruited.

## **2. BACKGROUND**

The current posts provide support for substantively funded Anaesthetics Sessions in Theatres and Consultant cover in ITU across both units. There is currently no spare capacity in the existing staffing establishment to cover clinical commitments in both Anaesthetics and Critical Care.

All of the current post holders are solely based at Good Hope Hospital (GHH). Two of the consultants deliver Anaesthetics Sessions and one consultant covers both Anaesthetic and ITU sessions. The posts will be changed to a cross site working post so that they can be utilised at which ever site needs support. This would be especially useful during peak leave seasons where annualised flexible sessions could be used to manage any potential rota gaps across all 3 sites. This will support job planning changes for future delivery of this service in making more posts cross site working posts.

The Trust has achieved the 92% RTT target for the past 12 months. The Anaesthetics Directorate supports all surgical specialties in delivering this KPI and has assisted with the increased demand that has been faced by the Trust. Critical Care has seen an increase in the number of admissions at BHH and has managed to reduce the length of stay at the same time. At GHH, the ICNARC standard mortality ratio has decreased from 1.23 to 1.11 which demonstrates the benefit of medically well-led teams. Critical Care services were recently rated as "Good" in the latest CQC report of HEFT (published 31/07/2017).

These are fully funded posts - there is a nil run rate impact as the replacement posts will cost the same based on the mid-point scale. The total cost of the replacement post is £199k for a Consultant Anaesthetist and £122k for a Consultant Anaesthetist with interest in Intensive Care Medicine.

## **3. ACTION**

The department has begun to scope for suitable candidates to appoint to the Consultant Anaesthetist with interest in Critical Care post before the expected retirement in May 2018.

We received notice of retirement from the 2 Consultant Anaesthetist posts at the end of August. The department has begun to scope for suitable candidates but it is unlikely that a successful candidate will be in post before these individuals retire in November and December 2018 respectively.

The directorate has been notified of the resignations, we hope that being able to start the recruitment process as early as possible will prevent need for any further interim cover. Within Critical Care, two new consultants will be starting clinical duties in October 2017

and February 2018. There should be sufficient time to recruit a new consultant before May 2018.

The Anaesthetics gaps present a more immediate risk to service delivery. The Anaesthetics Management team have decided that where consultants have “flexible sessions” within their job plan (i.e. they can work in any theatre) they will be encouraged to work across which ever site requires support.

One of the current Anaesthetics-only post holders also provides support to the on-call rota at GHH. It will be agreed that the on-call commitment at GHH will be increased from 1 in 11 to 1 in 10 with PAs being adjusted accordingly to reflect the increased activity. All these options shall be put into place to reduce the need to recruit a locum consultant. However, the directorate may need to use this alternative should we receive more retirements in the coming months.

#### **4. RECOMMENDATION(S)**

The Board of Directors are requested to approve:

- The replacement of 1.0 WTE Consultant Anaesthetist with interest in Intensive Care Medicine at a cost of £122k pa.
- The replacement of 2.0 WTE Consultant Anaesthetists at a cost of £119k pa (each)

Both the Anaesthetic and Critical Care Directorates will not be able to provide clinically safe and operationally efficient services if these posts are not approved.

#### **5. NEXT STEPS**

- Approval to be confirmed by Board of Directors
- EVAS to be submitted to recruit to these posts
- Recruitment process to be formally started after EVAS approval

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**23 OCTOBER 2017**

<b>Title:</b>	<b>RESPIRATORY MEDICINE CONSULTANT</b>
<b>Responsible Director:</b>	Jonathan Brotherton, Director of Operations
<b>Contact:</b>	Dr John Reynolds, Divisional Director, Division 3 Mr Paul Williams, Head of Operations, Division 3 Elizabeth McCarthy, Group Manager Respiratory

<b>Purpose:</b>	To request the creation of a new consultant post in the Respiratory Medicine Directorate.  The post is funded through a mixture of additional income and reallocation of existing resources.
<b>Confidentiality Level &amp; Reason:</b>	Confidential – Staff
<b>Annual Plan Ref:</b>	
<b>Key Issues Summary:</b>	<ul style="list-style-type: none"> <li>• Significant increases in GP outpatient referrals have resulted in inconsistent delivery of the national elective access and diagnostic standards.</li> <li>• Outpatient activity has increased by 7754 between 2013/14 and 2016/17. To date, this has been absorbed from within the Directorate.</li> <li>• However, the directorate is unable to achieve the elective access standards without waiting list initiatives and extended clinics. Currently the wait to first outpatient appointment is eleven weeks</li> <li>• The Sleep service has a significant and growing backlog which requires additional senior capacity to address.</li> </ul>

<b>Recommendations:</b>	The Board of Directors is requested to approve the creation and appointment of a full-time Consultant for the Respiratory Directorate.	
<b>Approved by:</b>	Chief Executive's Group	Date: 19/12/2016

# HEART OF ENGLAND NHS FOUNDATION TRUST

## BOARD OF DIRECTORS

23 October 2017

### NEW RESPIRATORY MEDICINE CONSULTANT

#### 1. Purpose

The purpose of this paper is to gain support for the substantive appointment of a new Respiratory Consultant. This requirement is driven by an increase of 4213 GP referrals since 2013/2014 which has placed extreme pressure on the Directorate's ability to achieve the elective access standard.

The £140k revenue required for the new consultant post has been identified following an internal service review:

- £48K generated from 4 PAs released by existing consultants
- £136k generated from additional income contribution

#### 2. Strategic Context

##### 2.1. Current Service - the Directorate

The Respiratory Medicine Directorate provides specialised services for the north and east of Birmingham, Solihull, and parts of Warwickshire and South Staffordshire. It has an excellent reputation locally, regionally and nationally. It provides specialist and generalist respiratory services across four sites, namely Solihull Hospital (SH), Birmingham Heartlands Hospital (BHH), Good Hope Hospital (GHH) and the Birmingham Chest Clinic (BCC). The Respiratory service covers:

- Ward 24 BHH, Ward 19 SH and Ward 10 GHH: a total of 96 respiratory medicine beds
- Ward 26 BHH Regional Cystic Fibrosis Centre: a total of 20 specialist Cystic Fibrosis beds and Cystic Fibrosis Outpatient Clinics
- General Respiratory Outpatient Clinics
- Specialist Sleep studies Outpatient Clinics and Inpatient investigations
- Birmingham Regional Severe Asthma Service (BRSAS), covering both Outpatient and Inpatient activities.
- Lung Cancer Outpatient Clinics
- Specialist Tuberculosis Outpatient Clinics
- Specialist Occupational Lung Outpatient Clinics
- Specialist Interstitial Lung Disease Clinics

### **3. Case For Change**

This post will be based at Good Hope, covering Ward 10, General Respiratory and Lung Cancer Clinics, whilst also participating in the GiM On-call Rota. The demands on the respiratory directorate have significantly increased over the past 4 years, with 4,213 additional referrals since 2013/14. Whilst the majority of the demand pressures had originally been absorbed from within the existing complement of staff, the unrelenting increases have driven significant demand for waiting list initiative clinics over the past 8 months. This in turn has increased the financial run-rate, whilst not always providing sufficient capacity to achieve the national RTT access standard.

Approval of this case would generate an additional 1000 outpatient slots a year.

The key benefits of this post are to:

- Support a reduction in wait to first outpatient appointment. Currently the average wait to first outpatient appointment is 11 weeks, against a pathway standard of 8.
- Improve current performance against the 18 week RTT standard for general respiratory patients in a reduced cost envelope. Approval of this post will reduce the volume of waiting list initiatives whilst facilitating a more sustainable approach.
- Improved response to the Emergency Department standard to review patients within 30 minutes, whilst supporting patients in AMU requiring specialist advice.
- Support the GiM On-call rota at Good Hope by reducing the need for Locum input.

### **4. Safety**

Previously this shortfall has been bridged via additional waiting list initiative sessions and by transferring senior medical staff from other sites. More recently a Directorate review of demand resulted in the realignment of the consultant team and an SpR has been in an acting-up position in order to provide safer patient care and stabilisation of the respiratory care model on the GHH site. This has reduced the risk of issues such as:

- Delays in collaborative working with other acute directorates
- Delay in initial patient treatments generated from front door referrals
- Locum and agency staff can lack in commitment and understanding of service provision expectations, including escalations and documentation.

## 5. Financial Performance

Tables 2 and 3 demonstrate the directorate's activity and income performance for the last four years, and the plan for 2017/18.

Table 2- Activity performance for Respiratory Medicine for past four years

	1314		1415		1516		1617		17/18
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Plan
Ambulatory Care	0	0	0	0	194	0	490	60	605
Block / Manual	0	0	0	0	0	0	0	0	0
Day Case	1,067	1,030	816	1,088	804	1,036	1,019	708	967
Elective	902	1,047	781	1,104	771	897	863	736	928
Emergency	1,187	1,071	1,633	991	1,637	1,428	1,940	1,703	2,045
Emergency Assessment Area	0	4	41	0	263	13	913	48	796
Other	962	1,003	897	932	730	901	1,021	762	878
Outpatients (ALL)	20,466	23,843	21,338	20,896	24,696	21,762	28,220	24,583	27,416
Unbundled HRGs	8	527	1	12	0	0	4	0	3

Table 2b - Activity performance for Respiratory Medicine for past four years (GHH only)

	1314		1415		1516		1617		17/18
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Plan
Ambulatory Care	0	0	0	0	9	0	5	6	0
Block / Manual	0	0	0	0	0	0	0	0	0
Day Case	497	402	285	516	332	349	249	176	437
Elective	34	39	14	54	11	23	9	1	9
Emergency	429	405	632	399	529	627	252	363	436
Emergency Assessment Area	0	4	0	0	0	0	0	0	0
Other	1	0	0	0	0	0	471	343	150
Outpatients (ALL)	3,865	4,051	3,826	4,152	6,423	4,610	4,605	3,535	7,749
Unbundled HRGs	3	160	0	4	0	0	0	0	0

Investment in the Consultant level workforce has not kept pace with the increasing demand, resulting in an over-reliance on WLI sessions during 2016/17 to deliver the RTT 18 week access standard. With the current levels of demand, the Directorate have been undertaking up to 4 additional clinics each week.

The position is currently underpinned by an SpR acting up to consultant level. They are focused on ward based activities, which allows for the established consultants to increase their planned outpatient templates in order to increase capacity.

This position is not sustainable. In addition to the significant additional demands on the medical workforce, the acting consultant is now being encouraged to consider alternative substantive consultant positions elsewhere, with no guarantee that a suitable alternative can be readily identified.

Table 3- Income performance for Respiratory Medicine for past four years

	1314		1415		1516		1617		17/18
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Plan
Ambulatory Care	£0	£0	£0	£0	£119,876	£0	£220,500	£22,034	£272,642
Block / Manual	£12,149,725	£10,192,188	£14,563,543	£12,185,657	£14,496,433	£15,126,686	£14,515,755	£15,624,312	£15,457,343
Day Case	£1,078,412	£803,807	£597,048	£1,048,403	£545,143	£631,350	£762,786	£452,221	£588,301
Elective	£978,999	£1,022,761	£861,088	£1,246,219	£858,044	£677,547	£952,039	£861,706	£715,525
Emergency	£3,634,259	£3,419,971	£4,591,263	£3,103,384	£4,432,926	£4,738,184	£5,314,842	£4,728,304	£6,125,714
Emergency Assessment Area	£0	£2,223	£26,404	£0	£160,306	£8,730	£608,026	£26,079	£502,397
Other	£575,783	£729,966	£511,354	£607,474	£364,635	£479,900	£567,071	£395,407	£556,865
Outpatients	£2,578,890	£2,038,054	£2,691,148	£2,597,248	£3,391,353	£2,731,784	£4,026,737	£3,370,659	£3,713,636
Unbundled HRGs	£1,609	£50,446	£0	£1,921	£0	£0	£1,055	£0	£463
	<b>£20,997,677</b>	<b>£18,259,416</b>	<b>£23,841,848</b>	<b>£20,790,304</b>	<b>£24,368,715</b>	<b>£24,394,181</b>	<b>£26,968,812</b>	<b>£25,480,722</b>	<b>£27,932,887</b>

Table 3b - Income performance for Respiratory Medicine for past four years (GHH only)

	1314		1415		1516		1617		17/18
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Plan
Ambulatory Care	0	0	0	0	4,050	0	2,250	2,191	0
Block / Manual	269,132	256,840	388,116	371,592	64,833	104,719	45,669	38,382	83,712
Day Case	750,998	420,547	386,565	715,397	281,000	307,902	251,810	143,412	293,691
Elective	100,253	82,940	26,524	147,318	16,009	31,287	17,001	537	11,474
Emergency	1,234,909	1,194,136	1,712,347	1,149,329	1,387,589	1,912,471	695,688	917,874	1,437,491
Other	0	0	0	0	74,157	0	92,490	65,474	32,326
Outpatients	545,674	430,531	518,414	581,056	1,168,351	734,608	865,422	642,697	1,211,282
Unbundled HRGs	483	15,454	0	641	0	0	0	0	0
	<b>2,901,449</b>	<b>2,402,670</b>	<b>2,931,967</b>	<b>2,965,332</b>	<b>2,995,988</b>	<b>3,090,987</b>	<b>1,970,330</b>	<b>1,808,220</b>	<b>3,071,571</b>

Income has grown over the last five years from £20.1m to a 2016/17 outturn value of £26.7m, i.e. 28%.

## 6. Proposed Service

This post is a substantive full time (10 PA) consultant generated from internal consultant team review and realignment to cover increased demand in all activities.

The post-holder will take on responsibility for all job roles currently being fulfilled by the acting up Consultant.

- Participation in the OOH GiM Roster at Good Hope Hospital contributing to the ease of flow at the front door during core and out of hours. (1.5 PA's)
- Providing three OP clinics per week and thus reducing the quantity of waiting list initiative clinics
- Providing senior ward cover for Ward 10 at Good Hope, undertaking daily ward rounds, providing clinical leadership at Jonah and Red2Green huddles. (2.5 PA's)
- Participation in the internal Acute Respiratory on-call in core hours. Receiving and reviewing acute referrals for ED, AMU and Outliers. Providing immediate advice for NIV patients referred from other areas. (1.5 PA's)
- Active involvement in regular mortality and morbidity meetings (0.5 SPA)
- Supervising and teaching junior doctors (1 SPA)
- Providing clinical support and leadership for respiratory services at Good Hope with a key role in the development of junior doctors and nursing staff

No additional secretarial support is required – this will be absorbed from within the current establishment.

## 7. Option Appraisal

### Option 1:

**Do nothing. Allow current NHS locum contract to expire with no cover in place.**

Safety and quality issues were reported on Ward 10 prior to the implementation of the acting up consultant. These were adversely impacting on staff morale, retention and patient experience.

If this post were not filled, there will be significant pressures on all access standards in addition to patient flow. Although contractual fines have been suspended for 2017/18, the directorate is aware that they are likely to be reinstated from 2018/19 onwards and this would create a significant and additional cost pressure to the Trust.

Inability to improve the Good Hope GiM OOH Rota - this will have an impact on the site's ability to manage flow and capacity and result in increased locum costs.

### Option 2: Preferred

**Approve and recruit to permanent Respiratory Consultant post**

Improved quality and safety through increased consultant cover on Ward 10 at Good Hope Hospital.

Able to provide coverage to the GiM OOH Rota, as well as covering the acute respiratory internal on-call rota that operates in hours 9am-5pm Monday to Friday.

Both rotas provide essential senior clinical decision making and leadership underpinning an overall improved site, in terms of patient safety, flow and capacity.

Improve current performance against RTT 18 Week target for General Respiratory and the Lung Cancer 2WW and 62 Day Standards. These positions are currently challenged. (See appendix 1- RTT incomplete position).

Longer term (as soon as backlog significantly reduced) aspirations would be to eliminate the need for Waiting List Initiative Clinics.

## 8. Financial Appraisal

Table 4: Projected Financial Performance Option 2

	<b>WTE</b>	<b>Part Year £000's</b>	<b>Full Year £000's</b>
<b>ADDITIONAL INCOME</b>		<b>68</b>	<b>136</b>
<b>REVENUE EXPENDITURE</b>			
<b>PAY</b>			
Consultant	<b>1</b>	-60	-119
Reallocation of consultant PA's		24	48
<b>Subtotal Pay</b>	<b>1</b>	<b>-36</b>	<b>-71</b>
<b>NON PAY</b>			
Training		-0.5	-1
CSS Outpatient Support		-2	-4
Variable Clinic Costs		-6	-12
CNST		-2	-4
		<b>-10.5</b>	<b>-21</b>
<b>GRAND TOTAL REVENUE EXPENDITURE</b>		<b>-46</b>	<b>-92</b>
<b>Net I&amp;E Impact</b>		<b>22</b>	<b>44</b>

The increased income contribution is based on three additional Outpatient clinics per week. Each additional outpatient clinic would consist of five new patients and three follow-ups.

Pay costs relate to the cost of an additional Consultant on a 10 PA contract, which equates to £119k. This is partially offset by the reduction of 4 PA's from current Consultant job plans, which would release £48k.

Non-Pay costs have been calculated to include training costs, increased CNST contribution, additional Outpatient support and variable patient consumables. This has been discussed with Division One HOO who will support the additional Outpatient clinic space required.

## 9. Risk, Benefits and Outcomes Matrix

Benefits and Outcomes	Risk	Owner	Control	Control Owner	Action Plan and Timescales	Key Players and Progress	Assurance
Improved response to the ED professional standards particularly the 30 minutes to review patients in ED	Successful recruitment	Elizabeth McCarthy	Consider temporary recruitment if substantive recruitment is not successful	Elizabeth McCarthy	To regularly review ED patient within 30min of referral. To achieve once recruitment complete	Elizabeth McCarthy, Rifat Rashid	Division 3 Operations Group
Improved daily review of patients outlying, in ED, AMU, NIV advice all impacting on flow and capacity from front to back door. This will support increase flow through AMU and help improve site safety	Successful recruitment	Elizabeth McCarthy	Consider temporary recruitment if substantive recruitment is not successful	Elizabeth McCarthy	Additional session to AMU upon recruitments	Elizabeth McCarthy, Rifat Rashid	Oversight from the Directorate
Support achievement of the COPD best practice tariff and therefore support CIP delivery of £339,364	Successful recruitment	Elizabeth McCarthy	Consider temporary recruitment if substantive recruitment is not successful	Elizabeth McCarthy	Delivery of COPD best practice tariff	Elizabeth McCarthy, Rifat Rashid	Division 3 Finance Report
Sustainable delivery of 18 week RTT performance	Successful recruitment	Elizabeth McCarthy	Consider temporary recruitment if substantive recruitment is not successful	Elizabeth McCarthy	Reduction in WLI payment upon recruitment and maintenance of 18 week performance. Unplanned pull of medical resource on other sites.	Elizabeth McCarthy, Rifat Rashid	Trust Performance Report
Improved clinical leadership at Jonah and maintenance of Red2Green initiative	Successful recruitment	Elizabeth McCarthy	Consider temporary recruitment if substantive recruitment is not successful	Elizabeth McCarthy	Reduction in WLI payment upon recruitment and maintenance of 18 week performance. Unplanned pull of medical resource on other sites.	Elizabeth McCarthy, Rifat Rashid	Red 2 Green

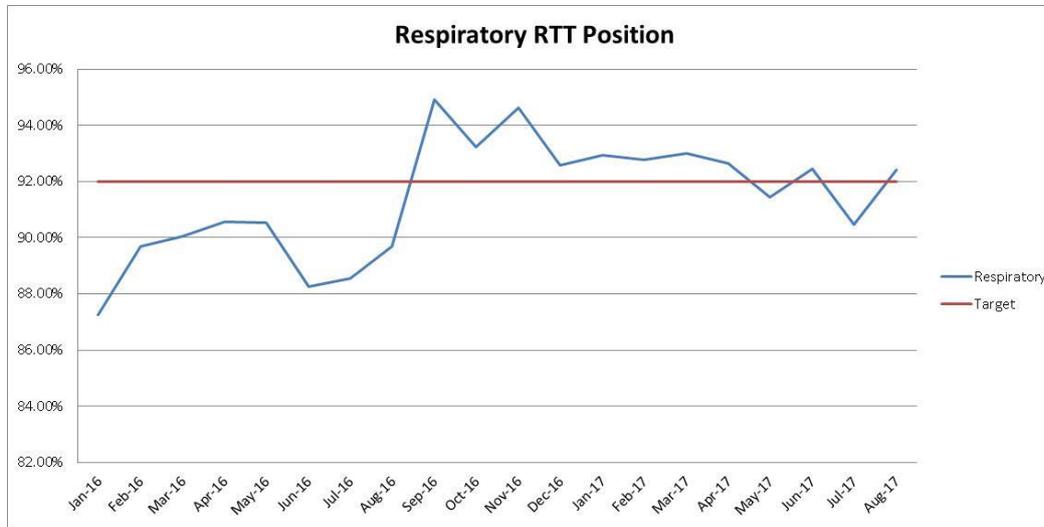
**10. Summary and Conclusion**

This case is requesting approval to recruit a full time Respiratory Medicine Consultant. This is a 10 PA post which would be partially offset by other members of the team dropping 4 PA's. The remainder of the costs would be funded through additional income from the significant backlog and increasing GP referrals.

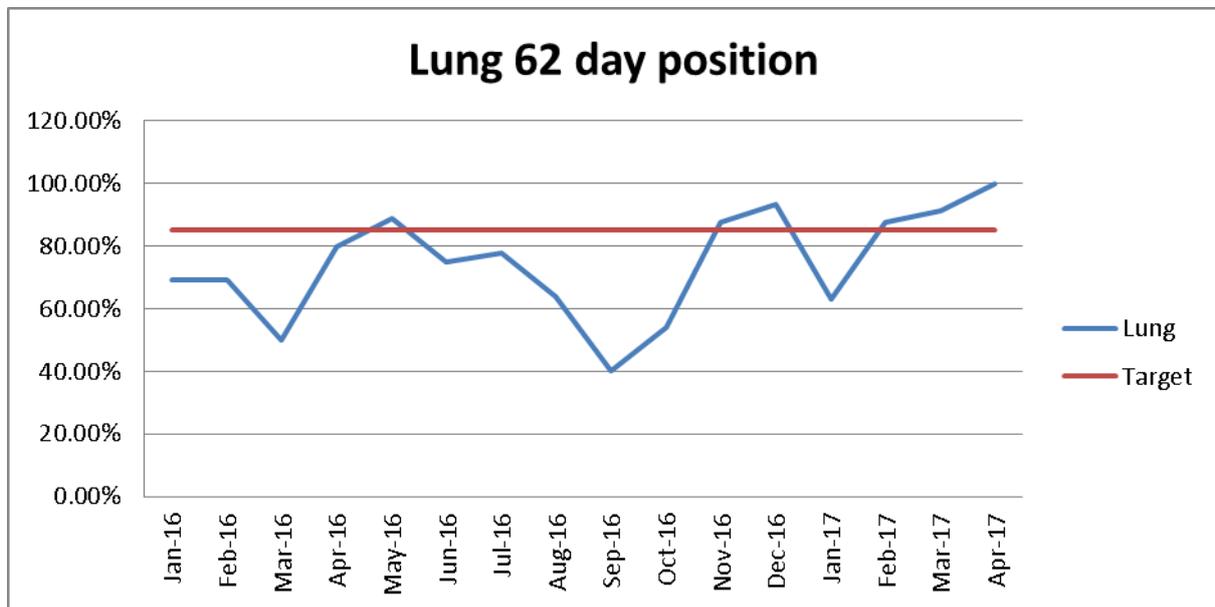
**11. Recommendations**

The Board of Directors is requested to approve the appointment of a full-time Respiratory Medicine consultant.

## Appendix 1. Respiratory Incomplete position



## Appendix 2. Lung 62 Day position



**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**23 OCTOBER 2017**

<b>Title: Conversion of Ward 7 at Good Hope to a Short Stay medical ward</b>							
<b>From:</b> Jonathan Brotherton, Director of Operations				<b>To:</b> Trust Board			
<b>The Report is being provided for:</b>							
Decision	Y	Discussion	Y	Assurance	N	<b>Endorsement</b>	N
<b>Purpose:</b> To request funding from the winter contingency allocation to convert Ward 7 at Good Hope Hospital from a Step-Down ward to a Short Stay facility.							
<b>Key points/Summary:</b>							
<ul style="list-style-type: none"> <li>• Bed modelling has identified that there is insufficient short stay medical capacity at Good Hope Hospital.</li> <li>• Increased medical input from acute physicians and allied health professionals will enhance the turnover of the ward through significantly reduced length of stay.</li> <li>• This change will facilitate enhanced access to an appropriate setting for non-elective patients</li> </ul>							
<b>Recommendation(s):</b>							
<b>The Board is asked to consider the information set out in this report</b>							
The Board is requested to <b>APPROVE</b> the proposed changes to the Ward 7 establishment in order to realise the stated benefits. The additional cost to the organisation for Winter will be £169k.							
<b>Assurance Implications:</b>							
Board Assurance Framework	N	BAF Risk Reference No.					
Performance KPIs year to date	Y	Resource/Assurance Implications (e.g. Financial/HR)			Y/N		
Information Exempt from Disclosure	Y/N	If yes, reason why.					
Identify any Equality & Diversity issues							
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.) CEAG</b>							

## 1. SUMMARY

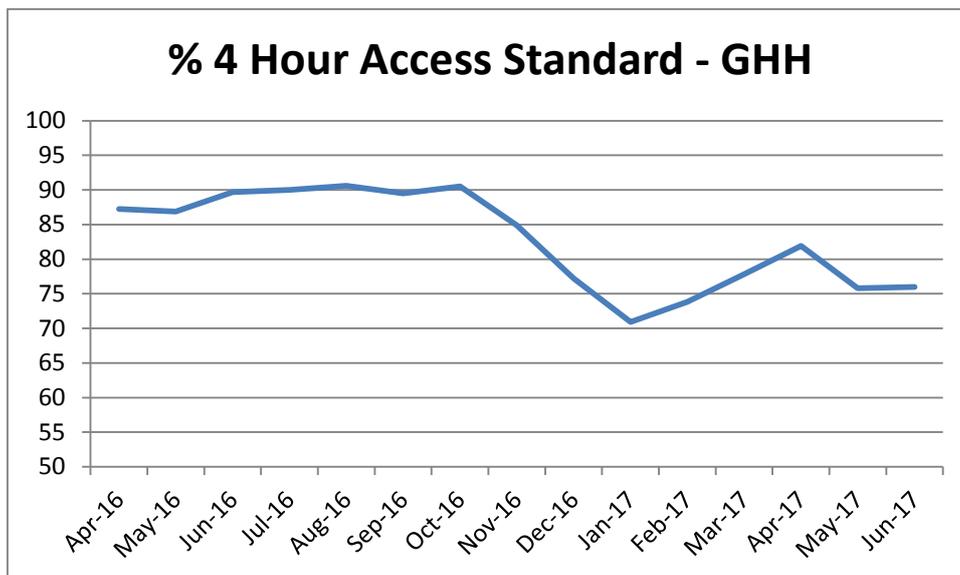
The purpose of this paper is to gain approval for the appropriate level of funding to convert Ward 7 at Good Hope Hospital from a Step Down facility for medically optimised patients into a Short Stay unit managed within the Acute Medicine Directorate.

The Good Hope site is unable to appropriately manage the level of non-elective admissions currently being encountered. Access standards are not being achieved and patients are staying for longer than previously experienced. Bed Modelling has identified insufficient numbers of short stay medical beds to efficiently manage this cohort of patients. This Business Case proposes an expansion of appropriate staff to convert Ward 7 from a step down area into a short stay medical ward.

This conversion will facilitate an additional 6 discharges a day once established, assisting in addressing the systemic issues currently being experienced on the Good Hope site.

## 2. BACKGROUND

Good Hope Hospital has struggled to achieve the 4 hour emergency access standard for several years, with the standard only being achieved for 3 weeks in the past 3 years.

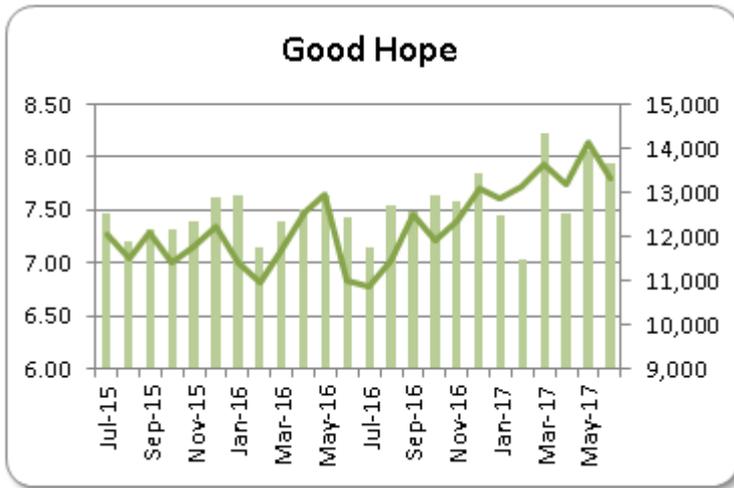


The site has not recovered in performance terms since the deterioration which commenced last autumn.

The over-riding reason for breaching the 4 hour standard has been identified as flow restrictions due to a lack of inpatient capacity, particularly for patients presenting with acute medical conditions. The lack of egress from the ED has restricted access to assessment space, leading to increased waits for patients to be seen and consequently, sub-optimal care.

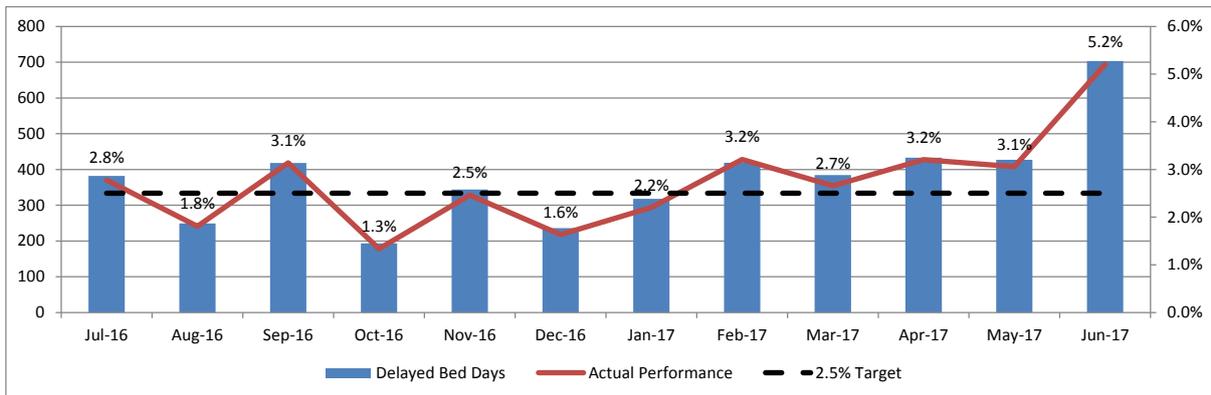
The volume of congestion issues can be tracked directly back to an increasing length of stay on the Good Hope site. From a low of 6.8 days in June 16, the length of stay has been steadily increasing for the past 12 months. The increasing length of stay

has used the equivalent of an additional ward in capacity terms. This has been reflected in high numbers of patients waiting admission from the emergency department at any time, together with an average of 20 medical outliers across the site.



Length of stay trend, reflecting increased occupancy of inpatient capacity.

Conversely, it is apparent that delayed transfers of care have only been a partial contributor to the deteriorating position, with just 1 month from the previous 12 being of significant concern.



Therefore the position appears to be influenced largely by patients who are not determined to be medically appropriate for discharge. A 'sense check' of the current medical front end configuration was undertaken to verify whether the Site had an appropriate level of acute assessment and short stay beds. The model used was developed by the Emergency Care Intensive Support Team (ECIST) and is widely accepted as providing a reliable approximation of the appropriate level of front end capacity requirements.

The current capacity of the Good Hope Short Stay ward is 28 beds. It is not uncommon for patients to have a length of stay above the intended maximum of 72 hours, as a result of a lack of inpatient options for patients under the age of 75 on this site. The output from the ECIST model indicated that the site would operate more effectively with 44 short stay beds.

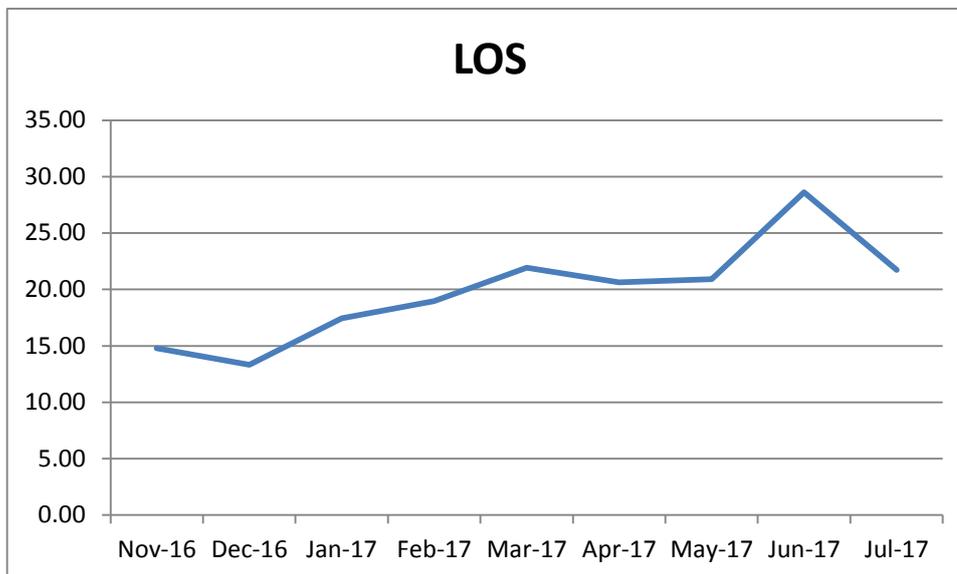
### 3. ACTION

Ward 7 is currently configured to operate as a step down ward for all medically optimised patients who are awaiting their discharge arrangements to be organised. Patients from all specialities are accommodated on the ward, including Orthopaedics.

Consultant cover was intended to be on an in-reach basis from the referring Consultant, hence the absence of any funding for medical staff in the established ward budget.

This arrangement has proven problematic, with patients experiencing an extended length of stay due to a lack of continuity of care as social workers, therapists, etc, alter due to the patient moving from their original ward. Daily senior medical review has also proven problematic, with patients deteriorating and being returned to their host ward.

#### LENGTH OF STAY – WARD 7



Ward 7 has 19 beds. It is proposed that this ward is configured to operate as a short stay medical ward. This would entail an amendment to the nursing establishment, substantive medical staff and increased input from supporting services such as therapies and pharmacy.

By implementing the proposed new establishment whilst integrating with the acute medical team, the model of care will provide a consultant presence on the ward over 7 days. Ward care will be prioritised in medical job plans allowing patients to spend their time in hospital under the care of a single consultant-led team. The substantive medical staff will also increase participation within the General Internal Medicine rota which operates with a significant reliance on locum staff.

## **Anticipated Benefits**

Once the ward has the appropriate staffing in place and agreed operating protocols established with AMU and the Site Team, the ward would be expected to generate a minimum of 6 discharges a day, rising to 10. Similarly the increased medical capacity will also generate increased compliance with placing patients in the appropriate speciality bed, leading to a reduced length of stay for the existing short stay ward. This is based upon the experience of the short stay wards (7 and 22) at Heartlands Hospital, which both operate with a median length of stay of 50 hours, generating between 12 and 20 discharges a day across them since being managed with improved protocols over the past 12 months.

The increase to the regular discharge rate at the hospital will reduce the number of people waiting admission within the Emergency Department each day, enhancing access performance.

The current financial position of both the Division and the Trust is fully recognised. It is proposed that the additional funding to fulfil this case is sourced from the winter contingency in the first instance, with a review of agreed key performance indicators during March 2018 undertaken to determine whether the case has fulfilled the anticipated benefits and thus should continue. The approximate additional cost of this approach is £169k.

## **Option Appraisal**

### **Option 1: Do nothing – maintain current arrangement**

Continuing with the existing model will not address the increasing length of stay on Ward 7. In addition, this will not assist in addressing the high volume of patients awaiting admission each day in the ED or the quantity of medical outliers across the Good Hope site. High agency medical costs will continue to be encountered, with patients frequently placed in an inappropriate speciality bed. These issues give rise to an increasing risk of patient safety and quality issues.

### **Option 2: Close Ward 7 at Good Hope Hospital.**

Rather than continuing to invest in this ward, the area could be closed. This would be a significant risk as all bed modelling exercises have identified an insufficient volume of medical beds on the Good Hope site. The current tendency to place patients in inappropriate beds will be exacerbated, length of stay will increase and patient experience and compliance with access standards will deteriorate further.

### **Option 3: Convert Ward 7 to a Short Stay facility**

This would provide compliance with the ECIST acute bed modelling, increasing discharges by approximately 5 more each day once established. The increased volume of front end beds will also reduce the frequency with which patients are placed in an inappropriate bed, reducing the consequential increase in length of stay across the Hospital. Integrating the ward with the Acute Medical Directorate will improve cross-cover arrangements and provide clear clinical leadership. These benefits will reduce medical agency costs and facilitate a more stable and reliable acute response to demand.

## Financial Analysis - Options Appraisal

Option 1 – Do nothing

Option 2 – Close Ward 7 at Good Hope Hospital

Option 3 – Convert to Ward 7 to a short stay facility

Option	Financial Impact
Option 1 – Do Nothing	This ward was originally opened as flex capacity and later permanently funded as a step down ward. If the ward remains as such there will be no further benefit to Trust performance and no improvement to the Trust's financial position.
Option 2 – Close Ward 7	Costs associated with Ward 7 at GHH currently amount to £1.9m per annum, however it is unlikely that this would translate in to a financial benefit if the ward were closed as the current patients would need to be seen in another setting within the hospital creating additional cost elsewhere.
Option 3 – Convert Ward 7 to Short stay	If the ward were converted to Short Stay, there would be an initial increase in expenditure of £349k per annum. These costs support the additional input from clinical support services and nursing costs to accommodate a shorter patient turnaround. It is expected that this approach will have a significant impact on Trust length of stay.

The preferred option is option 3 - Conversion of Ward 7 to Short Stay. The table overleaf illustrates the total funding requirement for the conversion along with the impact on expenditure by staff group or non pay item.

Expected Costs	GHH General Medicine Ward 7 Short Stay - Proposed Total Cost @ Substantive rates		Annual cost currently being incurred	(Increased)/ Decreased Annual cost	(Increased)/ Decreased cost over Winter Period
	WTE	£			
<b>STAFF GROUP</b>			£	£	
Consultant	1.0	111,400	183,828	<b>72,428</b>	<b>0</b>
Nursing Band 7	1.0	51,037	41,211	<b>(9,826)</b>	<b>0</b>
Nursing Band 6	2.0	86,709	103,782	<b>17,073</b>	<b>0</b>
Nursing Band 5	11.41	403,079	418,134	<b>15,055</b>	<b>652</b>
Nursing Band 2	16.10	380,176	359,373	<b>(20,803)</b>	<b>(47,992)</b>
Ward Clerk	1.00	20,501	20,501	<b>0</b>	<b>0</b>
Housekeeper	1.00	20,501	20,501	<b>0</b>	<b>0</b>
Trust Grade Training doctors	2.0	150,492	121,140	<b>(29,352)</b>	<b>(30,596)</b>
Band 7 Pharmacy Technician	1.2	54,522	62,496	<b>7,974</b>	<b>0</b>
Band 5 Medicine Management technician	1.2	37,303	0	<b>(37,303)</b>	<b>(12,434)</b>
Band 6 Physiotherapist	1.0	38,050	38,050	<b>0</b>	<b>0</b>
Band 6 Occupational Therapist	1.0	38,050	38,050	<b>0</b>	<b>0</b>
Band 6 Occupational Therapist - REACT	1.0	38,050	0	<b>(38,050)</b>	<b>(12,683)</b>
Band 3 Therapy support worker	1.0	23,340	23,340	<b>0</b>	<b>0</b>
Band 3 Medical Secretary	0.5	11,376	0	<b>(11,376)</b>	<b>(3,792)</b>
Drugs		156,752	53,396	<b>(103,356)</b>	<b>(34,452)</b>
Radiology		77,087	25,052	<b>(52,035)</b>	<b>(17,345)</b>
Pathology		32,036	15,273	<b>(16,763)</b>	<b>(5,588)</b>
General Non Pay		89,664	76,539	<b>(13,125)</b>	<b>(4,375)</b>
<b>TOTAL</b>		<b>1,820,125</b>	<b>1,600,666</b>	<b>(219,459)</b>	<b>(168,605)</b>

Notes;

- The nurse staffing models and levels of Non Pay expenditure are based upon the current expenditure levels within Ward 22 at Heartlands Hospital (Short Stay). This ward has an identical volume of beds and is the model for Ward 7 at Good Hope.
- Pay costs shown within the required funding section and the annual saving have been calculated at substantive rates. Where necessary agency rates have been used to calculate the part year effect dependent on whether substantive staff will be able to be sourced.

- The required funding for this project denotes the increase in budget required in order to complete the conversion from step down to short stay ward. Many of these elements already have a level of funding and in these cases only the additional funding is being requested.
- The increase in annual cost shows the movement in expenditure which will be realised if this project were to go live. This is different to the funding requirement as a number of these posts are already in place through temporary measures to manage capacity issues but are not funded.
- The PYE (Part Year Effect) of this project relates to additional cost which will be incurred if this project were to go ahead during the winter period (Dec 17- Mar 18).

In summary, the additional expenditure required to support the conversion of ward 7 to a short stay facility is £220k per annum if all posts are substantively recruited to.

### Key Risks associated with proposal

Risk	Mitigation	Risk Owner	Risk Score	Assurance / Monitoring
Unable to recruit to medical posts	The Ward will become part of the AMU directorate at GHH, which has a solid record of attracting good candidates. Rotational posts across AMU and AEC will be offered.	Dr Peri / Karen Hope	10	Via Divisional Meeting
Unable to recruit to Nursing Posts	The Ward has attracted nursing staff, predicated on this case being successful. Rotational posts with AMU and AEC will be offered to attract candidates.	Mandy Gillion / Karen Hope	10	Via Divisional Meeting
Projected LOS benefits not realised	Exemplar wards at BHH. Staff will ensure same approach / processes established to duplicate.	Karen Hope	10	LOS Group
Inappropriate patients on ward	Ordinarily Patients will be transferred to W7 by the AMU co-ordinator. This process works effectively at BHH and GHH are keen to adopt.	Mandy Gillion / Karen Hope	8	Daily Red / Green meeting. LOS Group

## Exit Strategy

In the event that this proposal does not deliver the proposed benefits, a decision will need to be made as to the long term configuration of this area. The vacancy position for nursing, allied health professionals and medical staff across the Division is such that any staff impacted by a reconfiguration could be easily absorbed into the funded establishment.

The key performance indicators used to judge the success of the ward configuration are proposed as:

Length of Stay: Reducing trajectory from 21days (current) to 3 days over the trial period.

Nursing: Maintenance of Nursing and patient experience metrics.

## Agreement from key stakeholders

Name	Role	Comments
Theresa Price	Head of Operations, Division 1	

## 4. RECOMMENDATION(S)

To approve the increased establishment required to convert Ward 7 into a Short Stay medical establishment for Winter 2017 / 18 at an additional cost of £169k.

## 5. NEXT STEPS

To support the proposal for a review of the success of this project during March 2018 with a view to substantively fund the changes if successful.

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**MONDAY 23 OCTOBER 2017**

<b>Title: REPLACEMENT OF TWO CONSULTANT OPHTHALMOLOGISTS</b>							
<b>From:</b> Jonathan Brotherton				<b>To:</b> Board of Directors			
<b>The Report is being provided for:</b>							
Decision	Y	Discussion	N	Assurance	N	Endorsement	N
<b>Purpose:</b>							
To gain Board of Directors approval for:							
<ul style="list-style-type: none"> <li>• The replacement of 2.0 WTE Consultant Ophthalmologists</li> </ul>							
<b>Key points/Summary:</b>							
<ul style="list-style-type: none"> <li>• Maintain patient safety</li> <li>• Maximize utilisation of capacity</li> <li>• Deliver RTT targets</li> <li>• Maintain service resilience and on the call rota</li> </ul>							
<b>Recommendation(s):</b>							
<b>The Board is asked to consider the information set out in this report</b>							
<b>Assurance Implications:</b>							
Board Assurance Framework	Y/N	BAF Risk Reference No.					
Performance KPIs year to date	Y/N	Resource/Assurance Implications (e.g. Financial/HR)			Y/N		
Information Exempt from Disclosure	Y/N	If yes, reason why.					
Identify any Equality & Diversity issues							
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							
Chief Executives Group							

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**MONDAY 23 OCTOBER 2017**

**1. Proposed Replacement Post Details**

Title	Consultant Ophthalmologists		Ref:	
<b>Current / former postholder PA's</b>	2 WTE Post 1 Post 2		<b>PA's:</b> 11 (old contract) 10 new contract	
<b>Leave Date:</b>	Post 1 Post 2		5 <sup>th</sup> June 2017 End of October	
<b>New Post Pas</b>	<b>DCC:</b> Post 1 – 8.5 Post 2 – 8.5	<b>SPA:</b> 1.5 1.5	<b>OTHER:</b> 0 0	<b>Total:</b> 10 10

<b>Post(s)</b>	<b>Former</b>	<b>Proposed</b>	<b>Replacement post(s) fully funded</b>	<b>Y</b>
Basic*	£162k + £7k add pa + £1k intensity	£182k	<b>Med Sec/office/IT funded &amp; in place</b>	Y
Local CEA	£12k	nil	<b>Run rate Impact</b>	£0k pa reduction
Nat'l CEA	nil	nil	<b>Temp cost avoided</b>	£264k pa
Oncosts	£49k	£49k	<b>Training costs pa</b>	£2k
<b>Total</b>	<b>£231k</b>	<b>£231k</b>	<b>Job plan agreed by College</b>	Y

## 2. Proposal

Key reasons for replacing post.	These replacement posts are essential to the delivery of the Oculoplastic service which is currently being delivered by 1.6 WTE Consultants following one WTE leaving the Trust on the 5 <sup>th</sup> June with a further reduction of one WTE at the end of October thus reducing the workforce to 0.6 WTE at that time. The current vacancy is minimally covered at present by the use of Waiting List Initiatives (WLI) whilst we are looking for a suitable locum consultant to fill this position in the interim, pending recruitment.
Current rota and implications	Currently required for outpatient clinics and theatre to deliver a full Oculoplastic job plan.
Trends in specialty activity levels, activity mix demand and income	Activity is stable with the majority of outpatient activity being carried out at BHH and operating at Solihull. The Income table at APPENDIX 1 shows that the Directorate are currently over performing to plan by £230k predominantly in Outpatients.
Potential for improved theatre utilisation/ skill mix / workforce review/ CIP/ new ways of working/ repatriation of SLAs / job planning changes / R&D activity review or pathway change which could impact on level of resource required	One of the previous post holders was employed on the old Consultant contract. The new appointment will be under the new Consultant contract.  Job planning changes for future delivery of this service.
Exit plan for replacement / Disinvestment Strategy	It is unlikely that Oculoplastic demand will reduce in the near future and thus an exit plan has not been considered at this time. There are no further retirements planned within this service.
Alternative Workforce model	The posts will need to be like for like given the nature of the surgery.
Outline of key responsibilities current post holder (out of hours, MDTs, SLAs, education leads)	Includes theatre and outpatient sessions at HEFT, MDT alongside Dermatology.
Outline any proposed changes to current duties and PAs	The new posts will replace the existing job plans (one of them being an old contract).
Base and main place of working.	Birmingham Heartlands and Solihull Hospital
Recruitment details. Likelihood, preferred skills, route to advert etc.	Recruitment of Consultant posts via Medical Recruitment Team.

Current performance and access performance	Early indications are that the Directorate achieved the RTT target in July 2017. RTT for June was 92.32% (RTT delivered since September 2016). However, the ability to deliver the RTT target has become increasingly difficult following the loss of 1 FT locum consultant post and 1 FT Consultant.
If not fully funded state additional funding required and source	N/A
How does this align with Divisional strategy	This post meets the requirement for meeting RTT position.
Impact on Quality & Safety of replacing this post	Continued delivery of a robust 5 day operating service, enabling full theatre recycling and maximizing theatre efficiency.  To retain and deliver clinical expertise as an Oculoplastic Ophthalmologist within HoEFT.  To meet the delivery needs of the Oculoplastic service.
Impact on finances of replacing this post? Salaries, SLA income, Cat A income	Fully funded post – there is a nil run rate impact as the replacement posts will cost the same based on the mid-point scale. The total cost of the replacement posts is £231k.
Risks to recruitment costs / timescales	Early advert essential to secure suitable candidates in this highly specialised area.
Interim cover and costs	A Locum Consultant has yet to be sourced to cover Post 1, which is currently with medical workforce as it is difficult to find an experienced Oculoplastic Locum Surgeon.  Some backfilling with current consultants under WLI arrangements.
Impact of not replacing this post by recruitment or locum	The service will not be viable should we not appoint to these posts. Discussions would need to be arranged with neighbouring Trusts regarding support.

### 3. Consultant Workforce and Clinical Service

The service offers Consultant support for outpatient / theatre and MDT sessions.

Recent changes: One SAS doctor has recently been recruited to the locum FT post leaving a gap of 1 WTE. EVAS has been submitted to backfill with a closing date of 15<sup>th</sup> August 2017. The recruitment team are engaging with agencies for an Oculoplastics locum to ease the pressure of this service whilst

we recruit into permanent replacement posts.

#### 4. Implementation/Phasing

<b>Milestone</b>	<b>Timescale for delivery</b>	<b>Monitoring mechanism</b>
Divisional Board approval	July 2017	Monday Divisional Team Meeting.
Operations Group approval to advertise	August 2017	Operations Group Minutes
CEG approval to recruit	August 2017	CEG Minutes
Board of Directors	September 2017	Minutes
Advertise for consultants	Advertise for Consultant for recruitment in Q2 2017/18	EVAS process
Recruitment to post	September 2017	Recruitment process
Consultant commences	January 2018	Recruitment process

The Directorate has approval from Operations Group to, by exception, to progress the EVAS in advance of the August Chief Executives Group so as not to miss the opportunity to recruit staff into this highly specialised area.

## APPENDIX 1

The table below shows the income plan and actual across four financial years which, includes the current financial year.

Income excluding MFF	14/15		15/16		16/17		17/18			Internal Annual NHSI Plan £000
	Actual £000	Plan £000	Actual £000	Plan £000	Actual £000	Internal NHSI Plan £000	Actual YTD M2 £000	Internal NHSI Plan YTD M2 £000	Variance YTD M2 £000	
Block / Manual	3,682	4,110	4,638	2,592	5,066	5,074	1,169	1,140	29	4,562
Day Case	6,045	5,150	5,944	5,856	6,004	6,772	1,271	1,309	-38	5,234
Elective	66	43	41	88	22	49	13	5	8	19
Emergency Spells	71	92	24	0	13	22	6	3	3	11
Other	1	1	1	1	1	1	0	0	0	1
Outpatients	7,528	7,544	7,241	7,250	7,561	7,473	1,893	1,680	213	6,720
Unbundled HRGs	33	26	43	43	79	54	36	21	15	83
	<b>17,427</b>	<b>16,966</b>	<b>17,932</b>	<b>15,830</b>	<b>18,746</b>	<b>19,444</b>	<b>4,387</b>	<b>4,158</b>	<b>230</b>	<b>16,630</b>

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**MONDAY 23 OCTOBER 2017**

<b>Title: REPLACEMENT TRAUMA AND ORTHOPAEDIC SURGEON</b>							
<b>From:</b> Jonathan Brotherton				<b>To:</b> Board of Directors			
<b>The Report is being provided for:</b>							
Decision	Y	Discussion	N	Assurance	N	Endorsement	N
<b>Purpose:</b>							
To gain Board of Directors approval for:							
<ul style="list-style-type: none"> <li>The replacement of 1.0 WTE Consultant</li> </ul>							
<b>Key points/Summary:</b>							
<ul style="list-style-type: none"> <li>Maintain patient safety</li> <li>Maximize utilisation of capacity</li> <li>Deliver RTT targets</li> <li>Maintain service resilience and on the call rota</li> </ul>							
<b>Recommendation(s):</b>							
<b>The Board is asked to consider the information set out in this report</b>							
<b>Assurance Implications:</b>							
Board Assurance Framework	Y/N	BAF Risk Reference No.					
Performance KPIs year to date	Y/N	Resource/Assurance Implications (e.g. Financial/HR)				Y/N	
Information Exempt from Disclosure	Y/N	If yes, reason why.					
Identify any Equality & Diversity issues							
<b>Which Committees has this paper been to? (e.g. AC, QC, etc.)</b>							
Chief Executives Group							

**HEART OF ENGLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**  
**MONDAY 23 OCTOBER 2017**

**1. Proposed Replacement Post Details**

<b>Title</b>	<b>Consultant Trauma and Orthopaedic Surgeon</b>			<b>Ref:</b>
<b>Current/former post holder PA's</b>	1.0 WTE Consultant	<b>PA's:10.5</b>		
<b>Reason for Leaving</b>	Retirement	<b>Leave Date: 30<sup>th</sup> September 2017</b>		
<b>New Post PAs</b>	<b>DCC:</b> 7	<b>SPA:</b> 1.5	<b>OTHER:</b> 1.5 (1:8) On Call	<b>Total:</b> 10

<b>Post(s)</b>	Former	Proposed	<b>Replacement post(s)fully funded</b>	Y
Basic*	£102k	£96k	<b>Med Sec/office/IT funded &amp; in place</b>	Y
Local CEA	£36k	nil	<b>Run rate Impact</b>	£48k pa reduction
Nat'l CEA	nil	nil	<b>Temp cost avoided</b>	£132k pa
On costs	£33k	£27k	<b>Training costs pa</b>	£1k
<b>Total</b>	<b>£171k</b>	<b>£123k</b>	<b>Job plan agreed by College</b>	Y

## 2. Proposal

Key reasons for replacing post.	This replacement post is essential to the delivery of the Trauma and Orthopaedics surgery service delivered by 20 Consultants (inclusive of this post).
Current rota and implications	Currently 1 in 8 rota required to retain the on call service with rotation for peripheral support for outpatient clinics. Also supports the seven day operating model.
Trends in specialty activity levels, activity mix demand and income	<p>The current post holder undertakes predominantly lower limb surgery. However, the current demand for upper limb exceeds the current capacity supplied at present. The Directorate are proposing to recruit into the vacancy with a consultant who specialises in upper limb surgery in an attempt to improve the RTT pathway for patients referred for upper limb treatment. It should be noted that there is a surplus of capacity over demand for lower limb work such that there will be no detrimental impact to the RTT by converting the post from lower limb to upper limb. APPENDIX 1 shows that the Directorate are below plan for Outpatients, Daycase and Elective and over plan for Emergency activity. Elective activity has been taken down as a result of high Trauma activity on the GHH and BHH sites and also bed capacity pressures on the GHH site. In addition the Directorate are experiencing significant issues with a lack of Junior Doctor cover with elective activity being taken down, where surgical assistance is required, in order to provide Junior Doctor cover to the ward areas.</p> <p>The majority of upper limb work is undertaken as a day case and the likelihood is that by recruiting to this post will enable day case work to deliver if not exceed the current LDP plan. By using an average of £2,103 per case at an average of 3 cases per all day session over a 36 week period would deliver £227k of income.</p>
Potential for improved theatre utilisation/ skill mix / workforce review/ CIP/ new ways of working/ repatriation of SLAs / job planning changes / R&D activity review or pathway change which could impact on level of resource required	<p>Theatre list utilisation for Trauma and orthopaedics is 98.48% with only 22 lists being deactivated during the year. Theatre session time utilisation was 87.61% against a target of 90%.</p> <p>Skill mix in place (4 ACPs currently in training and not incorporated into our rota for the first 6 months).</p> <p>Work underway to realign certain Trauma and</p>

	Orthopaedic services across site.
Exit plan for replacement	Trauma and Orthopaedic demand will not reduce in the near future and thus an exit plan has not been considered at this time. There are however, potential retirements planned in the next 2 – 3 years.
Outline of key responsibilities current post holder (out of hours, MDTs, SLAs, education leads)	Includes theatre and outpatient sessions at HEFT with on call commitment.
Outline any proposed changes to current duties and PAs	The post will replace the existing job plan. The new job plan contains 0.5 PA less than the previous post which will not affect activity as this PA was for SPA time.
Base and main place of working.	Heartlands Hospital, Solihull Hospital and Good Hope Hospital
Recruitment details. Likelihood, preferred skills, route to advert etc.	Recruitment of Consultant post via Medical Recruitment Team.
Current performance and access performance	June 2017 RTT 85.88% in month and 83.66% YTD.
If not fully funded state additional funding required and source	N/A
How does this align with Divisional strategy	This post aligns with the Divisional strategy supporting on-going development of Trauma and Orthopaedic services at HEFT.
Impact on Quality & Safety of replacing this post	Continued delivery of a robust 7 day operating model in line with best practice, enabling full theatre recycling and maximizing theatre efficiency. Continued delivery of RTT targets Sustain capacity to deliver current SLA's in place with peripheral hospital sites. Sustain the on call rota at 1 in 8. To provide inpatient ward Consultant capacity, supporting a reduction in length of stay in line with Trust strategy.
Impact on finances of replacing this post? Salaries, SLA income, Cat A income	Fully funded post - run rate savings estimated £48k per annum if recruited at £123k per annum. Category A Day Case activity should deliver or exceed the current LDP plan.

Risks to recruitment costs / timescales	Early advert essential to secure suitable candidates in this highly specialised area.
Interim cover and costs	An NHS locum costing equivalent £132k per annum will be appointed to retain service continuity pending recruitment.
Impact of not replacing this post by recruitment or locum	There will be insufficient Consultants to staff the on call rota and a further risk to the RTT position.

### 3. Consultant Workforce and Clinical Service

The service offers Consultant support for outpatient sessions and emergency access across 3 hospital sites. The demand for upper limb referrals exceeds the capacity supplied at present. The vacancy should be filled with a consultant who specialises in upper limb surgery in an attempt to improve the RTT pathway for patients referred for upper limb treatment. A cohort of 20 consultants (inclusive of this post) deliver a robust 7 day operating model in line with best practice, enabling full theatre recycling and maximizing theatre efficiency.

### 4. Implementation/Phasing

Milestone	Timescale for delivery	Monitoring mechanism
Divisional Board approval	July 2017	Monday Divisional Team Meeting.
Operations Group approval to advertise	August 2017	Operations Group Minutes
CEG approval to recruit	August 2017	CEG Minutes
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Recruitment to post	September 2017	Recruitment process
Consultant post commences	January 2018	Recruitment process

The Directorate has approval from Operations Group to, by exception, progress the EVAS in advance of the August Chief Executives Group so as not to miss the opportunity to recruit newly qualified staff into this highly specialised area.

## APPENDIX 1

The table below shows the income plan and actual across four financial years which, includes the current financial year.

Income	14/15		15/16		16/17		17/18			Internal Annual NHSI Plan £000
	Actual £000	Plan £000	Actual £000	Plan £000	Actual £000	Internal NHSI Plan £000	Actual YTD M3 £000	Internal NHSI Plan YTD M3 £000	Variance YTD M3 £000	
Ambulatory Care	0	0	1	0	2	2	1	0	1	2
Block / Manual	210	118	1,298	1,050	-397	1,391	327	360	-33	1,442
Day Case	6,854	5,372	6,712	5,710	5,941	7,854	1,625	1,732	-107	6,926
Elective Spells	16,822	15,242	15,425	16,198	14,996	16,503	3,142	3,650	-508	14,601
Emergency Assessment Area	20	1	15	27	6	11	1	1	0	3
Emergency Spells	14,158	11,010	13,913	11,722	14,076	14,714	4,034	3,826	208	15,305
Other	1	1	2	2	1	2	0	0	0	1
Outpatients	8,176	7,873	9,039	8,612	9,561	9,599	2,225	2,369	-144	9,475
Unbundled HRGs	71	82	74	62	102	71	23	26	-3	103
<b>Total £</b>	<b>46,312</b>	<b>39,699</b>	<b>46,479</b>	<b>43,382</b>	<b>44,289</b>	<b>50,148</b>	<b>11,379</b>	<b>11,964</b>	<b>-585</b>	<b>47,857</b>