Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION AGENDA

Venue: Training Room 2, Archer Ward, Rowley Regis Hospital **Date:** 3rd August 2017, 09:30h – 13:00h

Members:

Mr R Samuda	(RSM)	Chairman
Ms O Dutton	(OD)	Vice Chair
Mr M Hoare	(MH)	Non-Executive Director
Mr H Kang	(HK)	Non-Executive Director
Ms M Perry	(MP)	Non-Executive Director
Cllr W Zaffar	(WZ)	Non-Executive Director
Mr T Lewis	(TL)	Chief Executive
Dr R Stedman	(RST)	Medical Director
Ms E Newell	(EN)	Chief Nurse
Ms R Barlow	(RB)	Chief Operating Officer
Mr T Waite	(TW)	Director of Finance
Miss K Dhami	(KD)	Director of Governance
Mrs R Goodby	(RG)	Director of OD

In attendance:

Mrs C Rickards	(CR)	Trust Convenor
Mrs R Wilkin	(RW)	Director of Communications
Ms D Talbot	(DT)	On behalf of Chief Nurse

Board Support

Mrs E Quinn	(EQ)	

Time	Item	Title	Reference Number	Lead
0930h	**1.**	**Welcome, apologies and declarations of interest** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting.* **Apologies:** Elaine Newell	Verbal	**Chair**
0931h	**2.**	**Patient Story**	Presentation	**DT**
0940h	**3.**	**Questions from members of the public**	Verbal	**Chair**
0945h	**4.**	**Chair's opening comments**	Verbal	**Chair**
		UPDATES FROM THE BOARD COMMITTEES		
0950h	**5a**	To: (a) receive the update of the **Audit and Risk Management Committee** meeting held on 19th July 2017 (b) receive the minutes of the **Audit and Risk Management Committee** meeting held on 24th May 2017	Tabled SWBTB (08/17) 001	**MP**
0955h	**5b**	To: (c) receive the update of the **Quality and Safety Committee** meeting held on 28th July 2017 (d) receive the minutes of the **Quality and Safety Committee** meeting held on 30th June 2017	Tabled SWBTB (08/17) 002	**OD**

Time	Item	Title	Reference Number	Lead
1000h	**5c**	To: (a) receive the update of the **Finance & Investment Committee** meeting held on 28th July 2017 (b) receive the minutes of the **Finance & Investment** meeting held on 30th June 2017	Tabled SWBTB (08/17) 003	**MP**
		MATTERS FOR DISCUSS AND APPROVAL		
1005h	**6.**	**Chief Executive's Report**	SWBTB (08/17) 004	**TL**
1020h	**7.**	**Pathology proposal**	SWBTB (08/17) 005	**TL**
1045h	**8.**	**NHSE Emergency Preparedness, Response and Recovery Core Standards**	SWBTB (08/17) 006	**RB**
1100h	**9.**	**Staff Inclusion and Diversity pledges progress report**	SWBTB (08/17) 007	**RG**
		MATTERS FOR INFORMATION / NOTING		
1115h	**10.**	**Trust Risk Register**	SWBTB (08/17) 008	**KD**
1125h	**11.**	**Integrated Performance Report**	SWBTB (08/17) 009	**TW**
	12.	**Persistent reds**	SWBTB (08/17) 010	**TW**
1140h	**13.**	**Financial performance: P03 June 2017**	SWBTB (08/17) 011	**TW**
1155h	**14.**	**CIP Delivery: Q1**	SWBTB (08/17) 012	**RB**
1205h	**15.**	**Production Plan forecast**	SWBTB (08/17) 013	**RB**
1215h	**16.**	**Nurse recruitment update and retention: progress update**	SWBTB (08/17) 014	**RG**
1225h	**17.**	**Emergency Department scorecard**	SWBTB (08/17) 015	**RB**
1235h	**18.**	**Complaints Report: Q1**	SWBTB (08/17) 016	**KD**
1240h	**19.**	**Application of Trust Seal**	SWBTB (08/17) 017	**KD**
		UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS		
1245h	**20.**	**Minutes of the previous meeting and action log** (a) To approve the minutes of the meeting held on 6th July 2017 as a true and accurate records of discussions (b) Update on actions from previous meetings (action log)	SWBTB (08/17) 018 SWBTB (08/17) 019	**Chair** **KD**
		MATTERS FOR INFORMATION		
1255h	**21.**	**Any other business**	Verbal	**All**
	22.	**Details of next meeting** The next public Trust Board meeting will be held on **7th September 2017 starting at 09:30am** in the Anne Gibson Board Room, City Hospital		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Audit and Risk Committee

Venue Meeting Room 1, Old Management Block, City Hospital **Date** 24th May 2017; 1400h – 1600h

Present

Members Present		In Attendance
Ms M Perry	Chair	Miss K Dhami
Ms O Dutton	Non-Executive Director	Mr T Waite
Mr H Kang	Non-Executive Director	Mr T Lewis (item 4)
Cllr W Zaffar	Non-Executive Director	Mr T Reardon
		Mr A Bostock
		Mr R Chidlow
		Mr M Gennard
		Mr A Hussain
		Mrs E Quinn

Minutes	**Paper Reference**
1 Welcome, apologies and declarations of interest	**Verbal**
Ms Perry welcomed all present to the meeting. Apologies had been received from Elaine Newell.	
2 Minutes of the previous meeting held on 26th January 2017	**SWBAR (05/17) 002**
The minutes of the previous meeting held on 26th April 2017 were agreed as a true record.	
3 Matters and actions arising from previous meetings	**SWBAR (05/17) 003**
The Committee noted that any actions arising were to be discussed as part of the agenda.	
3.1 Reference Costs Timetable	**SWBAR (05/17) 003a**
Mr Waite presented the revised timetable for the reference costs submission. He reported that there had been a national delay that had meant that the Trust had not met the submission deadline, of which NHSI was aware. The Committee noted and approved the revised timetable and that submission would be challenged and confirmed by the Committee during late August and aligned for consideration and sign-off at the September Trust Board meeting.	
3.2 Approval of the Internal Audit Plan	**Verbal**

The plan was confirmed as unchanged from the version presented to the Committee at the meeting in May and was noted as having been approved by the Executive. The Committee accepted the plan.

4 Draft Annual Report, including the AGS	SWBAR (05/17) 004

Mr Lewis was in attendance to present the draft annual report, to include the Annual Governance Statement (AGS). It was noted that initial comments from the Trust's external auditors had been incorporated within this draft version. The AGS was discussed and the areas of concern and for focus in 2017/18 were drawn out, to include the business continuity plan, I.T. infrastructure, HR data quality, Deprivation of Liberty assessments and the changes needed to support changed performance in 2017-18 via EPR.

The remuneration report was discussed. Mr Waite highlighted that the revised draft remuneration report that had been circulated the previous evening superseded the version contained within the draft annual report and would be included in the final annual report. The Committee received and noted the revised draft remuneration report.

The Committee challenged and confirmed their recommendation for the Annual Report to be approved by the Board, subject to some minor amendments to wording.

5 2016/17 Annual Accounts	SWBAR (05/17) 005

Mr Waite presented the Trust's draft financial statements for the year ended 31 March 2017. He highlighted that there were minor disclosure changes to those set out in the draft Annual Report and invited the Committee to recommend the accounts to the Board. The Committee challenged and confirmed that it was content to recommend the accounts to the Board.

The Finance team was thanked for their work to ensure that the annual accounts were prepared and submitted to timescale.

6 2016/17 Audit Memorandum	SWBAR (05/17) 006

The Audit and Risk Management Committee received and noted the 2016/17 audit memorandum.

Mr Bostock reported KPMG's intention to issue an unqualified audit opinion on the accounts following adoption by the Board and receipt of the management representation letter. It was anticipated that the Value for Money opinion would be issued on a qualified basis. All other opinions were noted to be 'clean'.

Mr Chidlow highlighted the targeted risk work that had been undertaken by KPMG and that it was content with the Trust's approach. It was discussed and noted that there was no significant liability in relation to the redeployment of Healthcare Records staff. In terms of the building of the new Midland Metropolitan Hospital, it was noted that any issues/costs in relation to the delay would be accounted for in 2017/18. It was discussed and noted that following KPMG's review of the Trust's Finance and Investment Committee and Private Board papers, it was satisfied that the Board had been sighted on the in year and longer term financial challenges, including the underlying financial position in 2016/17 and in future years and was noted as being regularly discussed with NHS Improvement as part of the quarterly review process.

KPMG were thanked for their work.

7 Draft Management Representation Letter	SWBAR (05/17) 007

The draft letter of representation was received and noted. There were no issues raised.

8 Governance Pack	SWBAR (05/17) 008

Mr Waite presented the Governance Pack and highlighted that although work was still in progress, the pack represented a step forwards in improving relevant analysis and focus consistent with moving towards best practice. This development will continue and will be reflected in subsequent reports.

Mr Reardon highlighted the Trust's performance in relation to aged debt, losses and special payments, salary overpayment and single tender waivers. The Committee held a general discussion around the various areas of the pack.

The Committee discussed the Trust's procurement processes in terms of Single Tender Waivers and felt a more robust process was required in order to mitigate the high number of single tender waiver forms submitted without citing the relevant reason for doing so. It was agreed this would be highlighted at the June Trust Board meeting.

9 Data Quality Report	**SWBAR (05/17) 009**

Mr Waite presented the report that proposed a way forwards to re-invigorate work and ensure effective data quality arrangements are in place together with a specific data quality work plan for 2017/18 and indicative work plan for 2018/19.

Mr Waite highlighted that the Executive Management Team had reviewed the options available and had proposed an immediate commitment to invest 100 days of RSM's internal audit resource to progress the data quality work plan during 2017/18. It was also proposed to utilise the next 12 months to resolve sustainable arrangements, which may include the establishment of a dedicated internal capability.

The Committee challenged and confirmed the scope and focus of the work plan and management's proposal to utilise the expertise of RSM as the Trust's internal auditor for a period of 12 months.

10 Matters to raise to the Trust Board	**Verbal**

The Committee agreed the following matters should be raised to Trust Board:

- **(a)** Highlight the reference costs revised timetable in respect of consideration and sign-off;
- **(b)** Approval of the Internal Audit Plan 2017/18;
- **(c)** Approval of the scope and focus of the Data Quality work plan and management's proposal to utilise the expertise of RSM as the Trust's internal auditor for a period of 12 months to progress this work;
- **(d)** Recommendation to the Board to approve the Annual report, AGS and Annual Accounts, subject to some minor amendments to wording;
- **(e)** The Governance Pack highlighted the need for a more robust process in terms of the single tender waiver/procurement process;
- **(f)** To note the thanks to KPMG colleagues for their work involved in undertaking the annual reporting process and indeed for the work undertaken during their assignment with the Trust.

11 Any other business	**Verbal**

The Committee noted it was the last meeting with KPMG colleagues in attendance, as their contractual assignment had come to an end. Mr Bostock and Mr Chidlow were thanked for their contributions and work undertaken during their assignment with the Trust.

Details of the next meeting

The next meeting will be held on 19th July 2017 at 1000 – 1200h in the Anne Gibson Board Room, City Hospital.

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS

NHS Trust

QUALITY AND SAFETY COMMITTEE MINUTES

Venue Anne Gibson Committee Room, City Hospital **Date** 30 June 2017, 08.30 – 10.00 hours

Members attending:		**In attendance:**	
Ms. O. Dutton	Chair and Non-Executive Director	Mrs. S. Cattermole	Executive Assistant
Mr. R. Samuda	Chairman		
Ms. M. Perry	Non-Executive Director		
Ms. R. Barlow	Chief Operating Officer		
Ms. E. Newell	Chief Nurse		
Dr. R. Stedman	Medical Director		
Mr. T. Waite	Director of Finance		

Minutes	**Paper Reference**
1. Welcome, apologies for absence and declarations of interest	**Verbal**
Apologies were received from Miss Dhami, Mr. Hoare and Ms. Parker. The members present did not have any interests to declare.	
2. Minutes of the previous meeting	**SWBQS (06/17) 002**
The minutes of the meeting held on 26th May 2017 were agreed as a true record.	
3. Matters and actions arising from previous meetings	**SWBQS (06/17) 003**
a) Minute 7 (31.03.17): Mortality reviews for vulnerable patients : Dr. Stedman reported that there is a renewed approach for mortality reviews. A "Learning from Deaths" plan will be bought back to the July 2017 Q&S meeting. Ms. Dutton queried if Ms. Parker had dealt with the CCG issue. There was brief discussion around picking up deaths that occur after discharge but unless the death is raised as an incident we do not get to find out about it. Mr. Samuda asked if GPs are aware of the issue and was informed that they have their own process to deal with the matter and it depends if there is a coroner referral. There are different work streams used in general practice. Ms. Barlow informed the members that there is a Clinical Quality Review meeting in 2 weeks' time and suggested we ask Ms. Parker to put the item on the agenda. Care home deaths were briefly discussed. Mr. Samuda suggested that the systems be joined up and we work together with GPs. Dr. Stedman outlined a presentation that was displayed at a recent West Midlands Clinical Leadership forum. A system has been set up for GPs to anonymously report data but the initiative is not mandatory. b) Minute 7 (24.02.17): IPR – clinic cancellation – August Q&S. c) Minute 7 (24.02.17): IPR – SOPs for new indicators – not discussed. d) Minute 8 (24.02.17): IPR – Walsall score assessment audit – not discussed. e) Minute 9 (28.04.17): Clinical Audit – DNACPR – item on agenda.	
4. Patient story for the July Trust Board	***Verbal***
Committee members agreed that the last patient story went well.	

The patient story for the July Trust Board meeting is based on a patient where English is not her first language. She will outline (via video link) the issues she has encountered in ED with access to the interpreters. A Ward team member will attend the Board meeting to clarify any questions. The Trust has a group of interpreters that are used but sometimes there are issues with interpretation of treatment. Ms. Newell explained the challenges around screening and decisions made about care. A member of staff has to be present in the room to ensure the correct message is getting across as sometimes family members do not understand enough about the treatment being explained. Ms. Dutton asked if there was an issue with the gender of the interpreter and asked if stats could be provided on the difference in numbers for male/female interpreters. Ms. Barlow explained the differences in the provision of the interpreter services out of hours. Sometimes there is a delay in patient care due to the lack of access to an interpreter. When information is interpreted incorrectly, the issue is corrected and Trust Bank informed of misunderstanding.

ACTION : Ms. Newell to collate stats on the difference in numbers for male/female interpreter.

5. Safety Plan Update	***SWBQS (06/17) 004***

Following concerns raised at the last meeting, Ms. Newell report that 41 wards are now engaged in the deployment of the Trust's safety plan – medicine having commenced roll out on the 1st June. Detailed task level plans for each PDSA cycle are in place. Weekly meetings are taking place to look at red flags which are being monitored through the Consistency of Care Programme.

Ms. Newell presented the analysis of data for the 4 week period 21st May – 18th June (inclusive of Medicine) which shows 53,045 compliant checks against a possible 54,739 (97% compliance rate). A significant improvement in compliance can be expected in July once medicine has embedded the process within their ward areas. Electronic data is accessed across all wards with 98% compliance overall but more work needs to be done to achieve 100%. Wards who keep offending are reported to the GDON then escalated to the Chief Nurse to investigate. Repeat offenders will get coached and meet with the Chief Nurse to come up with a plan of action. Ms Barlow suggested that we make it a standard objective in their PDR. Communication to be circulated about improvement on the wards and how to access improvement tools.

30 day Improvement trajectories have been set for 4 ward areas (Lyndon 2, SAU, Newton 3 and D21) and an overarching consequences approach agreed. Ms. Newell confirmed that the admin tasks are in addition to their daily workload with extra time taken up. Dr. Stedman explained the EPR record of care which is being implemented to allow members of staff to stratify information working on reporting tools to pull off data.

Thematic areas of non-compliance are VTE; Medicines reconciliation and MCA/DoLs. A series of root cause analysis reviews will be carried out on each of these subject areas before the end of July and will inform a rapid programme of improvement actions. In conjunction, a series of quality assurance checks will validate compliance data across all standards. Following a query from Ms. Dutton, it was confirmed that the patient outcomes are being worked on. Dr. Stedman outlined the VTE figures and informed members that the VTE posters have been printed to be circulated to the relevant areas.

Following feedback from the PDSA 1 review, training has been revised for buddies. Initial feedback from the medicine roll out suggests that there has been greater visibility of buddies – possibly due to alignment with the Consistency of Care Programme. Information is dependent on buddy relationships. Weekly updates are sent to Ms. Newell.

The informatics team are currently working on capturing outcome data.

6. DNACPR and DOLS progress report	***SWBQS (05/17) 005***

Dr. Stedman outlined the snapshot of where we are with improvements following a recent audit of our processes highlighted inconsistencies in our implementation of DNACPR and DOLS. The continuing problem of not always recording assessments of patients' mental capacity and not documenting that discussions with family members have taking place where patients lack capacity are being looked at. A plan specifically outlining education plans for staff, changes in process within current/future state following implementation of EPR was outlined in detail; improvements are expected to be made following these changes with a re-audit to following when the measures are in place.

There was a lot of discussion around the state of the adequate recordings of DNACPR discussions with patients and family, DOLS and Best Interest decisions and how changes will be implemented. DOLs actions form part of the safety plan with

Claire Cotterill carrying out work on high risk areas. DNACPR gaps, trajectory and timeline work will be done in line with go live with EPR with a re-audit done when the measures are put in place.

ACTION : Dr. Stedman to provide information on DNACPR gaps, trajectory and timeline work that will be done in line with go live with EPR with a re-audit done when the measures are put in place.

7. Hip Fractures Data	***SWBQS (05/17) 006***

The data for the Hip Fractures Performance was presented by Ms. Barlow. The information showed that the Surgical Services Group failed to deliver against the fractured neck of femur pathway for the second consecutive month in 2017/18.

Performance has been poor over the previous 18 months delivering against the standard in only 5 of these months. Previously highlighted actions have shown an improved performance however this has not met the standard with low confidence levels in sustainability. Performance in June (21/6/17) shows further improvement at 92%. Tina Robinson, the new Group Director of Operations for Surgical Services is having daily conversations with her team to ensure improvements are retained. Ms. Dutton queried what happens when she goes on annual leave, Ms. Barlow confirmed that Liam Kennedy, Deputy COO for Planned Care will oversee the information while she is away.

Mr. Samuda queried if theatre efficiency will clash with this and disrupt flow and was informed that it will come down to timelines of review of demand. The team will function in activities so that work balance can be moved around.

8. Perinatal Mortality and Trust response to the MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2014.	***SWBQS (05/17) 007***

Ms. Newell outlined that the Trust Board sought assurance regarding the rates of perinatal mortality and governance processes, reviews and actions. A report was provided to CQC regarding the 17 perinatal mortality cases that occurred in Quarter 4 2016/17. The methodology for the report involved a thematic review of all of the cases that had been assessed in line with the measures that are routinely employed in the review of perinatal deaths within the Trust. The actions for each case were outlined together with common factors impacting perinatal mortality rates. The paper presented outlined the summary findings and actions identified to improve governance processes to ultimately provide assurance and reduce recurrence (where possible) and incidence as part of the national ambition to reduce rates of perinatal mortality by 30% by 2030 (approx. 30 deaths per year). As part of the commitment to this initiative, SWBH were also successful in a number of bids to support this ambition (wave 1 cohort of Trusts participating in the national perinatal safety collaborative, training funds to improve outcomes, internal investment to reduce perinatal mortality – funding for implementation of SCOR and additional funding for equipment to undertake foetal growth monitoring scanning).

Ms. Newell reported that all cases have been reviewed and it was found that there were spikes in data which needed investigation. Due to the national focus on perinatal cases, assurance work is being done by Miss Gabby Downey and her team. Within 6 months there have been slipped timelines of case reviews so we have now requested an external peer review to ensure conclusions and work done is accurate. The report will be available at the end of August. There were discussions around which meeting to bring it to for further discussion; Q&S or Board meeting. It was agreed that a conference call can take place to discuss the paper before being taken to the September Trust Board.

It was agreed that the August Q&S will need to look at the gap analysis on last week's *MBRRACE* report.

ACTION: MBRRACE report feedback at August Q&S. Audit data report to be discussed before being reported to Board in September 2017.

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

Mr. Waite summarised the IPR and items discussed included the RTT figures – May delivery at 93.79% against national standard of 92%. June tracking projections to deliver standard, internal forecast is 93.5%. Acute Diagnostic waiting times within 6 weeks is at May 99.4% recovering to compliance of 99%. Cancelled operations and ED 4 hours plans for improvements was briefly discussed. Improvement programme to be looked at and brought back to July Q&S meeting. Recruitment concerns were discussed following the Thornbury reduction and gaps in shifts. Other ways to improve

staffing are in place and leadership approach improvements are being looked at. Staff are working on performance improvements ie new pathways, ambulance waits. OPAU changes have been put in place. Evaluation criteria have been identified. Sustained improvements are being monitored. 28% of improvements are reliant on other areas. Patient experience and harm free care was briefly discussed. Friends and family tests were explained.

Mortality review – Dr. Stedman confirmed that learning from deaths work is being done, looking at week day/weekend data gaps.

10. Monthly Serious Incident report	***SWBQS (05/17) 009***

Dr. Stedman updated the committee members on the two SIs that have happened in Trauma and Orthopaedics. A T&O Safety Summit is being arranged for the end of July to look at the standards of medical care with the T&O Team. Ms. Dutton was asked to chair the meeting with other Execs invited to participate.

11. Patient experiences stories to the Board : wider learning	***SWBQS (05/17) 010***

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

1. Actions taken to establish a repository for patient stories in order that thematic trends can be identified and shared learning / actions can be evidenced.
2. Methods by which patient stories with associated learning and actions can be disseminated / shared with a wider audience. A checklist has been set up to link through the Connect website with key messages from patients.

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

12. Meeting effectiveness	***Verbal***

The meeting discussions were felt to be useful and constructive.

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

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

Monthly Serious Incident Report
There have been two SIs in Trauma and Orthopaedics, a T&O Safety Summit is being arranged for the end of July to look at the standards of medical care with the T&O Team.

Patient Experiences stories to the Board – wider learning : A schedule has been put together for each Group to bring their stories to the Board with a checklist set up with a link to Connect for wider sharing. Key messages from patients will be included.

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

No other items were called out for discussion.

Next meeting: 28th July 2017 at 10.30h in the Anne Gibson Committee Room at City Hospital.

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FINANCE & INVESTMENT COMMITTEE MINUTES

Venue: Anne Gibson Committee Room, City Hospital **Date**: 30 June 2017, 1030h – 1200h

Members present:		**In attendance:**	
Mr Richard Samuda	Chairman	Mr Toby Lewis	Chief Executive
Mrs Marie Perry	Non-Executive Director	Mrs Elaine Quinn	Executive Assistant
Mr Tony Waite	Director of Finance		
Ms Rachel Barlow	Chief Operating Officer		

Minutes	**Paper Reference**
1. Welcome, apologies and declarations of interest	**Verbal**
The Chair welcomed all to the meeting. Apologies had been received from Mrs Goodby, Mr Kang and Mr Reardon. The members present did not have any interests to declare.	
2. Minutes of the previous meeting held on 31 May 2017	**SWBFI (06/17) 002**
The minutes were agreed as a true record.	
2.1. Matters arising and update on actions from the previous meetings	SWBFI (06/17) 002(a)
The Committee noted that there were no on-going actions.	
3. Financial Performance & Outlook– P02 May 2017	**SWBFI (06/17) 003**
Mr Waite reported that that the P02 year to date headline performance reported as plan, but had been reliant on the recognition of significant unplanned technical support. The Committee noted the forward look to P03 which would require delivery of an in-month deficit of £2.2m as plan to secure STF funding. Delivery of the production plan, CIP to TPRS plan and the agency plan should moderate any requirement for use of flexibilities and contingencies. Mr Lewis highlighted a residual concern that the workforce plan and the Trust's financial plan were not aligned. It was noted however, that work was underway to assure that the workforce plan would be aligned with the Trust's financial plan. Mr Waite made it clear that current actions on pay and workforce were necessary but not sufficient to secure the scale of financial improvement required. It was reported that the Trust had received £3.2m of challenges from commissioners in respect of P01 activity and income. Mr Waite indicated that his concern was focussed on £0.5m of PLCV and £0.5m of Payment by Results challenges. The Trust was working proactively with NHSI to challenge and confirm its case for rebuttal. The deadline was noted to be 2 August for local resolution and 31 August for any escalated process. Delivery of control total surplus of £9.9m was still plausible but dependent on the realisation of a material profit on disposal of surplus assets. This remained to be confirmed. This was in addition to full delivery of production plan and CIPs.	

The FIP2 Phase 2 work was noted as having been discussed with EY at the informal Board meeting and was to be referred to the full Board for consideration at its July meeting.

Expenditure on capital was noted as being £2.8m below plan to date. The Committee challenged and confirmed that this was not a cause of concern at the current time as regards the critical path programme. CRL remains to be confirmed by NHSI, with dialogue on-going.

The Committee noted the update on cash remediation and revised forecast for any revenue loan deferred to Q4 subject to securing surplus asset disposal proceeds. The Committee challenged and confirmed that the loan process was being effectively managed with NHSI.

The Committee challenged the Q1 13 week plan and expressed its concern at the incomplete status of key actions. The Committee noted the remedial actions and wanted to draw this to the attention of the Board.

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

The Committee wished to highlight the following matters:

- Remedial actions for Q1 I&E 13 week plan.
- Workforce plan alignment and requirement for further pay improvement actions.
- FIP2 next steps

5. Meeting Effectiveness Feedback	**Verbal**

The Committee felt the matters on the agenda were the key matters that it needed to focus its attention on.

9. Any Other Business	**Verbal**

There were no items of any other business.

10. Details of the next meeting	**Verbal**

The next Finance and Investment Committee meeting will be held on 28th July 2017 at 0830h – 1000h in the Anne Gibson Committee Room, City Hospital.

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Public Trust Board

Chief Executive's Report – August 2017

The Board meets at Rowley Regis Hospital. Over the course of recent times the site has seen a number of new service openings, most excitingly perhaps our Day Hospice model which is the centrepiece of our partnership to deliver outstanding End of Life care to local people. Aided considerably by a seven year contract, and therefore scope to invest and to a degree experiment with service design, we have had a very successful first year. In addition to looking to further localise options for home support in the year ahead we have an important collaboration with Sandwell Metropolitan Borough Council, and other local partners, to develop community awareness around end of life care, service options, and the support available in different communities. We are also looking to invest further time and resource in supporting general practice excellence as well as developing better care models to support deaths among patients with heart failure and COPD. The CQC have looked at our end of life care offer as part of their wider inspection. We now anticipate site of a draft report from them towards the end of August.

The last month has seen a continued focus on implementation of change around our IT and case-note systems, as well as on consistency of care in medicine and the Safety Plan, which we discussed last month with the wider Board. Our cost improvement programme continues to deliver but the next 8-10 weeks are key in closing the remaining unfunded beds and seeing temporary pay spend continue to reduce. The papers for the Board's meeting include an assessment of our forward income position, albeit we continue to have to divert time and resource to address commissioning disputes over invoices issued for care. By the end of Q1 we expect this threat to reach around £9m, and to scale up across the year to more than 10% of our overall income. We are working with regulators to understand how this transactional process is best managed proportionately, bearing in mind that our deficit in 2016-17 was less than our commissioners' surplus and accordingly on the face of it our 'system' is in some measure of financial balance.

1. Our patients

NHS Improvement has specifically commended the Trust for our continued delivery of national wait time targets for planned care, including cancer. That said, we are not satisfied with our delivery standards and wish to make further improvements. The new planned care delivery group will seek to ensure that all initiatives across theatres and clinics have a common thread of patient experience improvement. Looking forward there are risks to future delivery, associated with the perceived uncertainty over solid tumour oncology service provision, and changed national guidance on referrals and on diagnostic modalities. We have seen a surging rise in referrals for cancer in recent months associated with revised national guidance in general practice and likewise for cardiac CT investigation, associated with altered NICE guidance. In both cases therefore the changes reflect good practice and better care and we will look to respond positively to that. At the same time our financial model for the new investments associated with the Midland Metropolitan Hospital relies on meeting the needs of more local practices, who may have traditionally made referrals to neighbouring hospitals further from local services and reducing wait times even further will be part of that campaign. Developments locally

to better align GPs and our work are progressing well with memorandums of understanding being signed, and work continuing to seek to locate a GP practice on the Sandwell site by 2019, and potentially one on our Dudley Road site in the year after.

Emergency care waits times are still longer than we would all want, albeit the last month has seen our best "performance" for some time. That improvement reflects concerted action to improve flow within the A&E departments and better success at managing twilight hours. Consistent delivery of our consultant led review model (RATs) has been important. In coming weeks, we will alter our bed model within the Trust to better move specialty patients into specialty wards from acute medicine, and also will see the benefit of a big expansion in GP appointment slots locally. We very much hope that such appointments will be bookable by clinicians in our Emergency Department and a proposal to support that is expected at the next A&E Delivery Board, which I chair, from CCG colleagues. Further to national and local publicity about the unacceptable waits for mental health patients, we have conducted a review of the key issues, and of the circumstances whereby interpreting services form a barrier to care. A set of actions to tackle the latter issue are now in place for the next two months.

Our 12 week Consistency of Care event was attended by over 100 clinicians earlier in the month. The drive to change behaviours and improve results was exceptional. Over the next 12 weeks we will work with each medical ward to examine how they might deliver the standards each shift. Changes to how we conduct handover will be central to the effort to make sure our documentation always reflects the care plan agreed with our patients. The new EPR will 'hard code' VTE and will help with medicines reconciliation. The focus of effort in the weeks ahead is how we convert daily Safety Plan scores of 98%+ into 24 hours later results at 100%. It is intensely exciting that 2017 could be the year in which we 'crack' this core standards position in our wards. The wish to do so reflects our staff view, as well as feedback from Healthwatch and from our patient members.

More urgently we are determined to resolve the issues we perceive, and so do key local stakeholders such as Coroners, in our processes around deprivation of liberty and Do Not Resuscitate Orders. To that end we have been clear that all patients assessed through these processes should be entered onto our main IT system (eBMS) such that we can audit and continuously improve our practice. Our audit data based on sample suggests typical good practice but room for improvement around the timeliness of family involvement. We are determined to match our calibre of service for defined end of life patients, which has seen a huge rise in the proportion of patients dying in a place for their choosing with a focus on the patients who die in our care without recourse to the specialist palliative care team. To deliver the promise of our Connected Palliative Care Partnership we know that infrastructure for cardiac and respiratory deaths, and the liaison with GP colleagues, must be improved.

The Board has been concerned for some time about cancellations for surgery on the day of care. Over the last month we have had a focused effort to change the historic pattern of on the day cancellations, piloted in three specialties. This has seen real impact through greater grip over decision making, led by the senior management team in surgery. Over the coming month the techniques applied will spread to all disciplines. We know that that will drive down cancellation rates, but only after deployment will it be possible to assess whether we can reduce rates below 0.5% which is the standard for which we are aiming as a minimum. I would propose that we reserve time at our October Board to consider the sufficiency of our operational response.

The Trust has received a CQC outlier alert relating to an increase in reported cases of puerperal sepsis within 42 days of delivery between July and November 2016. The Board will recall that a report was provided to the May Q & S Committee and reported that we had reviewed the puerperal sepsis by conducting a 'look back' exercise in Q3 2016/17 which indicated that we were over diagnosing (and treating) sepsis in view of the high number of low risk, labouring women being treated on the sepsis pathway and then, neonates requiring prophylactic IV antibiotics. This review identified that women were 'triggering' with mild pyrexia and increased heart rate and respiratory rate when in established labour. The review correlated this with epidural infusion which is recognised to be associated with mild

pyrexia. Additionally, physiological (normal) labour increases respiratory rate and heart rate and also is associated with an increased WCC. In response to this and anecdotal observations, we reviewed the sepsis pathway and identified that our thresholds for trigger were too low. We have since been proactively involved with Dr Ron Daniels (national sepsis lead) in leading work to develop regional maternity sepsis pathway. The response to the CQC outlier alert will be reported to the August Q & S Committee.

2. Our workforce

We continue to see major success with our work on recruitment, and this is reflected in part in Raffaela Goodby's nurse recruitment update about our employment offers, (item 16 on the agenda). All HCA vacancies now have offers made against them, and almost 100 nursing offers have been made as well. Converting those offers into starters is being assertively managed by local leaders. At the same time overseas recruitment options continue to be pursued, whilst we are attending all relevant national job fairs. As the Board discussed last month retention is then crucial to our strategy to reduce vacancy levels.

We have reduced further our agency expenditure and at time of writing have reached almost two months without resort to Thornbury. We have a commitment to achieve similar transformation in the use of medical agency. Revised approval limits for local managers are in place as we look to tackle high cost agency use.

Over the last month the Trust has again been successful in winning awards locally. The Making Birmingham Greener awards saw us win the overall prize and three others, tribute to our longstanding efforts on energy efficiency, green transport and wider sustainability. At the same time we have won ENEI awards for our work of diversity, focused on our staff networks, with the Disability and Long Term Conditions network now having started worked. This network will focus on both staff and patients, and will incorporate work we have begun on Learning Disabilities, as well as prioritising a fair offer for all employees and potential employees reflecting a determination to make reasonable adjustments to support people in the workplace.

At the end of June, we went live with our casenote scanning project. This moves us away from paper notes to use of a scanned record accessed via CDA. We are working with our supply chain to improve the timeliness of record availability and the first few weeks have seen some challenges with availability. A post project review is underway to resolve residual issues and to ensure we learn lessons from this deployment targeted at future projects such as our final move to voice recognition, and the transfer to our electronic patient record later in the year.

3. Our partners

The Sandwell and West Birmingham Sustainability review is now well underway. A report from that collaborative process is expected over the next month. The review looks at the viability of future commissioning plans as well as at the future finances of key organisations such as our own. The review includes an updated appraisal of assumptions made in the business case for Midland Met. This piece of work also incorporates the bed review promised when we signed off the new hospital, which we will make publicly available when it is concluded.

Inevitably this review work also considers issues associated with the so-called West Birmingham question. I have reminded the Board previously of the intrinsic nature of this population to the underpinning case for the Midland Met. Any transfer of responsibility for Perry Barr and Ladywood into a wider city entity raises fundamental questions about the future of the new hospital, both financially and as an operational entity. We continue to work to ensure that decisions made on these matters are fairly informed by facts and are made with the consequences understood by all. The risk register for the Trust, and our board assurance framework, needs to reflect these considerations in the coming weeks.

4. Our commissioners

The Trust continues to develop the Co-operative Working agreement with Sandwell Metropolitan Borough Council. The last month has seen the go-live for the new service supporting vulnerable parents which replaces the Family Nurse Partnership services. Discussions continue about the final scope of the cooperative working agreement but to date, in my view, it is helping considerably to join up previously disparate services and to provide continuity and space to innovate. We are aiming to agree a joint Public Health Plan by the end of the month.

We have contributed latterly to exciting plans to invest the new Better Care Fund in preventing hospital attendance, and readmission, as well as to tackle rates of community institutionalisation. Over the next six weeks the multi-agency partnership will consider:

- How to address delayed care transfers for Sandwell residents in neighbouring hospitals
- How to reduce attendance rates with a focus on complex repeat attendees
- Further steps to address re admission rates in the borough

5. The Black Country STP

Since the last Board meeting the STP partnership body has not met. However, the four largest NHS providers locally have develop a draft protocol for better joint working, reflecting the recent collaborative experience of the Black Country Alliance which has in practice incorporated Royal Wolverhampton's expertise as well. Today's Board meeting will explore the latest pathology proposal.

In addition to my standard attachment to this report, I also include two others:

- Our national cancer experience survey results; a response to which will be developed via the CLE Cancer Board, which Rachel Barlow chairs and

- A standard report on the business of the Clinical Leadership Executive (CLE) drawing Board members' attention to the key consideration we addressed there in the prior month. The inclusion of this routinely was an outcome of the review Kam Dhami conducted for the Chairman into our Board's governance.

I undertook after the last Board meeting to re-examine the processes behind our Never Event governance. I will talk the meeting through my emerging conclusions, which reflect the work to revise the Serious Incident reporting practice which we brought to the Board in March 2017. In summary my proposal is that:

- We undertake our investigations over a 50 working day period, meaning that our final reports into the Board will come in detail slightly more slowly than presently.
- That we undertake formal training of a revised list of lead investigators, equipping them with the knowledge to conduct not simply root cause analysis training but better development of action plans and project management.
- That each incident in practice gives rise to two action plans. One specific to the incident under investigation, and a second aimed at identifying and tackling similar or related risks across the wider organisation.
- That the tracking of delivery of both SI and Never Event action plans moves to the central Governance team and is routinely reported to the Board's Q&S committee, and to the new streamlined Executive Quality Committee which will support CLE.

I have not yet concluded work defining the circumstances under which such investigations would give rise to conduct action against an individual employee. We recognise that we want a culture of learning and insight, but also one of responsibility and accountability. We will bring this work back to the Board in September alongside our wider "consequences" paper, which covers rewards and remedies for individuals, teams and directorates.

Toby Lewis
Chief Executive

July 27th 2017

Appendix A: Safe Staffing
Appendix B: National Cancer Experience Survey Results
Appendix C: July CLE Update

Appendix A

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD	
DOCUMENT TITLE:	Safe staffing
SPONSOR (EXECUTIVE DIRECTOR):	Elaine Newell –Chief Nurse
AUTHOR:	Elaine Newell
DATE OF MEETING:	3rd August 2017

EXECUTIVE SUMMARY:

June Summary

It is with interest that the June safe staffing data is considered this month given that this is the first report following the Thornbury 'switch off'.

The summary level Unify data does not demonstrate any major variance across this period. The average CHPPD for registered nurses across the trust is 4.7 hours which is consistent with the rolling 3 month average The average fill rates across the trust for registered nurses, which includes permanent, bank and Agency staff for both day and night shifts has remained stable in June at 98.2 and 96 % respectively (97.3% and 95.4% respectively in May). HCA fill rates are also stable at 95.2% and 104% respectively.

There are likely to be a number of reasons for a lower than anticipated impact on shift fills:

- Whilst acknowledging that there is significant improvement still to be made, there is some evidence that roster management has improved across the majority of areas.
- Work on a revised model of focussed care has been implemented across a number of areas and has assisted in reducing the demand on bank and agency thus channelling resources more appropriately
- Block booking of a 3 person bank 'hit team' for out of hours.
- Progress in terms of bed closure programme.
- Steady progress in filling vacancies.

44 nurse offers were made at the local recruitment fayre in July (against a trajectory of 15). A further 40 HCA offers were also made. This should close the HCA vacancy gap once those offers have been converted.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

PREVIOUS CONSIDERATION:

July Trust Board

Safe Staffing Return Summary

			Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
			Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
Month	Site Code	Site Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives / nurses	Care Staff	Overall
Jul-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2138	2330	526	527	414	500	0	18	109.0%	100.2%	120.8%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	25676	27032	15249	16705	14064	17337	6905	8503	105.3%	109.5%	123.3%	123.1%				
	RXK10	ROWLEY REGIS HOSPITAL	2826	3265	4417	4556	1243	1985	1788	2085	115.5%	103.2%	159.7%	116.6%				
	RXK01	SANDWELL GENERAL HOSPITAL	30666	32776	19123	22015	15612	18588	8817	13232	106.9%	115.1%	119.1%	150.1%				
	Total		61305	65403	39314	43803	31332	38409	17510	23837	106.7%	111.4%	122.6%	136.1%				
Aug-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1839	1807	497	475	472	560	0	28	98.3%	95.6%	118.7%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	24155	24753	13808	14687	13967	16362	6858	8233	102.5%	106.4%	117.2%	120.0%				
	RXK10	ROWLEY REGIS HOSPITAL	2964	3200	3816	3937	1176	1794	1553	1860	107.9%	103.2%	152.6%	119.8%				
	RXK01	SANDWELL GENERAL HOSPITAL	28245	29172	16759	19191	14679	16520	7932	11384	103.3%	114.5%	112.5%	143.5%				
	Total		57202	58932	34879	38290	30293	35236	16343	21505	103.0%	109.8%	116.3%	131.6%				
Sep-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2137	2080	454	475	472	532	0	119	97.3%	104.5%	112.8%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	24208	27604	14308	17278	13993	20283	6794	10406	114.0%	120.8%	144.9%	153.2%				
	RXK10	ROWLEY REGIS HOSPITAL	1274	1472	1216	1382	403	1185	587	756	115.5%	113.6%	294.4%	128.9%				
	RXK01	SANDWELL GENERAL HOSPITAL	27883	32528	16822	23743	14654	20124	7392	15185	116.7%	141.1%	137.3%	205.4%				
	Total		55501	63684	32800	42877	29521	42124	14773	26466	114.7%	130.7%	142.7%	179.2%				
Oct-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2199	2139.917	546.75	548.5	434.75	519	0	28	97.3%	100.3%	119.4%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	25273	27384.5	14779.5	15814.42	14038.5	16711.07	6797	8913.5	108.4%	107.0%	119.0%	131.1%				
	RXK10	ROWLEY REGIS HOSPITAL	3308	3480.067	3886.5	4283.25	1230	1876.5	1590	2006	105.2%	110.2%	152.6%	126.2%				
	RXK01	SANDWELL GENERAL HOSPITAL	31768.25	33296.75	19265.22	21818.3	16182.5	19034.25	8175	11998.83	104.8%	113.3%	117.6%	146.8%				
	Total		62548	66301	38478	42464	31886	38141	16562	22946	106.0%	110.4%	119.6%	138.5%				
Nov-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2082.5	2122.167	569.75	590.9167	490.25	499.75	0	55.75	101.9%	103.7%	101.9%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	26188.75	26959.63	15119	15017.5	14937	16194.5	6939	8142	102.9%	99.3%	108.4%	117.3%				
	RXK10	ROWLEY REGIS HOSPITAL	3040.5	2955.25	3894	3722.75	1306.5	1463	1511.5	1800	97.2%	95.6%	112.0%	119.1%				
	RXK01	SANDWELL GENERAL HOSPITAL	29371	30796.57	18168.5	19839.58	15566	17377.82	7733	11116.5	104.9%	109.2%	111.6%	143.8%				
	Total		60683	62834	37751	39171	32300	35535	16184	21114	103.5%	103.8%	110.0%	130.5%				
Dec-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1963.75	1844.167	554	471.5	518	465.5	0	139.25	93.9%	85.1%	89.9%	0.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	26367.75	26839.52	15860.5	15872.08	15638.5	16717.67	7044	7930	101.8%	100.1%	106.9%	112.6%				
	RXK10	ROWLEY REGIS HOSPITAL	3280	3003	3634.5	3553.5	1262.5	1255.5	1501.5	1622.5	91.6%	97.8%	99.4%	108.1%				
	RXK01	SANDWELL GENERAL HOSPITAL	30676	30848.75	17822	19391.08	16710.5	17467	8177.017	10390.08	100.6%	108.8%	104.5%	127.1%				
	Total		62288	62535	37871	39288	34130	35906	16723	20082	100.4%	103.7%	105.2%	120.1%				
Jan-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2123.25	2227.333	505.5	492.25	582.75	555	129.5	157.5	104.9%	97.4%	95.2%	121.6%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	30328.5	30574.63	15962.5	15937.82	18989.5	20653.42	7731	8767.25	100.8%	99.8%	108.8%	113.4%				
	RXK10	ROWLEY REGIS HOSPITAL	2919	3183.5	3472.5	3411.5	1333	1558.5	1429	1542.25	109.1%	98.2%	116.9%	107.9%				
	RXK01	SANDWELL GENERAL HOSPITAL	29286.5	30702.12	17609.5	19883.43	16561.5	18341	8455	11660.25	104.8%	112.9%	110.7%	137.9%				
			64657	66688	37550	39725	37467	41108	17745	22127	103.1%	105.8%	109.7%	124.7%				
Feb-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1867.25	2053.5	464.5	462	490.25	518	129.5	101.75	110.0%	99.5%	105.7%	78.6%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	27390.25	27677.75	14544.5	14620.48	17409.5	18193.92	6915.5	7414.25	101.0%	100.5%	104.5%	107.2%				
	RXK10	ROWLEY REGIS HOSPITAL	2542	2743.25	3000.5	3185.5	1194.5	1192	1457.5	1407	107.9%	106.2%	99.8%	96.5%				
	RXK01	SANDWELL GENERAL HOSPITAL	25298.5	27136.1	14521.5	16240.82	14720	16798	7292	9867.25	107.3%	111.8%	114.1%	135.3%				
			57098	59611	32531	34509	33814	36702	15795	18790	104.4%	106.1%	108.5%	119.0%				
Mar-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2353.25	2352.417	501.5	447	573.5	565.25	148	139.5	100.0%	89.1%	98.6%	94.3%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	29823.73	30744.15	16727.5	15515.32	18670	21136.23	7507.5	7752	103.1%	92.8%	113.2%	103.3%				
	RXK10	ROWLEY REGIS HOSPITAL	2702.5	3084.9	3546.75	3896.583	1211.5	1717.75	1670.5	2067	114.1%	109.9%	141.8%	123.7%				
	RXK01	SANDWELL GENERAL HOSPITAL	28133.5	30365.28	15989.5	17373.25	15995	20147.07	7760.517	10975.02	107.9%	108.7%	126.0%	141.4%				
			63013	66547	36765	37232	36450	43566	17087	20934	105.6%	101.3%	119.5%	122.5%				
Apr-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1502	1941	305.5	396.25	444	536.5	92.5	101.75	129.2%	129.7%	120.8%	110.0%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
	RXK02	CITY HOSPITAL	30171.5	31776.33	16684	15468.25	18810.5	20221.75	7285.5	8325	105.3%	92.7%	107.5%	114.3%				

	RXK10	ROWLEY REGIS HOSPITAL	2614	2568.5	3772	3448.067	1116.5	1351.5	1763	1778	98.3%	91.4%	121.0%	100.9%
	RXK01	SANDWELL GENERAL HOSPITAL	27100	29153.3	15850.25	17460.35	16443.5	18445.28	7508	10431.5	107.6%	110.2%	112.2%	138.9%
			61388	65439	36612	36773	36815	40555	16649	20636	106.6%	100.4%	110.2%	123.9%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2034.5	1941	434	402.25	573.5	527.25	138.75	138.75	95.4%	92.7%	91.9%	100.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
May-15	RXK02	CITY HOSPITAL	32094.5	32675.33	16822.25	16256	19465	21176.25	7493	8437	101.8%	96.6%	108.8%	112.6%
	RXK10	ROWLEY REGIS HOSPITAL	2645.5	2576.067	3508.5	3169.083	1083.5	1475.067	1842.5	2033	97.4%	90.3%	136.1%	110.3%
	RXK01	SANDWELL GENERAL HOSPITAL	26561	27802.15	15591.5	17242.17	16839	17383.17	8199.5	10655	104.7%	110.6%	103.2%	129.9%
			63336	64995	36356	37070	37961	40562	17674	21264	102.6%	102.0%	106.9%	120.3%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2276.25	2172.167	419	426	555	527.25	166.5	184.75	95.4%	101.7%	95.0%	111.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Jun-15	RXK02	CITY HOSPITAL	28309.5	29468.17	15410.18	14755.27	18281	19637.77	6748.5	7504.317	104.1%	95.8%	107.4%	111.2%
	RXK10	ROWLEY REGIS HOSPITAL	2442	2374.75	3676.5	3263	1302.5	1494	1587	1916.5	97.2%	88.8%	114.7%	120.8%
	RXK01	SANDWELL GENERAL HOSPITAL	26826	28578.08	15516.5	17366.28	15139.5	17222.75	8432.5	10183	106.5%	111.9%	113.8%	120.8%
			59854	62593	35022	35811	35278	38882	16935	19789	104.6%	102.3%	110.2%	116.9%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	930	1951.583	465	512.75	589	555	0	166.5	209.8%	110.3%	94.2%	0.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Jul-15	RXK02	CITY HOSPITAL	32069.5	27187.57	13190.5	13134.5	27450.5	19260.02	8199.5	7613.267	84.8%	99.6%	70.2%	92.9%
	RXK10	ROWLEY REGIS HOSPITAL	3208	2495	3565	2970.667	2139	1486.75	2495.5	1923	77.8%	83.3%	69.5%	77.1%
	RXK01	SANDWELL GENERAL HOSPITAL	30178.5	26279.73	15686	15236.02	23885.5	17973.25	11764.5	11337.25	87.1%	97.1%	75.2%	96.4%
			66386	57914	32907	31854	54064	39275	22460	21040	87.2%	96.8%	72.6%	93.7%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	930	806	465	370.75	573	518.25	0	171	86.7%	79.7%	90.4%	0.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Aug-15	RXK02	CITY HOSPITAL	31861.5	24502	13158.25	11459.75	27419.5	18006.17	7843	7162.517	76.9%	87.1%	65.7%	91.3%
	RXK10	ROWLEY REGIS HOSPITAL	3208.5	2431.5	3565	3108.117	2139	1589.75	2495.5	2150.5	75.8%	87.2%	74.3%	86.2%
	RXK01	SANDWELL GENERAL HOSPITAL	29192	24223	14735.5	15146	22765.5	17481.07	11251	11176.75	83.0%	102.8%	76.8%	99.3%
			65192	51963	31924	30085	52897	37595	21590	20661	79.7%	94.2%	71.1%	95.7%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	900	935	450	378.5	555	472	166.5	194.75	103.9%	84.1%	85.0%	117.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Sep-15	RXK02	CITY HOSPITAL	28394	26595.9	11679	13003.83	24495	20277.5	7651	7903	93.7%	111.3%	82.8%	103.3%
	RXK10	ROWLEY REGIS HOSPITAL	3105	2663	3450	3364.5	2070	1881.25	2415	2336	85.8%	97.5%	90.9%	96.7%
	RXK01	SANDWELL GENERAL HOSPITAL	27587	25604	14651	16277.83	21016	18495	11561.5	11814.52	92.8%	111.1%	88.0%	102.2%
			59986	55798	30230	33025	48136	41126	21794	22248	93.0%	109.2%	85.4%	102.1%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	930	969.3333	465	344.75	573.5	536.75	157.25	178.25	104.2%	74.1%	93.6%	113.4%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Oct-15	RXK02	CITY HOSPITAL	30986	34295.28	13485.5	16855.07	26737.5	28120.5	8215	10881.25	110.7%	125.0%	105.2%	132.5%
	RXK10	ROWLEY REGIS HOSPITAL	3208.5	3267.667	3565	3678	2139	2590.25	2495.5	2913.5	101.8%	103.2%	121.1%	116.8%
	RXK01	SANDWELL GENERAL HOSPITAL	27183.5	30355.55	15523.5	21546.75	21761	24224.5	10848	16673.5	111.7%	138.8%	111.3%	153.7%
			62308	68888	33039	42425	51211	55472	21716	30647	110.6%	128.4%	108.3%	141.1%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	435	435	217	191	536	536	157	138	104.2%	74.1%	93.6%	113.4%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Nov-15	RXK02	CITY HOSPITAL	24755	23194	9789	9919	22694	21079	7217	7434	110.7%	125.0%	105.2%	132.5%
	RXK10	ROWLEY REGIS HOSPITAL	2738	2309	1738	1837	1826	1871	1493	1446	101.8%	103.2%	121.1%	116.8%
	RXK01	SANDWELL GENERAL HOSPITAL	24276	23016	12497	12096	20417	19181	10173	9660	111.7%	138.8%	111.3%	153.7%
			52204	48954	24241	24043	45473	42667	19040	18678	93.8%	99.2%	93.8%	98.1%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	450	232	195	573	545	185	148	96.8%	84.1%	95.1%	80.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Dec-15	RXK02	CITY HOSPITAL	28783	27400	12089	11327	27170	24752	9454	8471	95.2%	93.7%	91.1%	89.6%
	RXK10	ROWLEY REGIS HOSPITAL	3044	2561	1975	2027	2030	2007	1689	1586	84.1%	102.6%	98.9%	93.9%
	RXK01	SANDWELL GENERAL HOSPITAL	26109	24203	13225	12669	21872	20396	10342	10095	92.7%	95.8%	93.3%	97.6%
			58401	54614	27521	26218	51645	47700	21670	20300	93.5%	95.3%	92.4%	93.7%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	198	573	564	148	148	100.0%	85.3%	98.4%	100.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Jan-16	RXK02	CITY HOSPITAL	26001	24220	10586	9949	24291	23361	8611	7795	93.2%	94.0%	96.2%	90.5%
	RXK10	ROWLEY REGIS HOSPITAL	2867	2417	1798	1775	1912	1888	1235	1223	84.3%	98.7%	98.7%	99.0%
	RXK01	SANDWELL GENERAL HOSPITAL	25861	24488	12914	12728	21731	20994	10454	10439	94.7%	98.6%	96.6%	99.9%
			55194	51590	25530	24650	48507	46807	20448	19605	93.5%	96.6%	96.5%	95.9%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	420	420	210	195	518	518	148	148	100.0%	92.9%	100.0%	100.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Feb-16	RXK02	CITY HOSPITAL	27047	25992	11249	10768	25705	24916	8501	8412	96.1%	95.7%	96.9%	99.0%
	RXK10	ROWLEY REGIS HOSPITAL	3906	3279	3664	3960	2604	2557	2779	3098	83.9%	108.1%	98.2%	111.5%

	RXK01	SANDWELL GENERAL HOSPITAL	25483	23052	12166	12244	21532	19958	9856	9788	90.5%	100.6%	92.7%	99.3%				
			56856	52743	27289	27167	50359	47949	21284	21446	92.8%	99.6%	95.2%	100.8%				
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	555	465	277	221	462	573	157	194	83.8%	79.8%	124.0%	123.6%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
Mar-16	RXK02	CITY HOSPITAL	24357	27553	10043	11106	22770	26280	7890	8653	113.1%	110.6%	115.4%	109.7%				
	RXK10	ROWLEY REGIS HOSPITAL	3936	3194	4367	4836	2625	2530	3224	3693	81.1%	110.7%	96.4%	114.5%				
	RXK01	SANDWELL GENERAL HOSPITAL	28158	25581	13813	13543	23643	21025	10958	10617	90.8%	98.0%	88.9%	96.9%				
			57006	56793	28500	29706	49500	50408	22229	23157	99.6%	104.2%	101.8%	104.2%				
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	457	225	206	555	555	148	175	101.6%	91.6%	100.0%	118.2%				
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%				
Apr-16	RXK02	CITY HOSPITAL	28863	27928	11830	10759	27267	25879	9244	8557	96.8%	90.9%	94.9%	92.6%				
	RXK10	ROWLEY REGIS HOSPITAL	4185	3631	4702	5260	2790	2754	3417	3881	86.8%	111.9%	98.7%	113.6%				
	RXK01	SANDWELL GENERAL HOSPITAL	27066	24907	13360	13080	21663	20686	10532	10611	92.0%	97.9%	95.5%	100.8%				
			60564	56923	30117	29305	52275	49874	23341	23224	94.0%	97.3%	95.4%	99.5%				
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	435	435	217	195	536	536	166	185	100.0%	89.9%	100.0%	111.4%	192	5.1	2.0	7.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
May-16	RXK02	CITY HOSPITAL	29134	29287	11975	11748	27549	27239	9115	8696	100.5%	98.1%	98.9%	95.4%	8856	6.4	2.3	8.7
	RXK10	ROWLEY REGIS HOSPITAL	4323	3879	4858	5417	2883	2871	3605	4005	89.7%	111.5%	99.6%	111.1%	2624	2.6	3.6	6.2
	RXK01	SANDWELL GENERAL HOSPITAL	28077	26369	14260	13294	22336	21643	10737	10506	93.9%	93.2%	96.9%	97.8%	9535	5.0	2.5	7.5
			61969	59970	31310	30654	53304	52289	23623	23392	96.8%	97.9%	98.1%	99.0%	21207.00	5.3	2.5	7.8
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	453	225	198	555	555	166	138	100.7%	88.0%	100.0%	83.1%	135	7.5	2.5	10.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jun-16	RXK02	CITY HOSPITAL	28741	27744	12036	11512	27323	25997	9142	8558	96.5%	95.6%	95.1%	93.6%	8704	6.2	2.3	8.5
	RXK10	ROWLEY REGIS HOSPITAL	4144	3873	4656	4953	2790	2801	3495	3805	93.5%	106.4%	100.4%	108.9%	2222	3.0	3.9	6.9
	RXK01	SANDWELL GENERAL HOSPITAL	26756	25382	13609	13418	21064	20441	10916	10982	94.9%	98.6%	97.0%	100.6%	9235	5.0	2.6	7.6
			60091	57452	30526	30081	51732	49794	23719	23483	95.6%	98.5%	96.3%	99.0%	20296			
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	232	573	573	148	148	100.0%	100.0%	100.0%	100.0%	228	4.6	1.7	6.2
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jul-16	RXK02	CITY HOSPITAL	29688	29249	12664	12068	28090	27187	9242	8886	98.5%	95.3%	96.8%	96.1%	9155	6.2	2.3	8.5
	RXK10	ROWLEY REGIS HOSPITAL	4242	3762	5170	5197	3500	3465	3455	3540	88.7%	100.5%	99.0%	102.5%	2178	3.3	4.0	7.3
	RXK01	SANDWELL GENERAL HOSPITAL	27279	25652	14225	14196	21640	20847	11353	11587	94.0%	99.8%	96.3%	102.1%	9872	4.7	2.6	7.3
			61674	59128	32291	31693	53803	52072	24198	24161	95.9%	98.1%	96.8%	99.8%	21433	19	11	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	221	573	573	175	175	100.0%	95.3%	100.0%	100.0%	228	4.6	1.7	6.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Aug-16	RXK02	CITY HOSPITAL	29313	27693	12062	12037	27582	25849	8198	8735	94.5%	99.8%	93.7%	106.6%	9155	5.8	2.3	8.1
	RXK10	ROWLEY REGIS HOSPITAL	3967	3395	4972	4965	3439	3310	3067	3079	85.6%	99.9%	96.2%	100.4%	2178	3.1	3.7	6.8
	RXK01	SANDWELL GENERAL HOSPITAL	25853	25600	20636	14598	21640	20464	11640	12846	99.0%	70.7%	94.6%	110.4%	9872	4.7	2.8	7.4
			59598	57153	37902	31821	53234	50196	23080	24835	95.9%	84.0%	94.3%	107.6%	21433	18	10	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	476	225	195	555	555	157	222	105.8%	86.7%	100.0%	141.4%	174	5.9	2.4	8.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Sep-16	RXK02	CITY HOSPITAL	29457	28063	12304	12574	27112	25549	8197	8677	95.3%	102.2%	94.2%	105.9%	9026	5.9	2.4	8.3
	RXK10	ROWLEY REGIS HOSPITAL	3028	2638	3851	3963	2773	2726	2426	2426	87.1%	102.9%	98.3%	100.0%	1852	2.9	3.4	6.3
	RXK01	SANDWELL GENERAL HOSPITAL	26309	25107	13815	14727	20919	19649	11129	12282	95.4%	106.6%	93.9%	110.4%	9236	4.8	2.9	7.8
			59244	56284	30195	31459	51359	48479	21909	23607	95.0%	104.2%	94.4%	107.8%	20288	20	11	31
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	446	232	217	573	573	157	120	95.9%	93.5%	100.0%	76.4%	144	7.1	2.3	9.4
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Oct-16	RXK02	CITY HOSPITAL	32594	31145	15120	15025	28558	26663	9885	10501	95.6%	99.4%	93.4%	106.2%	9327	6.2	2.7	8.9
	RXK10	ROWLEY REGIS HOSPITAL	2219	2103	2656	2717	2744	1844	2560	2536	94.8%	102.3%	67.2%	99.1%	2262	1.7	2.3	4.1
	RXK01	SANDWELL GENERAL HOSPITAL	28494	27372	14486	16860	22514	21304	12135	13988	96.1%	116.4%	94.6%	115.3%	10266	4.7	3.0	7.7
			63772	61066	32494	34819	54389	50384	24737	27145	95.8%	107.2%	92.6%	109.7%	21999	20	10	30
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	442	225	210	555	545	166	148	98.2%	93.3%	98.2%	89.2%	557	1.8	0.6	2.4
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Nov-16	RXK02	CITY HOSPITAL	31002	30282	13483	13765	27240	25886	8953	9971	97.7%	102.1%	95.0%	111.4%	8630	6.5	2.8	9.3
	RXK10	ROWLEY REGIS HOSPITAL	3382	3220	4072	4197	3874	3257	2981	2957	95.2%	103.1%	84.1%	99.2%	808	8.0	8.9	16.9
	RXK01	SANDWELL GENERAL HOSPITAL	27689	27013	14098	15959	21701	21057	11727	13140	97.6%	113.2%	97.0%	112.0%	7341	6.5	4.0	10.5
			62523	60957	31878	34131	53370	50745	23827	26216	97.5%	107.1%	95.1%	110.0%	17336	23	16	39
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	465	465	232	202	573	573	157	138	100.0%	87.1%	100.0%	87.9%	188	5.5	1.8	7.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Dec-16	RXK02	CITY HOSPITAL	31106	30016	13528	12482	27055	26094	8854	8909	96.5%	92.3%	96.4%	100.6%	8615	6.5	2.5	9.0
	RXK10	ROWLEY REGIS HOSPITAL	3242	3102	3941	4041	3456	2845	2830	2890	95.7%	102.5%	82.3%	102.1%	2679	2.2	2.6	4.8
	RXK01	SANDWELL GENERAL HOSPITAL	28559	27573	14815	15907	22509	21876	12260	13625	96.5%	107.4%	97.2%	111.1%	10387	4.8	2.8	7.6
			63372	61156	32516	32632	53593	51388	24101	25562	96.5%	100.4%	95.9%	106.1%	21869	19	10	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	322	356	217	210	536	536	37	37	110.6%	96.8%	100.0%	100.0%	180	5.0	1.4	6.3
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jan-17	RXK02	CITY HOSPITAL	31579	31020	13938	13564	27429	26766	8904	9225	98.2%	97.3%	97.6%	103.6%	9215	6.3	2.5	8.7
	RXK10	ROWLEY REGIS HOSPITAL	2924	3101	3578	4062	3168	2880	2614	2998	106.1%	113.5%	90.9%	114.7%	2607	2.3	2.7	5.0

	RXK01	SANDWELL GENERAL HOSPITAL	28919	27969	14877	17262	22491	22021	12307	14590	96.7%	116.0%	97.9%	118.6%	10304	4.9	3.1	7.9
			63744	62446	32610	35098	53624	52203	23862	26850	98.0%	107.6%	97.4%	112.5%	22306	18	10	28
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	270	315	210	191	518	481	0	46	116.7%	91.0%	92.9%	#DIV/0!	175	4.5	1.4	5.9
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Feb-17	RXK02	CITY HOSPITAL	27838	27199	13363	13030	24460	23721	8831	9138	97.7%	97.5%	97.0%	103.5%	8319	6.1	2.7	8.8
	RXK10	ROWLEY REGIS HOSPITAL	2852	2816	3409	3694	3110	2722	2512	2655	98.7%	108.4%	87.5%	105.7%	2242	2.5	2.8	5.3
	RXK01	SANDWELL GENERAL HOSPITAL	26276	25767	13759	15260	19922	19628	12317	13527	98.1%	110.9%	98.5%	109.8%	9359	4.9	3.1	7.9
			57236	56097	30741	32175	48010	46552	23660	25366	98.0%	104.7%	97.0%	107.2%	20095	18	10	28
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1361	1521	945	615	1642	1430	356	525	111.8%	65.1%	87.1%	147.5%	207	14.3	5.5	19.8
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Mar-17	RXK02	CITY HOSPITAL	27241	26683	13748	13163	24777	23662	10047	9645	98.0%	95.7%	95.5%	96.0%	9536	5.3	2.4	7.7
	RXK10	ROWLEY REGIS HOSPITAL	3239	3038	3947	4107	3588	3072	3340	3328	93.8%	104.1%	85.6%	99.6%	2420	2.5	3.1	5.6
	RXK01	SANDWELL GENERAL HOSPITAL	23762	23020	13865	15342	18052	17437	12492	13552	96.9%	110.7%	96.6%	108.5%	9625	4.2	3.0	7.2
			55603	54262	32505	33227	48059	45601	26235	27050	97.6%	102.2%	94.9%	103.1%	21788	26	14	40
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1335	1416	915	648	1590	1541	345	363	106.1%	70.8%	96.9%	105.2%	210	14.1	4.8	18.9
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Apr-17	RXK02	CITY HOSPITAL	28695	27561	13723	13252	26964	24779	9890	9750	96.0%	96.6%	91.9%	98.6%	9329	5.6	2.5	8.1
	RXK10	ROWLEY REGIS HOSPITAL	3144	2958	3855	4022	2820	2460	3885	3897	94.1%	104.3%	87.2%	100.3%	2274	2.4	3.5	5.9
	RXK01	SANDWELL GENERAL HOSPITAL	23021	21873	13713	14464	17400	16747	12336	12769	95.0%	105.5%	96.2%	103.5%	9569	4.0	2.8	6.9
			56195	53808	32206	32386	48774	45527	26456	26779	95.8%	100.6%	93.3%	101.2%	21382	26	14	40
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	292	337	232	217	573	518	0	55	115.4%	93.5%	90.4%	#DIV/0!	238	3.6	1.1	4.7
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
May-17	RXK02	CITY HOSPITAL	30870	31048	14867	13613	28345	27360	10345	10004	100.6%	91.6%	96.5%	96.7%	9915	5.9	2.4	8.3
	RXK10	ROWLEY REGIS HOSPITAL	3254	3078	4397	4186	2914	2536	4014	3919	94.6%	95.2%	87.0%	97.6%	1536	3.7	5.3	8.9
	RXK01	SANDWELL GENERAL HOSPITAL	26141	25145	14245	14637	22440	22611	12412	12946	96.2%	102.8%	100.8%	104.3%	10047	4.8	2.7	7.5
			60557	59608	33741	32653	54272	53025	26771	26924	98.4%	96.8%	97.7%	100.6%	21736	18	12	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	0	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	328	0.0	0.0	0.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jun-17	RXK02	CITY HOSPITAL	32092	31476	15977	14308	29009	27747	11086	11521	98.1%	89.6%	95.6%	103.9%	9390	6.3	2.8	9.1
	RXK10	ROWLEY REGIS HOSPITAL	3157	2937	4381	3949	2825	2476	3890	3867	93.0%	90.1%	87.6%	99.4%	2282	2.4	3.4	5.8
	RXK01	SANDWELL GENERAL HOSPITAL	24642	24373	13973	14438	19970	19498	12336	13033	98.9%	103.3%	97.6%	105.7%	9303	4.7	3.0	7.7
			59891	58786	34331	32695	51804	49721	27312	28421	98.2%	95.2%	96.0%	104.1%	21303	13	9	23
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	551	619	392	277	738	649	119	193	112.4%	70.7%	87.9%	162.9%	258	4.9	1.8	6.8
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0	#DIV/0!	#DIV/0!	#DIV/0!
3-month Avges	RXK02	CITY HOSPITAL	30068	29736	14864	13695	27377	26256	10493	10390	98.9%	92.1%	95.9%	99.0%	9614	5.8	2.5	8.3
	RXK10	ROWLEY REGIS HOSPITAL	3217	3018	4242	4081	3109	2695	3748	3705	93.8%	96.2%	86.7%	98.8%	2079	2.7	3.7	6.5
	RXK01	SANDWELL GENERAL HOSPITAL	24848	24179	14028	14806	20154	19849	12413	13177	97.3%	105.5%	98.5%	106.2%	9658	4.6	2.9	7.5
	Total	*Latest 3 month average====>*	58881	57401	33426	32578	51617	49424	26846	27375	97.5%	97.5%	95.8%	102.0%	21474	5.0	2.8	7.8

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

Ward name	Main 2 Specialties on each ward	Main 2 Specialties on each ward	Day	Day	Day	Day	Night	Night	Night	Night	Day	Day	Night	Night	Care Hours Per Patient Day (CHPPD)				Note
			Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff										
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	
Critical Care - Sandwell	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	2496	2653	312	428	2915	2794	0	0	106.3%	137.2%	95.8%	#DIV/0!	182	29.9	2.4	32.3	
AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3323	3415	1253	1483	3243	3346	1253	1506	102.8%	118.4%	103.2%	120.2%	1081	6.3	2.8	9.0	
Older Persons Assessment Unit (OPAU) -	430 - GERIATRIC MEDICINE	430 - GERIATRIC MEDICINE	1334	1213	1035	1012	1035	1035	1035	1023	90.9%	97.8%	100.0%	98.8%	542	4.1	3.8	7.9	New Oct 16
Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	540	522	360	327	990	858	330	220	96.7%	90.8%	86.7%	66.7%	302	4.6	1.8	6.4	
Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1437	1345	1000	977	989	966	690	690	93.6%	97.7%	97.7%	100.0%	636	3.6	2.6	6.3	
Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPAEDICS	160 - PLASTIC SURGERY	1322	1673	1058	1736	793	1035	793	1667	126.6%	164.1%	130.5%	210.2%	719	3.8	4.7	8.5	
Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	2070	1960	1725	1644	1035	1035	1725	1621	94.7%	95.3%	100.0%	94.0%	990	3.0	3.3	6.3	
Lyndon 5 - Acute Medicine	100 - GENERAL SURGERY	300 - GENERAL MEDICINE									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	Decant
Lyndon Ground - PAU/Adolescents	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	1080	1020	330	319	0	0	990	660	94.4%	96.7%	#DIV/0!	66.7%	218	4.7	4.5	9.2	
AMU B - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	Closed
Priory 3 - General Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	
Newton 3 - T&O	110 - TRAUMA & ORTHOPAEDICS	430 - GERIATRIC MEDICINE	1725	1759	1380	1656	1035	1035	1035	1587	102.0%	120.0%	100.0%	153.3%	825	3.4	3.9	7.3	
Newton 4 - Stepdown/Stroke/Neurology	314 - REHABILITATION	300 - GENERAL MEDICINE	1380	1357	1035	948	1380	1357	1035	1035	98.3%	91.6%	98.3%	100.0%	833	3.3	2.4	5.6	
Newton 5 - Haematology	304 - CLINICAL PHYSIOLOGY	300 - GENERAL MEDICINE	690	764	345	304	690	690	345	345	110.7%	88.1%	100.0%	100.0%	395	3.7	1.6	5.3	
Priory 2 - Colorectal/General Surgery	100 - GENERAL SURGERY	100 - GENERAL SURGERY	1725	1656	1035	989	1035	1035	690	667	96.0%	95.6%	100.0%	96.7%	681	4.0	2.4	6.4	
Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2070	1742	1380	868	2070	1702	1380	908	84.2%	62.9%	82.2%	65.8%	616	5.6	2.9	8.5	
Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1725	1587	1035	1069	1380	1242	690	759	92.0%	103.3%	90.0%	110.0%	946	3.0	1.9	4.9	
SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1725	1707	690	678	1380	1368	345	345	99.0%	98.3%	99.1%	100.0%	337	9.1	3.0	12.2	See N2
CCS - Critical Care Services - City	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2880	3036	360	264	2640	2728	0	0	105.4%	73.3%	103.3%	#DIV/0!	254	22.7	1.0	23.7	
D5 - Cardiology (Female)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1380	1598	345	322	1035	1322	0	0	115.8%	93.3%	127.7%	#DIV/0!	383	7.6	0.8	8.5	
D11 - Male Older Adult	430 - GERIATRIC MEDICINE	430 - GERIATRIC MEDICINE	1035	1046	1380	1207	1035	1069	736	701	101.1%	87.5%	103.3%	95.2%	590	3.6	3.2	6.8	
D12 - Isolation	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	
D15 - Gastro/Resp/Haem (Male)	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1035	1104	690	667	1035	1035	345	563	106.7%	96.7%	100.0%	163.2%	636	3.4	1.9	5.3	
D16 - (Female)	301 - GASTROENTEROLOGY	340 - RESPIRATORY MEDICINE	1196	1161	690	603	1035	1023	506	563	97.1%	87.4%	98.8%	111.3%	609	3.6	1.9	5.5	
D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	720	696	165	159	660	330	330	253	96.7%	96.4%	50.0%	76.7%	244	4.2	1.7	5.9	
D21 - Male Urology / ENT	101 - UROLOGY	120 - ENT	3070	3047	2231	2196	1955	1943	1955	2461	99.3%	98.4%	99.4%	125.9%	500	10.0	9.3	19.3	
D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1035	1029	1380	1270	1035	1023	736	690	99.4%	92.0%	98.8%	93.8%	610	3.4	3.2	6.6	
D27 - Oncology	502 - GYNAECOLOGY		571	546	393	327	720	624	360	348	95.6%	83.2%	86.7%	96.7%	427	2.7	1.6	4.3	521
AMU 2 & West Midlands Poisons Unit - C	300 - GENERAL MEDICINE	305 - CLINICAL PHARMACOLOGY	1725	1828	345	327	1644	1460	345	345	106.0%	94.8%	88.8%	100.0%	449	7.3	1.5	8.8	
Surgical Assesment Unit - City	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	Closed
D43 - Community RTG	318- INTERMEDIATE CARE	430 - GERIATRIC MEDICINE	1380	1270	1380	1207	1035	1000	1035	1000	92.0%	87.5%	96.6%	96.6%	748	3.0	3.0	6.0	
D47 - Geriatric MEDICAL			1230	960	1207	1012	690	690	690	690	78.0%	83.8%	100.0%	100.0%	510	3.2	3.3	6.6	
D7 - Cardiology (Male)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	2070	2041	345	345	1725	1748	0	0	98.6%	100.0%	101.3%	#DIV/0!	541	7.0	0.6	7.6	
Female Surgical (D17)	101 - UROLOGY	120 - ENT	1035	1029	621	609	1035	1035	598	586	99.4%	98.1%	100.0%	98.0%	303	6.8	3.9	10.8	
Labour Ward - City	501 - OBSTETRICS	501 - OBSTETRICS	3795	2871	690	667	3795	3220	690	678	75.7%	96.7%	84.8%	98.3%	286	21.3	4.7	26.0	
City Maternity - M1	501 - OBSTETRICS	424- WELL BABIES	1035	1017	690	690	1035	839	345	402	98.3%	100.0%	81.1%	116.5%	478	3.9	2.3	6.2	
City Maternity - M2	501 - OBSTETRICS	424- WELL BABIES	1035	937	650	655	1035	805	345	379	90.5%	100.8%	77.8%	109.9%	443	3.9	2.3	6.3	
AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	2415	2426	1035	989	2415	2415	1035	1046	100.5%	95.6%	100.0%	101.1%	674	7.2	3.0	10.2	
Neonatal			2415	2742	690	327	2415	2495	690	448	113.5%	47.4%	103.3%	64.9%	641	8.2	1.2	9.4	
Serenity Birth Centre - City	501 - OBSTETRICS	501 - OBSTETRICS	1035	1092	690	465	1035	943	345	368	105.5%	67.4%	91.1%	106.7%	64	31.8	13.0	44.8	
Ophthalmology Main Ward - City	130 - OPHTHALMOLOGY	180 - ACCIDENT & EMERGENCY									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	328	0.0	0.0	0.0	
Eliza Tinsley Ward - Community RTG	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	540	519	720	666	720	360	1080	1080	96.1%	92.5%	50.0%	100.0%	642	1.4	2.7	4.1	
Henderson	318- INTERMEDIATE CARE		1035	966	1725	1380	690	701	1035	966	93.3%	80.0%	101.6%	93.3%	496	3.4	4.7	8.1	
Leasowes	318- INTERMEDIATE CARE		1042	915	1216	1216	695	695	695	729	87.8%	100.0%	100.0%	104.9%	496	3.2	3.9	7.2	
MCCarthy	318- INTERMEDIATE CARE		540	537	720	687	720	720	1080	1092	1	95.4%	100.0%	101.1%	648	1.9	2.7	4.7	
	Trust Totals		**59891**	**58786**	**34331**	**32695**	**51804**	**49721**	**27312**	**28421**	**1**	**95.2%**	**96.0%**	**104.1%**		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	

5

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

Appendix Aiii

Org: RXK Sandwell And West Birmingham Hospitals NHS Trust

Period: June_2017-18

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

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

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

Comments

Validation alerts (see control panel)	Hospital Site Details		Only complete sites your organisation is accountable for	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site Name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Critical Care - Sandwell	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2496	2653	312	428	2915	2794	0	0	106.3%	137.2%	95.8%	-	182	29.9	2.4	32.3
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3323	3415	1253	1483	3243	3346	1253	1506	102.8%	118.4%	103.2%	120.2%	1081	6.3	2.8	9.0
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Older Persons Assessment Un	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1334	1213	1035	1012	1035	1035	1035	1023	90.9%	97.8%	100.0%	98.8%	542	4.1	3.8	7.9
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	540	522	360	327	990	858	330	220	96.7%	90.8%	86.7%	66.7%	302	4.6	1.8	6.4
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1437	1345	1000	977	989	966	690	690	93.6%	97.7%	97.7%	100.0%	636	3.6	2.6	6.3
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPAEDICS	160 - PLASTIC SURGERY	1322	1673	1058	1736	793	1035	793	1667	126.6%	164.1%	130.5%	210.2%	719	3.8	4.7	8.5
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	2070	1960	1725	1644	1035	1035	1725	1621	94.7%	95.3%	100.0%	94.0%	990	3.0	3.3	6.3
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon Ground - PAU/Adolesc	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	1080	1020	330	319	0	0	990	660	94.4%	96.7%	-	66.7%	218	4.7	4.5	9.2
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 3 - T&O	110 - TRAUMA & ORTHOPAEDICS	430 - GERIATRIC MEDICINE	1725	1759	1380	1656	1035	1035	1035	1587	102.0%	120.0%	100.0%	153.3%	825	3.4	3.9	7.3
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 4 - Stepdown/Stroke/N	314 - REHABILITATION	300 - GENERAL MEDICINE	1380	1357	1035	948	1380	1357	1035	1035	98.3%	91.6%	98.3%	100.0%	833	3.3	2.4	5.6
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 5 - Haematology	304 - CLINICAL PHYSIOLOGY	300 - GENERAL MEDICINE	690	764	345	304	690	690	345	345	110.7%	88.1%	100.0%	100.0%	395	3.7	1.6	5.3
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 2 - Colorectal/General S	100 - GENERAL SURGERY	100 - GENERAL SURGERY	1725	1656	1035	989	1035	1035	690	667	96.0%	95.6%	100.0%	96.7%	681	4.0	2.4	6.4
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2070	1742	1380	868	2070	1702	1380	908	84.2%	62.9%	82.2%	65.8%	616	5.6	2.9	8.5
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1725	1587	1035	1069	1380	1242	690	759	92.0%	103.3%	90.0%	110.0%	946	3.0	1.9	4.9
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1725	1707	690	678	1380	1368	345	345	99.0%	98.3%	99.1%	100.0%	337	9.1	3.0	12.2
	RXK02	CITY HOSPITAL - RXK02	CCS - Critical Care Services -	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2880	3036	360	264	2640	2728	0	0	105.4%	73.3%	103.3%	-	254	22.7	1.0	23.7
	RXK02	CITY HOSPITAL - RXK02	D5 - Cardiology (Female)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1380	1598	345	322	1035	1322	0	0	115.8%	93.3%	127.7%	-	383	7.6	0.8	8.5
	RXK02	CITY HOSPITAL - RXK02	D11 - Male Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1035	1046	1380	1207	1035	1069	736	701	101.1%	87.5%	103.3%	95.2%	590	3.6	3.2	6.8
	RXK02	CITY HOSPITAL - RXK02	D15 - Gastro/Resp/Haem (Mal	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1035	1104	690	667	1035	1035	345	563	106.7%	96.7%	100.0%	163.2%	636	3.4	1.9	5.3
	RXK02	CITY HOSPITAL - RXK02	D16 - (Female)	301 - GASTROENTEROLOGY	340 - RESPIRATORY MEDICINE	1196	1161	690	603	1035	1023	506	563	97.1%	87.4%	98.8%	111.3%	609	3.6	1.9	5.5
	RXK02	CITY HOSPITAL - RXK02	D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	720	696	165	159	660	330	330	253	96.7%	96.4%	50.0%	76.7%	244	4.2	1.7	5.9
	RXK02	CITY HOSPITAL - RXK02	D21 - Male Urology / ENT	101 - UROLOGY	120 - ENT	3070	3047	2231	2196	1955	1943	1955	2461	99.3%	98.4%	99.4%	125.9%	500	10.0	9.3	19.3
	RXK02	CITY HOSPITAL - RXK02	D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1035	1029	1380	1270	1035	1023	736	690	99.4%	92.0%	98.8%	93.8%	610	3.4	3.2	6.6
	RXK02	CITY HOSPITAL - RXK02	D27 - Oncology	502 - GYNAECOLOGY		571	546	393	327	720	624	360	348	95.6%	83.2%	86.7%	96.7%	427	2.7	1.6	4.3
	RXK02	CITY HOSPITAL - RXK02	AMU 2 & West Midlands Poisc	300 - GENERAL MEDICINE	305 - CLINICAL PHARMACOLOGY	1725	1828	345	327	1644	1460	345	345	106.0%	94.8%	88.8%	100.0%	449	7.3	1.5	8.8
	RXK02	CITY HOSPITAL - RXK02	D43 - Community RTG	318- INTERMEDIATE CARE	430 - GERIATRIC MEDICINE	1380	1270	1380	1207	1035	1000	1035	1000	92.0%	87.5%	96.6%	96.6%	748	3.0	3.0	6.0
	RXK02	CITY HOSPITAL - RXK02	D47 - Geriatric MEDICAL	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1230	960	1207	1012	690	690	690	690	78.0%	83.8%	100.0%	100.0%	510	3.2	3.3	6.6
	RXK02	CITY HOSPITAL - RXK02	D7 - Cardiology (Male)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	2070	2041	345	345	1725	1748	0	0	98.6%	100.0%	101.3%	-	541	7.0	0.6	7.6
	RXK02	CITY HOSPITAL - RXK02	Female Surgical Ward	101 - UROLOGY	120 - ENT	1035	1029	621	609	1035	1035	598	586	99.4%	98.1%	100.0%	98.0%	303	6.8	3.9	10.8
	RXK02	CITY HOSPITAL - RXK02	Labour Ward - City	501 - OBSTETRICS	501 - OBSTETRICS	3795	2871	690	667	3795	3220	690	678	75.7%	96.7%	84.8%	98.3%	286	21.3	4.7	26.0
	RXK02	CITY HOSPITAL - RXK02	City Maternity - 1	501 - OBSTETRICS	424- WELL BABIES	1035	1017	690	690	1035	839	345	402	98.3%	100.0%	81.1%	116.5%	478	9.9	2.3	6.2
	RXK02	CITY HOSPITAL - RXK02	City Maternity - 2	501 - OBSTETRICS	424- WELL BABIES	1035	937	650	655	1035	805	345	379	90.5%	100.8%	77.8%	109.9%	443	3.9	2.3	6.3
	RXK02	CITY HOSPITAL - RXK02	AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	2415	2426	1035	989	2415	2415	1035	1046	100.5%	95.6%	100.0%	101.1%	674	7.2	3.0	10.2
	RXK02	CITY HOSPITAL - RXK02	Neonatal	422- NEONATOLOGY		2415	2742	690	327	2415	2495	690	448	113.5%	47.4%	103.3%	64.9%	641	8.2	1.2	9.4
	RXK02	CITY HOSPITAL - RXK02	Serenity Birth Centre - City	501 - OBSTETRICS	501 - OBSTETRICS	1035	1092	690	465	1035	943	345	368	105.5%	67.4%	91.1%	106.7%	64	31.8	13.0	44.8
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BM	Ophthalmology Main Ward - Ci	130 - OPHTHALMOLOGY	180 - ACCIDENT & EMERGENCY													328	0.0	0.0	0.0
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	Eliza Tinsley Ward - Communit	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	540	519	720	666	720	360	1080	1080	96.1%	92.5%	50.0%	100.0%	642	1.4	2.7	4.1
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	Henderson	318- INTERMEDIATE CARE		1035	966	1725	1380	690	701	1035	966	93.3%	80.0%	101.6%	93.3%	496	3.4	4.7	8.1
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	Leasowes	318- INTERMEDIATE CARE		1042	915	1216	1216	695	695	695	729	87.8%	100.0%	100.0%	104.9%	496	3.2	3.9	7.2
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	McCarthy	318- INTERMEDIATE CARE		540	537	720	687	720	720	1080	1092	99.4%	95.4%	100.0%	101.1%	648	1.9	2.7	4.7

Appendix B

National Cancer Patient Experience Survey

2016 Results

Sandwell and West Birmingham Hospitals NHS Trust

Published July 2017

The National Cancer Patient Experience Survey is undertaken by Quality Health on behalf of NHS England

Introduction

The National Cancer Patient Experience Survey 2016 is the sixth iteration of the survey first undertaken in 2010. It has been designed to monitor national progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients.

The survey was overseen by a national Cancer Patient Experience Advisory Group. This Advisory Group set the principles and objectives of the survey programme and guided questionnaire development.

The survey was commissioned and managed by NHS England. The survey provider, Quality Health, is responsible for designing, running and analysing the survey.

Full national results and other reports are available at www.ncpes.co.uk .

Further details on the survey methodology and changes to the 2016 survey can be found in the Annex.

This report

The report shows how this Trust scored for each question in the survey, compared with national results. It is aimed at helping individual Trusts to understand their performance and identify areas for local improvement.

Note that responses for questions with 1-20 respondents have been suppressed. This is to protect patient confidentiality and because uncertainty around the result is too great.

Data tables

The data tables presented in this report show the following for each question:

- **Column 1** shows the number of respondents for 2015 to this question
- **Column 2** shows the unadjusted 2015 score for this Trust
- **Column 3** shows the number of respondents for 2016 to this question
- **Column 4** shows the unadjusted 2016 score for this Trust
- **Column 5** shows whether a score has significantly increased or decreased compared with the last survey
- **Column 6** shows the case-mix adjusted 2016 score for this Trust
- **Column 7** shows the lower limit of the expected range of case-mix adjusted scores for this Trust (the top of the pale blue section on the comparability chart - see below)
- **Column 8** shows the upper limit of the expected range of case-mix adjusted scores for this Trust (the bottom of the dark blue section on the comparability chart - see below)
- **Column 9** shows the national average score for this question.

Results for individual response options are presented in the detailed data tables available at www.ncpes.co.uk . Confidence Intervals for unadjusted and case-mix adjusted data are provided in these tables.

Expected ranges and 95% confidence intervals highlight the uncertainty around the results. The size of the expected ranges and confidence intervals will be different for each question, and depends on the number of respondents and the range of their responses.

For further details on case-mix adjustment and the scoring methodology used, please refer to the Annex.

Comparability charts

For the 2016 survey, we have adopted the CQC standard for reporting comparative performance, based on calculation of "expected ranges". This means that Trusts will be flagged as outliers only if there is statistical evidence that their scores deviate (positively or negatively) from the range of scores that would be expected for Trusts of the same size.

The comparability charts in this report show a bar with these expected ranges (in grey), higher than expected (in dark blue), and lower than expected (in pale blue). A black dot represents the actual score of this Trust.

The same colour convention has been used in Column 6 of the data tables.

For further details on expected ranges, please refer to the technical document at www.ncpes.co.uk .

Tumour group tables

The final set of tables in this report show the scores for each question for each of the 13 tumour groups, with a comparative national score for that tumour group.

These breakdowns are intended as additional information for Trusts to understand the differences between the experiences of patients with different types of cancer. The numbers are generally relatively small and may not be statistically significant. They should therefore be treated with some caution.

Notes on specific questions

Questions used to direct respondents to different parts of the survey (questions 4, 24, 27, 40, 43, 46) and other demographic and information questions are not reported.

How to use the data

Unadjusted data should be used to see the actual responses from patients relating to the Trust.

Case-mix adjusted data, together with expected ranges, should be used to understand whether the results are significantly higher or lower than national results.

Case-mix adjusted data, together with (case-mix adjusted) confidence intervals (presented in the detailed data tables at www.ncpes.co.uk), should be used to understand whether the results are significantly higher or lower than the results for another Trust.

Response rates

Numbers of respondents by tumour group, age and gender can be found in the Annex.

Executive Summary

Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of **8.7** .

The following questions are included in phase 1 of the Cancer Dashboard developed by Public Health England and NHS England*:

- **78%** of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment
- **92%** of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment
- **88%** of respondents said that it had been ‘quite easy’ or ‘very easy’ to contact their Clinical Nurse Specialist
- **84%** of respondents said that, overall, they were always treated with dignity and respect while they were in hospital
- **93%** of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital
- **56%** of respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.

Detailed results for these and other questions are set out in the sections that follow.

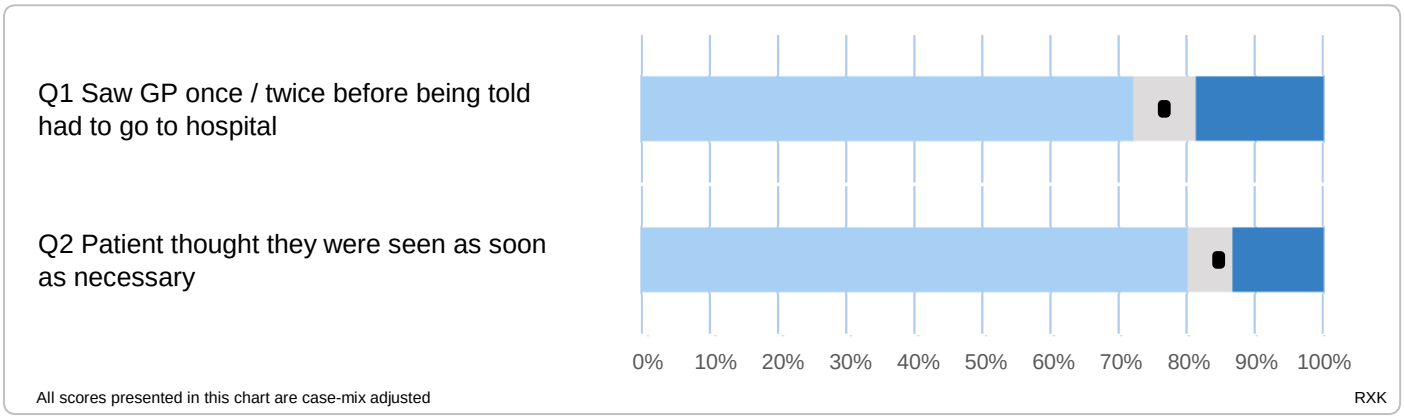
* www.cancerdata.nhs.uk/dashboard
The questions were selected in discussion with the national Cancer Patient Experience Advisory Group and reflect four key patient experience domains: provision of information; involvement in decisions; care transition; interpersonal relations, respect and dignity. The figures presented above are all case-mix adjusted.

Questions which scored outside expected range

Question		Number of respondents for this Trust	2016 Case-mix Adjusted			National Average Score
			2016 Percentage for this Trust	Lower limit of expected range	Upper limit of expected range	
Finding out what was wrong with you						
Q8	Patient told they could bring a family member or friend when first told they had cancer	477	86%	71%	81%	76%
Q9	Patient felt they were told sensitively that they had cancer	490	89%	81%	87%	84%
Q11	Patient given easy to understand written information about the type of cancer they had	454	80%	68%	77%	72%
Hospital care as an inpatient						
Q29	Patient had confidence and trust in all doctors treating them	299	80%	81%	89%	85%
Q30	Patient's family or someone close definitely had opportunity to talk to doctor	244	66%	67%	79%	73%
Q36	Hospital staff definitely did everything to help control pain	267	77%	80%	88%	84%
Q37	Always treated with respect and dignity by staff	298	84%	84%	92%	88%
Q38	Given clear written information about what should / should not do post discharge	275	81%	81%	90%	86%
Hospital care as a day patient / outpatient						
Q42	Doctor had the right notes and other documentation with them	420	93%	94%	98%	96%

Trust results

Seeing your GP

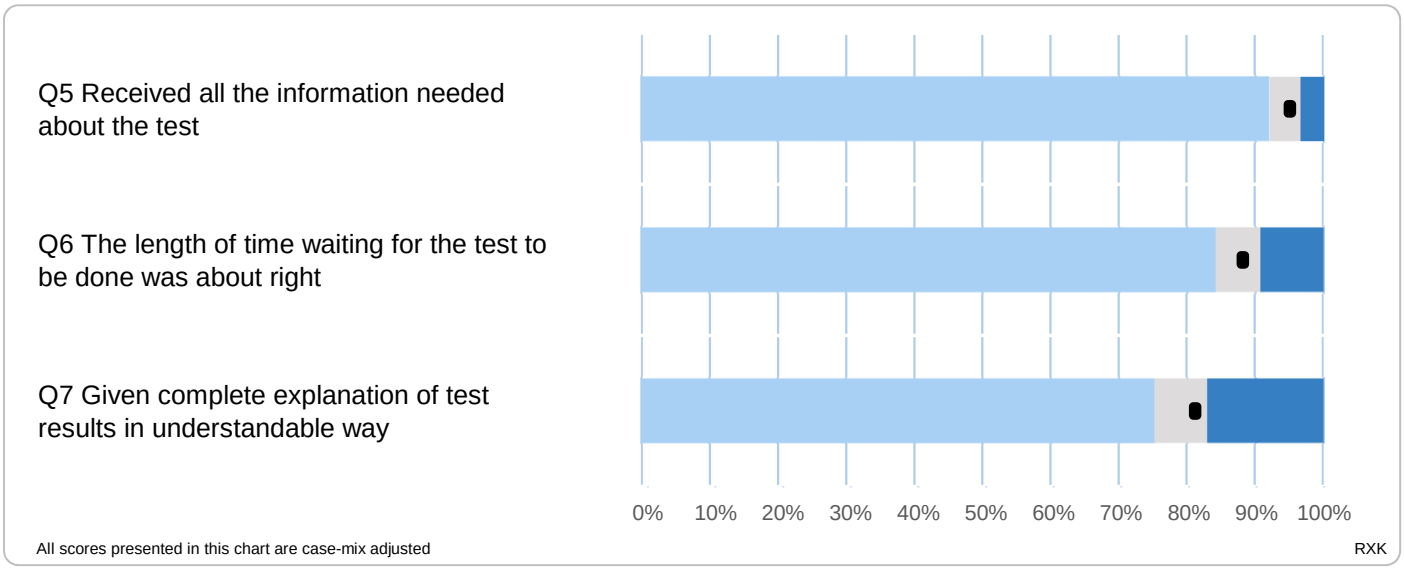


	Question	Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016		Change from 2015				
		Number of respondents	Score	Number of respondents	Score		2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q1	Saw GP once / twice before being told had to go to hospital	316	73%	324	75%		76%	72%	81%	77%
Q2	Patient thought they were seen as soon as necessary	485	81%	493	84%		84%	80%	87%	83%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Diagnostic Tests

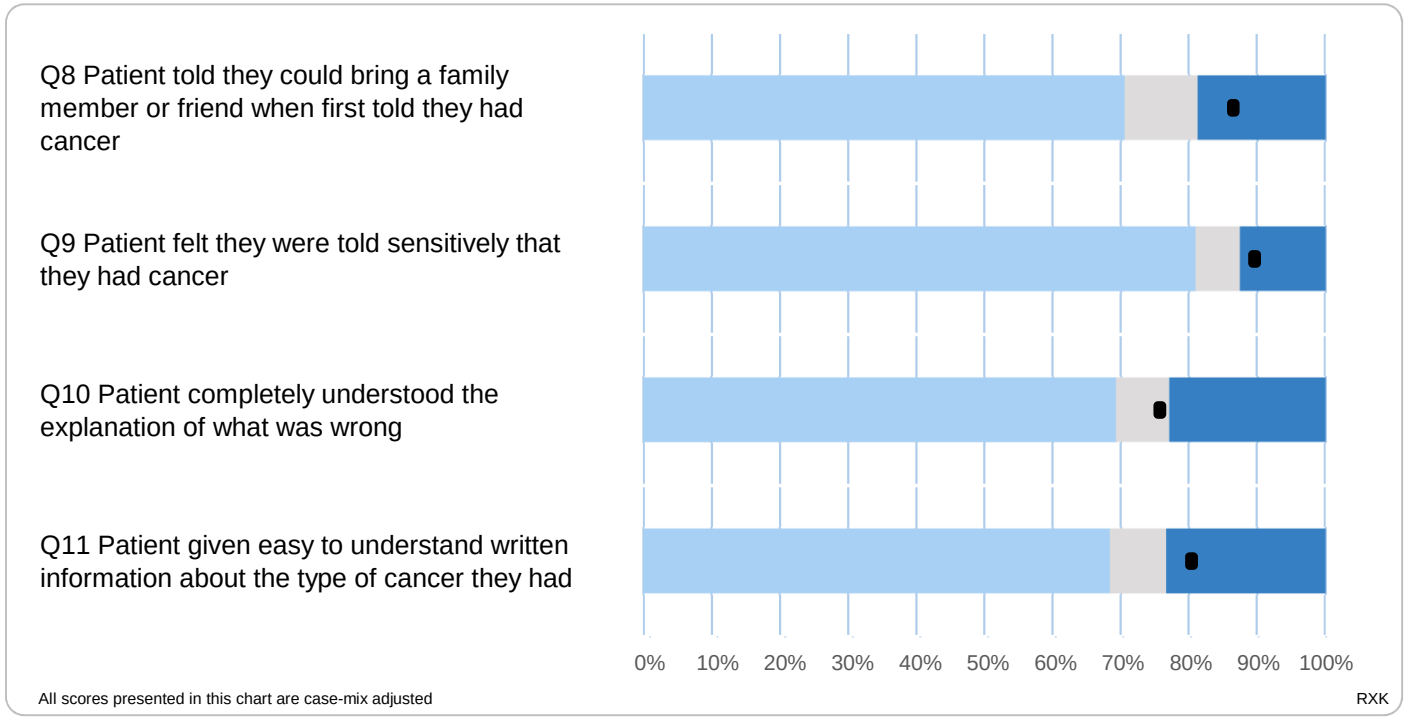


Question		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016		Change from 2015				
		Number of respondents	Score	Number of respondents	Score		2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q5	Received all the information needed about the test	-	-	427	94%		95%	92%	97%	94%
Q6	The length of time waiting for the test to be done was about right	419	89%	434	88%		88%	84%	91%	87%
Q7	Given complete explanation of test results in understandable way	419	77%	437	80%		81%	75%	83%	79%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Finding out what was wrong with you

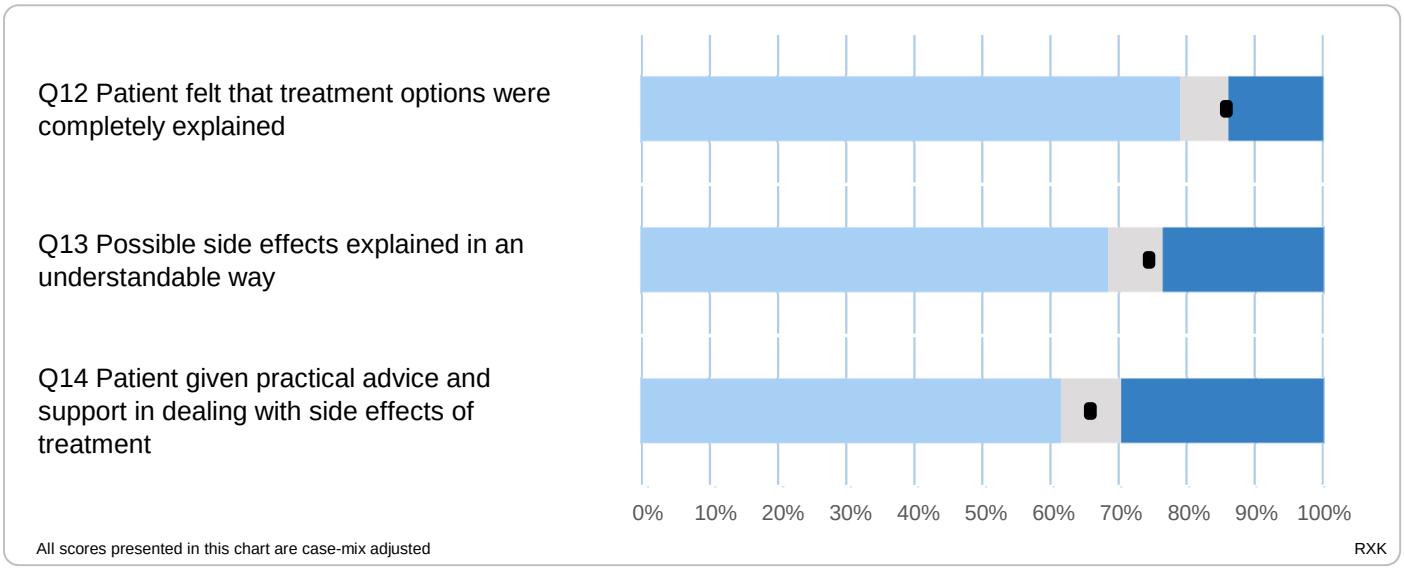


	Question	Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016		Change from 2015				
		Number of respondents	Score	Number of respondents	Score		2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q8	Patient told they could bring a family member or friend when first told they had cancer	-	-	478	87%		86%	71%	81%	76%
Q9	Patient felt they were told sensitively that they had cancer	486	86%	491	90%		89%	81%	87%	84%
Q10	Patient completely understood the explanation of what was wrong	487	72%	500	75%		76%	69%	77%	73%
Q11	Patient given easy to understand written information about the type of cancer they had	445	76%	455	79%		80%	68%	77%	72%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Deciding the best treatment for you (Part 1 of 2)

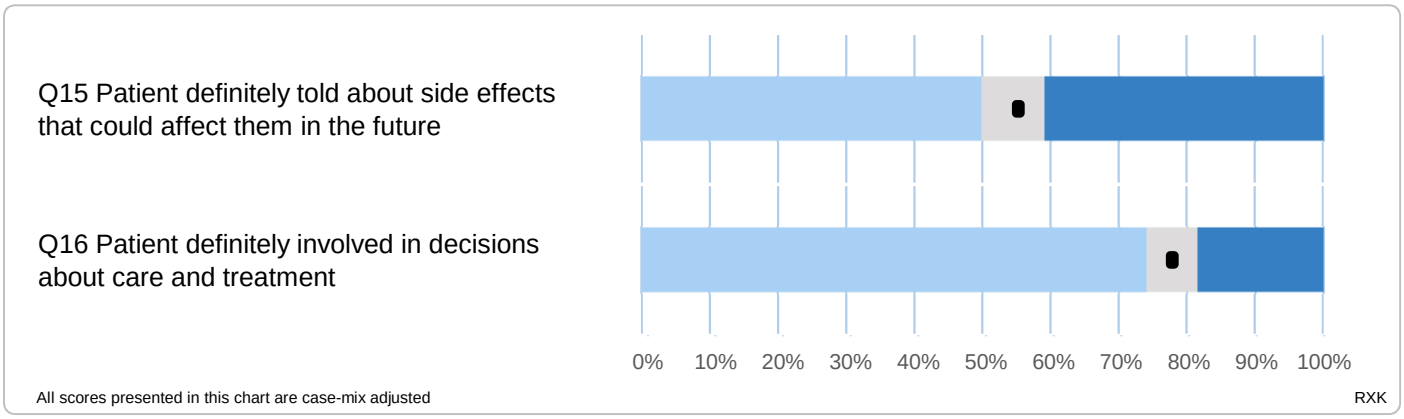


		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016						
Question		Number of respondents	Score	Number of respondents	Score	Change from 2015	2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q12	Patient felt that treatment options were completely explained	432	85%	446	85%		86%	79%	86%	83%
Q13	Possible side effects explained in an understandable way	478	73%	485	74%		74%	68%	76%	72%
Q14	Patient given practical advice and support in dealing with side effects of treatment	471	68%	485	66%		66%	61%	70%	66%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Deciding the best treatment for you (Part 2 of 2)

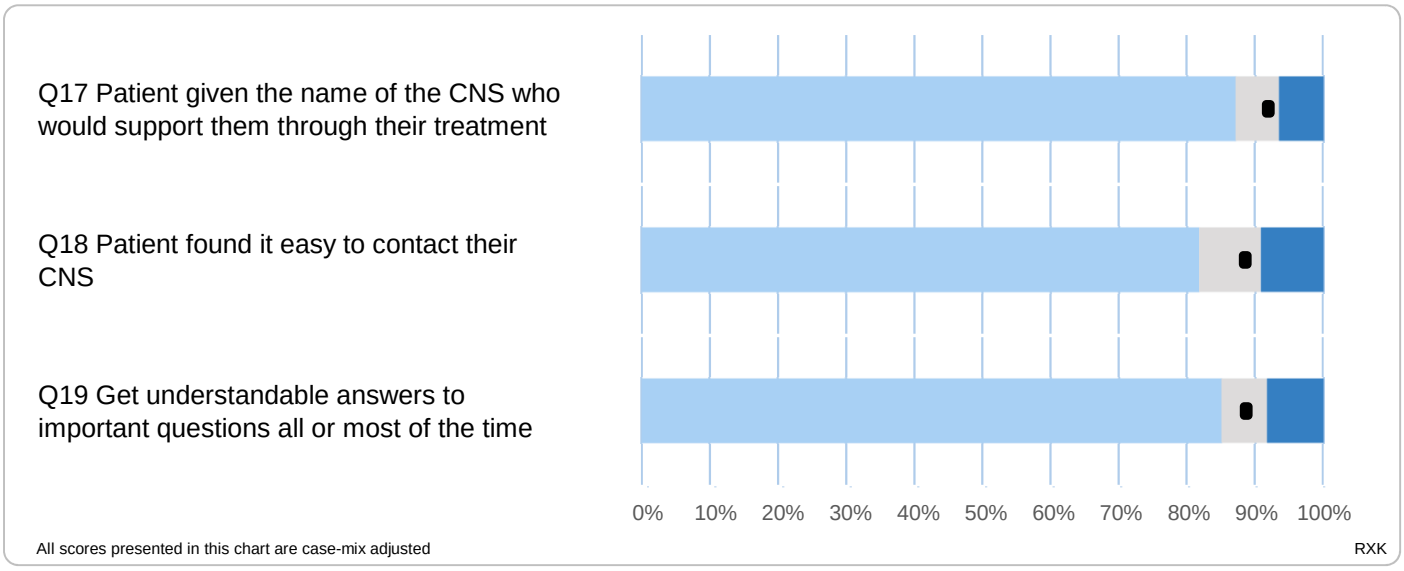


Question		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016						
		Number of respondents	Score	Number of respondents	Score	Change from 2015	2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q15	Patient definitely told about side effects that could affect them in the future	460	59%	460	55%		55%	50%	59%	54%
Q16	Patient definitely involved in decisions about care and treatment	472	77%	473	77%		78%	74%	82%	78%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Clinical Nurse Specialist

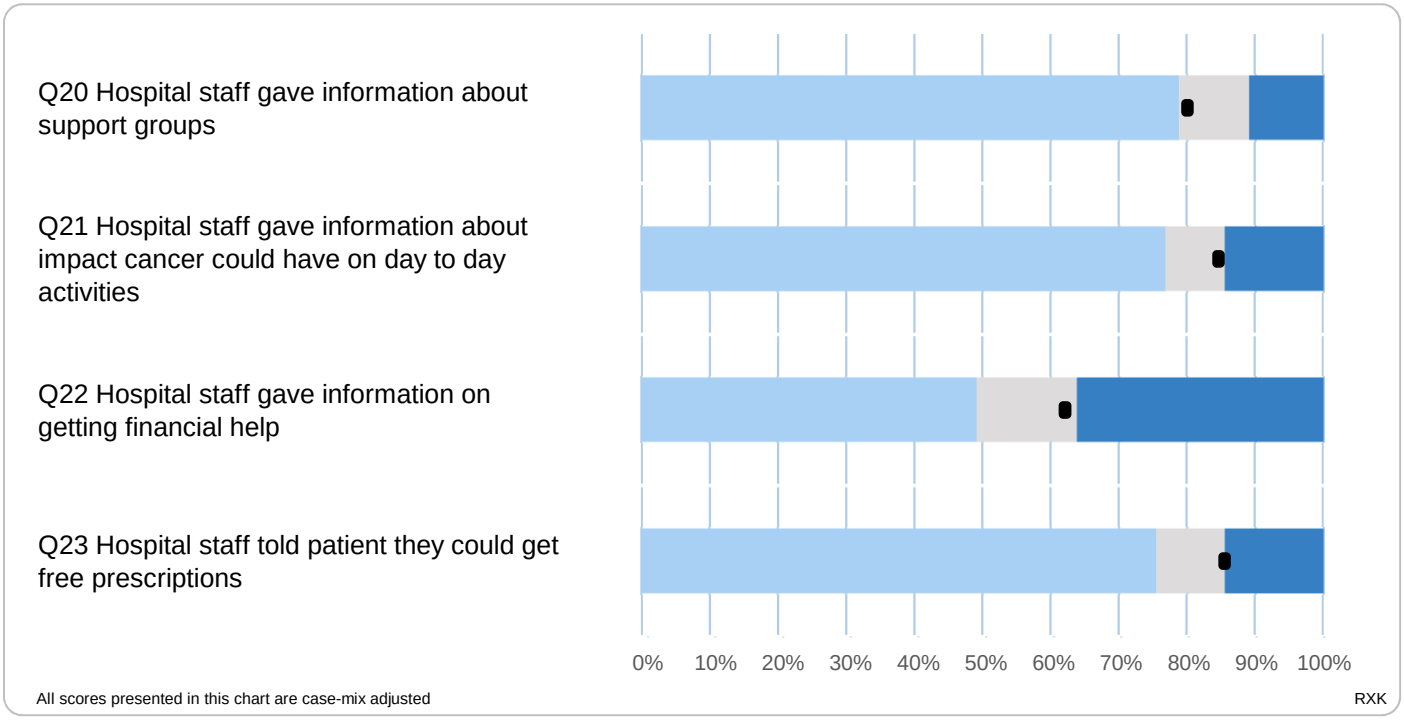


		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016						
Question		Number of respondents	Score	Number of respondents	Score	Change from 2015	2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q17	Patient given the name of the CNS who would support them through their treatment	457	94%	476	92%		92%	87%	93%	90%
Q18	Patient found it easy to contact their CNS	377	84%	363	88%		88%	82%	91%	86%
Q19	Get understandable answers to important questions all or most of the time	359	86%	354	87%		89%	85%	92%	88%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Support for people with cancer

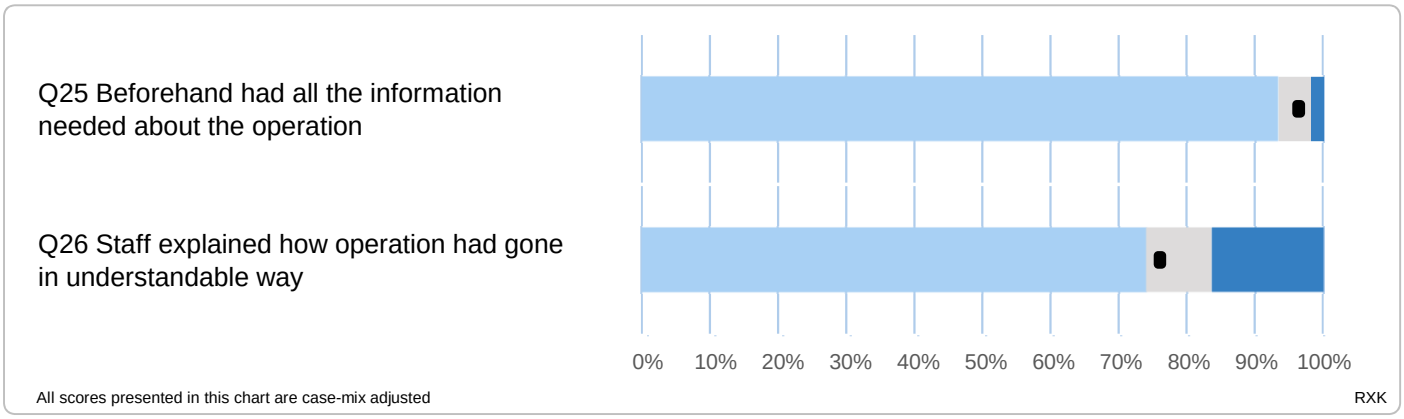


		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016		Change from 2015				
Question		Number of respondents	Score	Number of respondents	Score		2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q20	Hospital staff gave information about support groups	389	84%	375	79%		80%	79%	89%	84%
Q21	Hospital staff gave information about impact cancer could have on day to day activities	368	82%	339	84%		84%	77%	86%	81%
Q22	Hospital staff gave information on getting financial help	326	57%	307	62%		62%	49%	64%	56%
Q23	Hospital staff told patient they could get free prescriptions	263	78%	244	86%		85%	75%	85%	80%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Operations

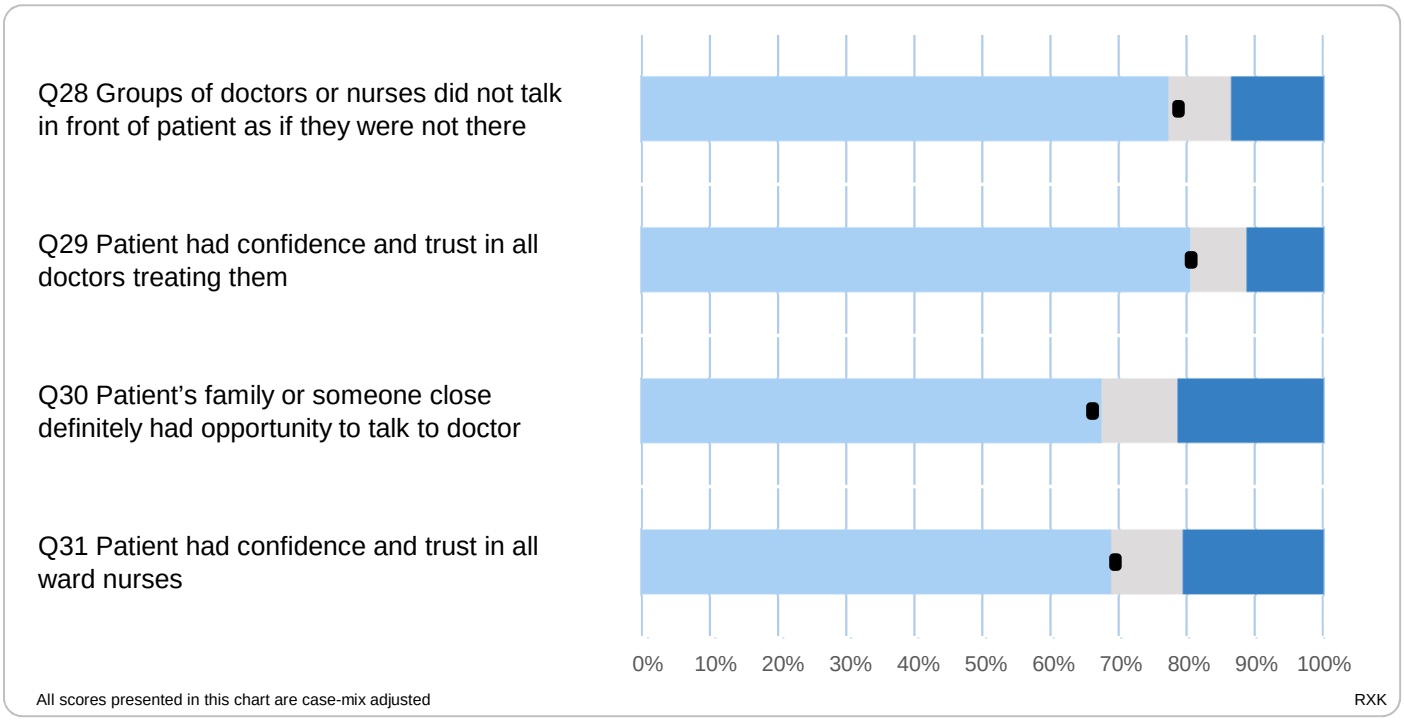


	Question	Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016		Change from 2015				
		Number of respondents	Score	Number of respondents	Score		2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q25	Beforehand had all the information needed about the operation	-	-	277	96%		96%	93%	98%	96%
Q26	Staff explained how operation had gone in understandable way	274	74%	280	75%		76%	74%	84%	79%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Hospital care as an inpatient (Part 1 of 3)

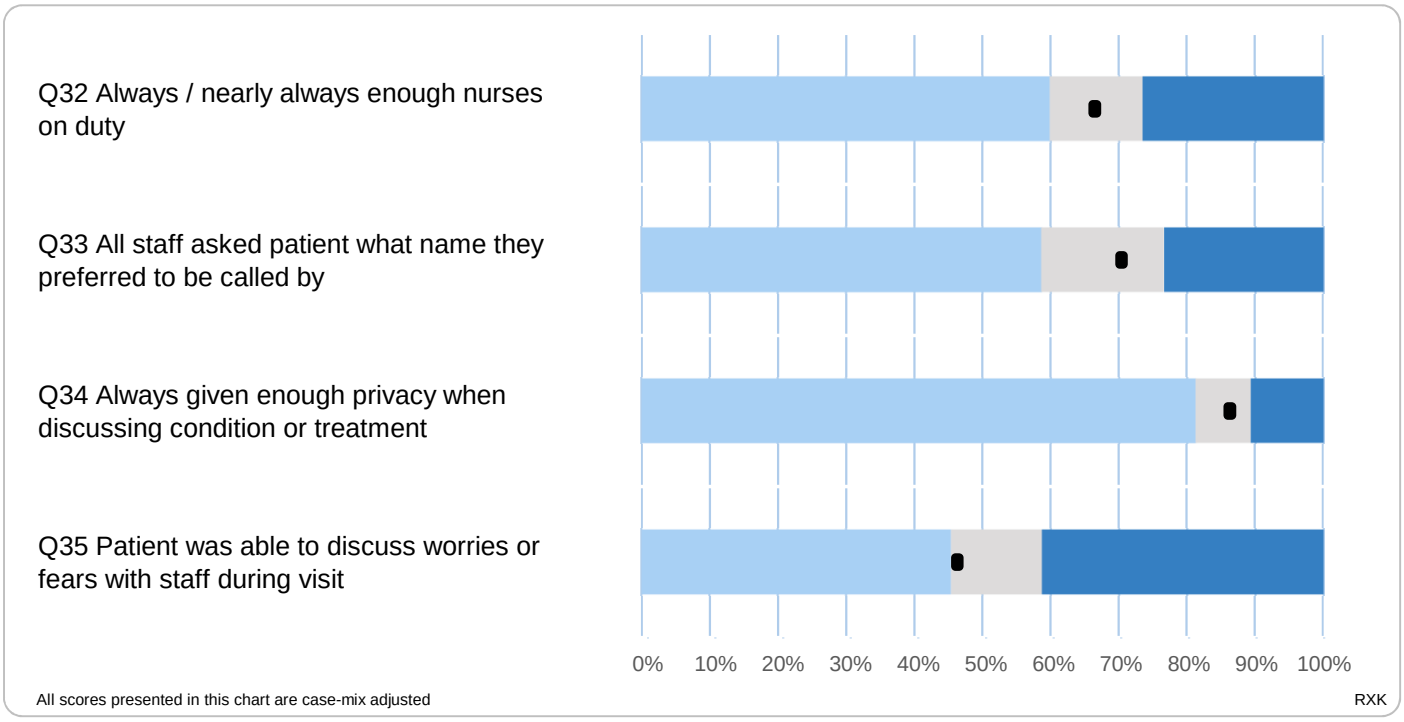


Question		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016		Change from 2015				
		Number of respondents	Score	Number of respondents	Score		2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q28	Groups of doctors or nurses did not talk in front of patient as if they were not there	279	76%	299	77%		79%	77%	86%	82%
Q29	Patient had confidence and trust in all doctors treating them	281	79%	300	81%		80%	81%	89%	85%
Q30	Patient's family or someone close definitely had opportunity to talk to doctor	243	69%	245	67%		66%	67%	79%	73%
Q31	Patient had confidence and trust in all ward nurses	278	72%	299	70%		69%	69%	79%	74%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Hospital care as an inpatient (Part 2 of 3)

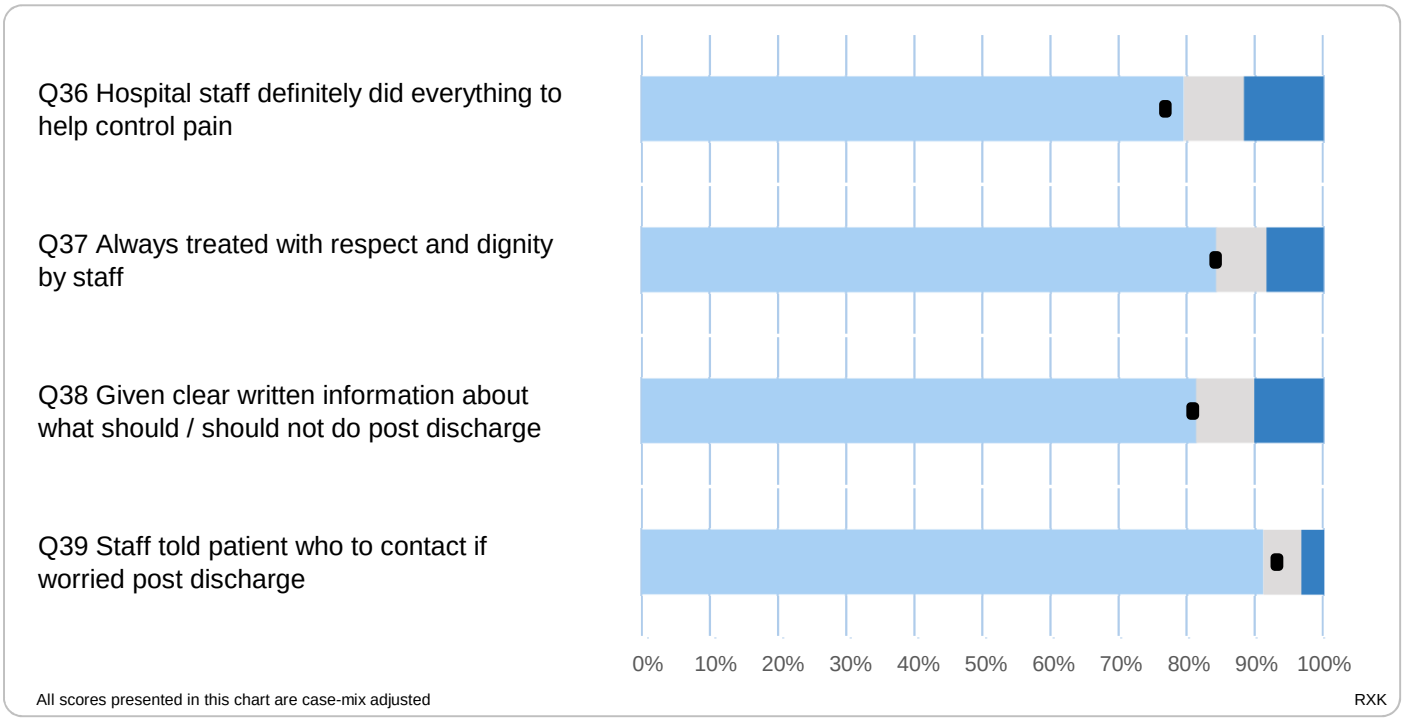


		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016		Change from 2015				
Question		Number of respondents	Score	Number of respondents	Score		2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q32	Always / nearly always enough nurses on duty	279	73%	298	66%		66%	60%	73%	67%
Q33	All staff asked patient what name they preferred to be called by	280	68%	300	69%		70%	59%	77%	68%
Q34	Always given enough privacy when discussing condition or treatment	282	84%	298	86%		86%	81%	89%	85%
Q35	Patient was able to discuss worries or fears with staff during visit	225	48%	215	47%		46%	45%	59%	52%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Hospital care as an inpatient (Part 3 of 3)

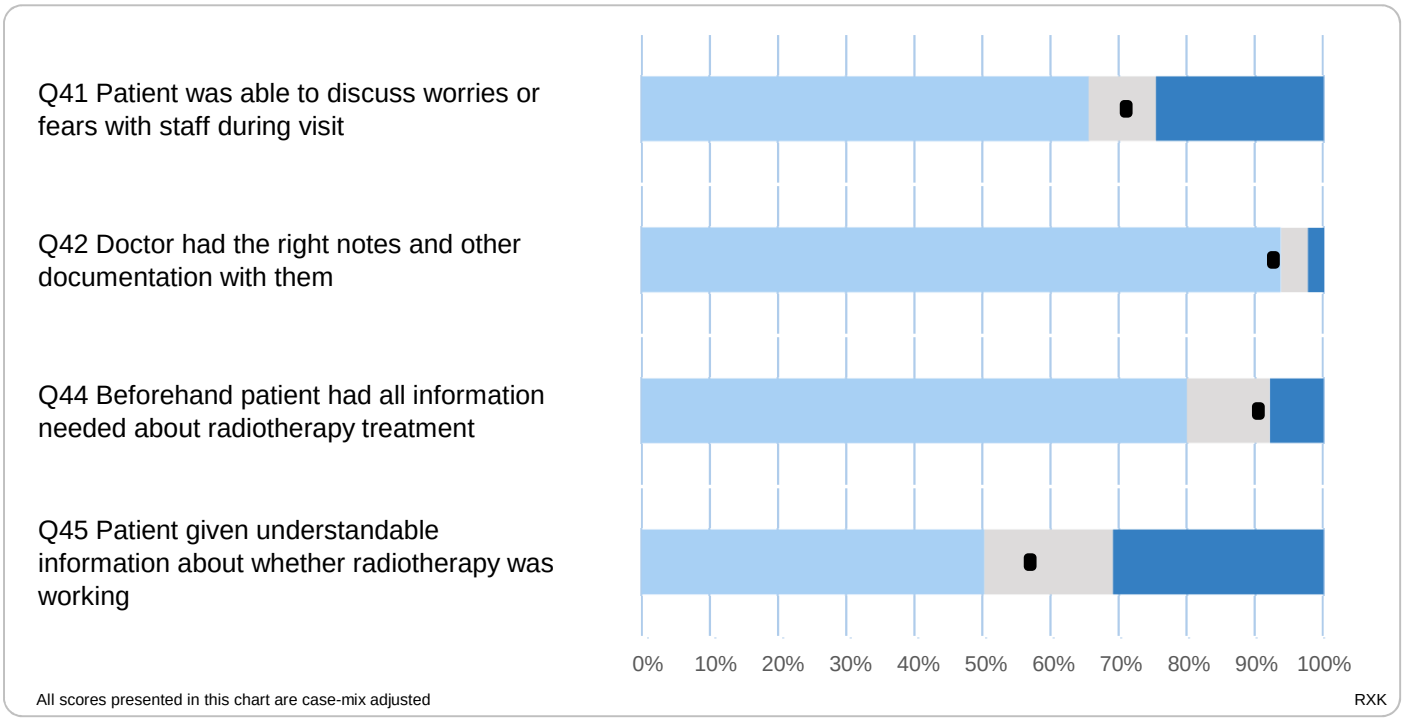


		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016		Change from 2015				
Question		Number of respondents	Score	Number of respondents	Score		2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q36	Hospital staff definitely did everything to help control pain	260	83%	268	76%		77%	80%	88%	84%
Q37	Always treated with respect and dignity by staff	280	82%	299	84%		84%	84%	92%	88%
Q38	Given clear written information about what should / should not do post discharge	264	88%	276	83%		81%	81%	90%	86%
Q39	Staff told patient who to contact if worried post discharge	270	94%	288	93%		93%	91%	97%	94%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Hospital care as a day patient / outpatient (Part 1 of 2)

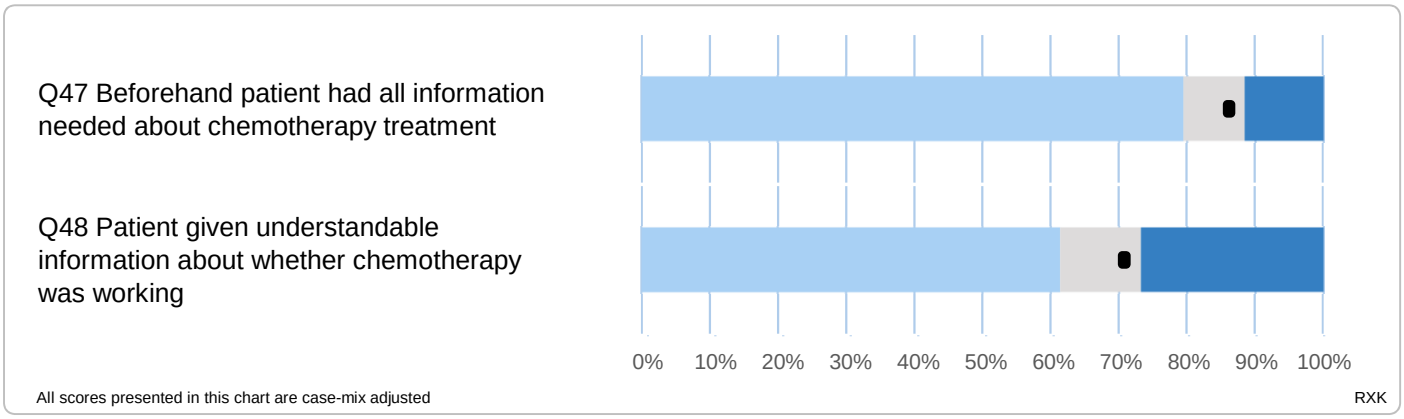


		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016						
Question		Number of respondents	Score	Number of respondents	Score	Change from 2015	2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q41	Patient was able to discuss worries or fears with staff during visit	379	68%	355	70%		71%	66%	75%	70%
Q42	Doctor had the right notes and other documentation with them	438	94%	421	93%		93%	94%	98%	96%
Q44	Beforehand patient had all information needed about radiotherapy treatment	125	85%	124	90%		90%	80%	92%	86%
Q45	Patient given understandable information about whether radiotherapy was working	112	56%	104	59%		57%	50%	69%	60%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Hospital care as a day patient / outpatient (Part 2 of 2)

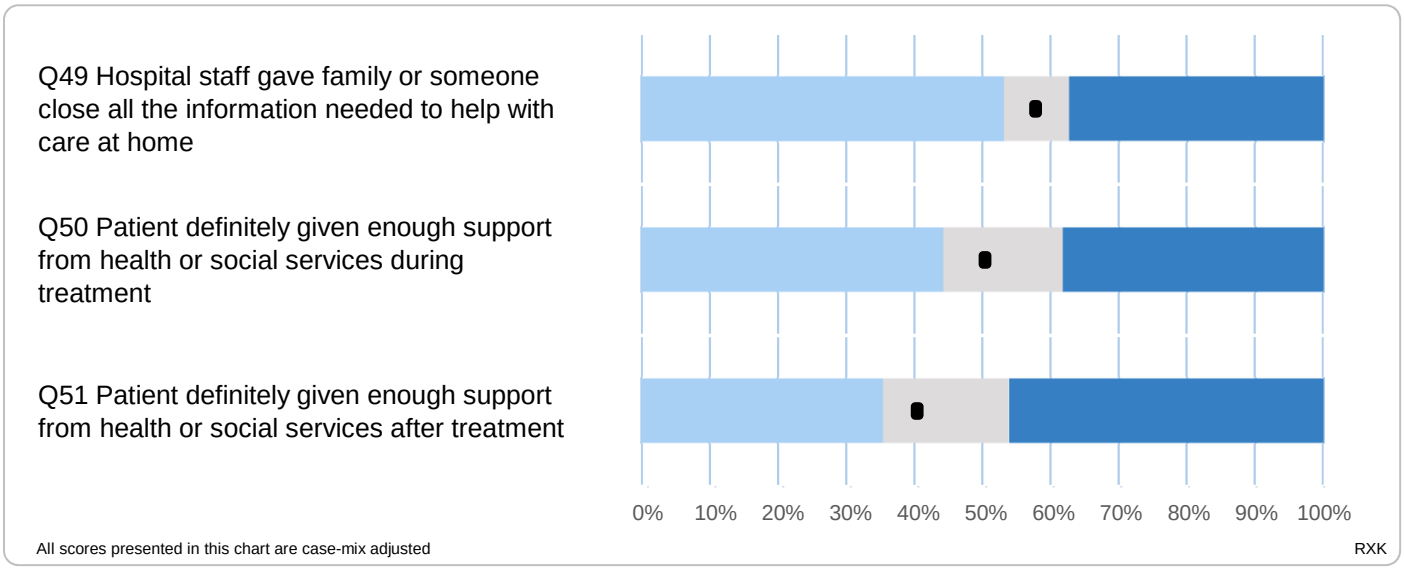


		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016						
Question		Number of respondents	Score	Number of respondents	Score	Change from 2015	2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q47	Beforehand patient had all information needed about chemotherapy treatment	295	83%	258	86%		86%	79%	88%	84%
Q48	Patient given understandable information about whether chemotherapy was working	271	65%	242	71%		71%	61%	73%	67%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Home care and support

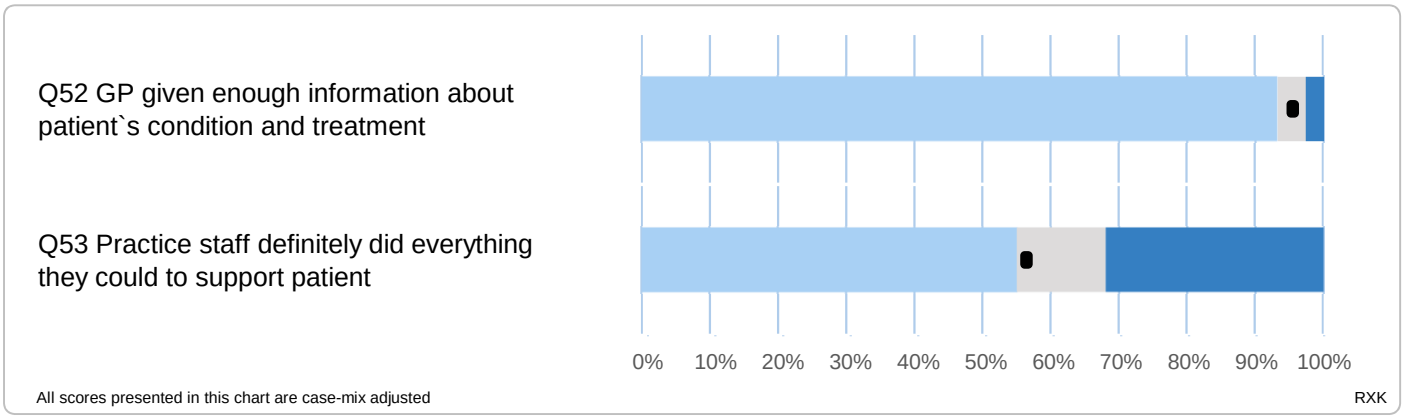


	Question	Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016		Change from 2015				
		Number of respondents	Score	Number of respondents	Score		2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q49	Hospital staff gave family or someone close all the information needed to help with care at home	395	59%	418	57%		58%	53%	63%	58%
Q50	Patient definitely given enough support from health or social services during treatment	260	49%	254	49%		50%	44%	62%	53%
Q51	Patient definitely given enough support from health or social services after treatment	157	41%	153	39%		40%	35%	54%	45%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Care from your general practice

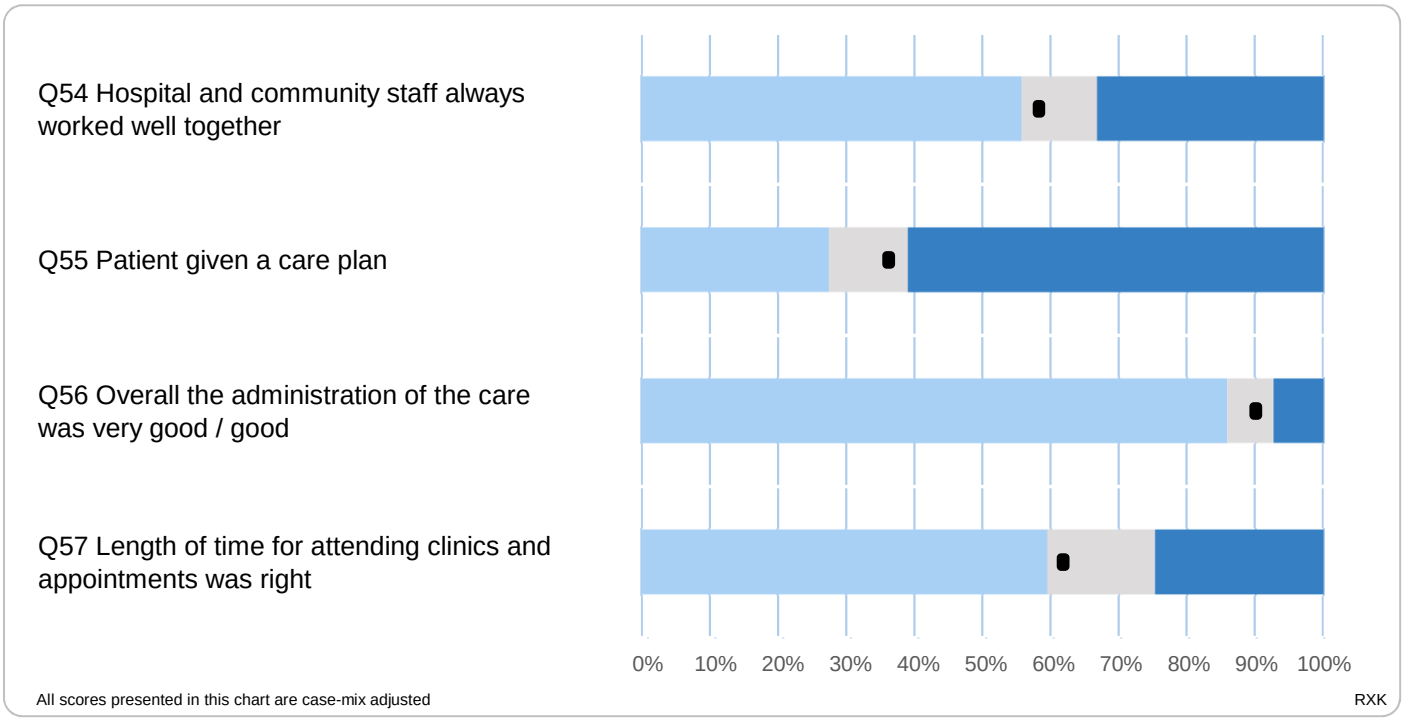


	Question	Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016		Change from 2015				
		Number of respondents	Score	Number of respondents	Score		2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q52	GP given enough information about patient`s condition and treatment	399	94%	399	94%		95%	93%	97%	95%
Q53	Practice staff definitely did everything they could to support patient	337	47%	322	55%		56%	55%	68%	62%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Your overall NHS care (Part 1 of 2)



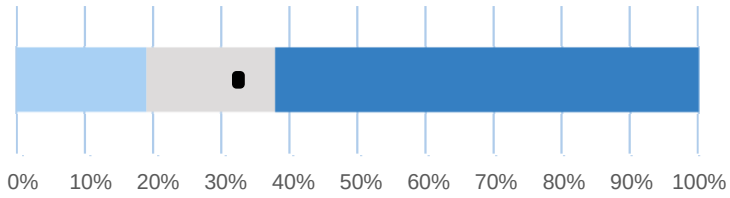
		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016						
Question		Number of respondents	Score	Number of respondents	Score	Change from 2015	2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q54	Hospital and community staff always worked well together	463	60%	475	58%		58%	56%	67%	61%
Q55	Patient given a care plan	382	40%	375	39%		36%	28%	39%	33%
Q56	Overall the administration of the care was very good / good	475	91%	495	91%		90%	86%	93%	89%
Q57	Length of time for attending clinics and appointments was right	470	56%	491	61%		62%	60%	75%	67%

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Trust results

Your overall NHS care (Part 2 of 2)

Q58 Taking part in cancer research discussed with patient

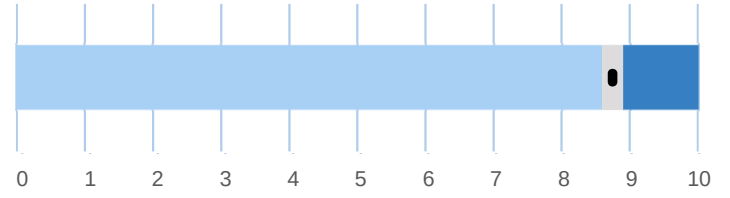


All scores presented in this chart are case-mix adjusted

RXK

		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016						
Question		Number of respondents	Score	Number of respondents	Score	Change from 2015	2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q58	Taking part in cancer research discussed with patient	441	35%	458	33%		32%	19%	38%	29%

Q59 Patient`s average rating of care scored from very poor to very good



All scores presented in this chart are case-mix adjusted

RXK

		Unadjusted Scores					2016 Case Mix Adjusted			
		2015		2016						
Question		Number of respondents	Score	Number of respondents	Score	Change from 2015	2016 Score	Expected range - lower	Expected range - upper	National Average Score
Q59	Patient`s average rating of care scored from very poor to very good	466	8.6	489	8.7		8.7	8.6	8.9	8.7

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available * Indicates where a score has been suppressed because there are less than 21 respondents.

Comparisons by tumour group for this Trust

The following tables show the unadjusted Trust and the national percentage scores for each question broken down by tumour group. Where a cell in the table contains an asterisk this indicates that the number of patients in that group was below 21 and too small to display. Where a cell in the table contains "n.a." this indicates that there were no respondents for that tumour group.

Seeing your GP

	Q1. Saw GP once / twice before being told had to go to hospital		Q2. Patient thought they were seen as soon as necessary	
Cancer type	**This Trust[$]**	**National**	**This Trust[$]**	**National**
Brain / CNS	n.a.	63%	n.a.	79%
Breast	95%	94%	94%	90%
Colorectal / LGT	57%	71%	76%	81%
Gynaecological	68%	75%	82%	79%
Haematological	65%	65%	84%	81%
Head and Neck	*	77%	*	79%
Lung	*	70%	*	83%
Prostate	85%	78%	92%	86%
Sarcoma	n.a.	66%	n.a.	67%
Skin	*	90%	*	86%
Upper Gastro	*	72%	*	78%
Urological	73%	82%	68%	85%
Other	63%	72%	79%	79%
All Cancers	75%	77%	84%	83%

[$] These are unadjusted scores

Diagnostic tests

	Q5. Received all the information needed about the test		Q6. The length of time waiting for the test to be done was about right		Q7. Given complete explanation of test results in understandable way	
Cancer type	**This Trust[$]**	**National**	**This Trust[$]**	**National**	**This Trust[$]**	**National**
Brain / CNS	n.a.	90%	n.a.	81%	n.a.	70%
Breast	97%	95%	94%	92%	80%	82%
Colorectal / LGT	90%	95%	84%	87%	81%	80%
Gynaecological	94%	93%	82%	85%	80%	75%
Haematological	96%	94%	98%	89%	77%	77%
Head and Neck	*	93%	*	85%	*	78%
Lung	*	94%	*	87%	*	78%
Prostate	97%	95%	97%	86%	86%	80%
Sarcoma	n.a.	93%	n.a.	79%	n.a.	74%
Skin	*	95%	*	88%	*	85%
Upper Gastro	*	93%	*	82%	*	77%
Urological	93%	94%	71%	87%	79%	79%
Other	96%	95%	86%	86%	76%	76%
All Cancers	94%	94%	88%	87%	80%	79%

[$] These are unadjusted scores

Finding out what was wrong with you

	Q8. Patient told they could bring a family member or friend when first told they had cancer		Q9. Patient felt they were told sensitively that they had cancer		Q10. Patient completely understood the explanation of what was wrong		Q11. Patient given easy to understand written information about the type of cancer they had	
Cancer type	This Trust[$]	National	This Trust[$]	National	This Trust[$]	National	This Trust[$]	National
Brain / CNS	n.a.	83%	n.a.	73%	n.a.	63%	n.a.	63%
Breast	90%	82%	94%	88%	83%	78%	89%	77%
Colorectal / LGT	87%	80%	91%	86%	76%	78%	71%	71%
Gynaecological	88%	71%	85%	82%	71%	72%	72%	69%
Haematological	88%	71%	93%	83%	60%	60%	80%	74%
Head and Neck	*	70%	*	86%	*	75%	*	64%
Lung	*	78%	*	83%	71%	75%	*	65%
Prostate	77%	77%	94%	84%	79%	78%	83%	81%
Sarcoma	n.a.	72%	n.a.	81%	n.a.	67%	n.a.	64%
Skin	*	63%	*	89%	*	79%	*	83%
Upper Gastro	*	77%	*	80%	*	72%	*	66%
Urological	80%	72%	73%	83%	77%	77%	81%	72%
Other	89%	74%	90%	82%	75%	70%	78%	62%
All Cancers	87%	76%	90%	84%	75%	73%	79%	72%

[$] These are unadjusted scores

Deciding the best treatment for you

	Q12. Patient felt that treatment options were completely explained		Q13. Possible side effects explained in an understandable way		Q14. Patient given practical advice and support in dealing with side effects of treatment	
Cancer type	This Trust[$]	National	This Trust[$]	National	This Trust[$]	National
Brain / CNS	n.a.	78%	n.a.	72%	n.a.	61%
Breast	85%	84%	79%	75%	71%	69%
Colorectal / LGT	81%	85%	62%	75%	52%	68%
Gynaecological	86%	84%	78%	74%	67%	66%
Haematological	88%	81%	80%	69%	61%	64%
Head and Neck	*	85%	*	70%	*	68%
Lung	*	83%	*	74%	*	68%
Prostate	90%	81%	69%	72%	81%	62%
Sarcoma	n.a.	83%	n.a.	72%	n.a.	66%
Skin	*	88%	*	76%	*	70%
Upper Gastro	*	83%	*	73%	*	67%
Urological	75%	81%	68%	72%	58%	62%
Other	86%	79%	71%	70%	63%	63%
All Cancers	85%	83%	74%	72%	66%	66%

	Q15. Patient definitely told about side effects that could affect them in the future		Q16. Patient definitely involved in decisions about care and treatment	
Cancer type	This Trust[$]	National	This Trust[$]	National
Brain / CNS	n.a.	55%	n.a.	73%
Breast	61%	56%	74%	79%
Colorectal / LGT	44%	56%	67%	79%
Gynaecological	51%	52%	79%	77%
Haematological	57%	49%	76%	77%
Head and Neck	*	59%	*	78%
Lung	*	54%	*	79%
Prostate	70%	63%	93%	79%
Sarcoma	n.a.	54%	n.a.	80%
Skin	*	61%	*	85%
Upper Gastro	*	53%	*	77%
Urological	40%	53%	71%	77%
Other	54%	50%	81%	74%
All Cancers	55%	54%	77%	78%

[$] These are unadjusted scores

Clinical Nurse Specialist

	Q17. Patient given the name of the CNS who would support them through their treatment		Q18. Patient found it easy to contact their CNS		Q19. Get understandable answers to important questions all or most of the time	
Cancer type	**This Trust[$]**	**National**	**This Trust[$]**	**National**	**This Trust[$]**	**National**
Brain / CNS	n.a.	95%	n.a.	82%	n.a.	83%
Breast	92%	94%	89%	86%	88%	89%
Colorectal / LGT	88%	91%	93%	88%	81%	89%
Gynaecological	94%	94%	75%	84%	87%	87%
Haematological	97%	90%	90%	88%	93%	89%
Head and Neck	*	88%	*	87%	*	87%
Lung	95%	94%	*	88%	*	88%
Prostate	92%	88%	100%	84%	92%	88%
Sarcoma	n.a.	88%	n.a.	87%	n.a.	90%
Skin	*	88%	*	89%	*	90%
Upper Gastro	*	92%	*	86%	*	87%
Urological	90%	81%	*	85%	*	89%
Other	87%	87%	86%	85%	77%	86%
All Cancers	92%	90%	88%	86%	87%	88%

[$] These are unadjusted scores

Support for people with cancer

	Q20. Hospital staff gave information about support groups		Q21. Hospital staff gave information about impact cancer could have on day to day activities		Q22. Hospital staff gave information on getting financial help		Q23. Hospital staff told patient they could get free prescriptions	
Cancer type	**This Trust[$]**	**National**	**This Trust[$]**	**National**	**This Trust[$]**	**National**	**This Trust[$]**	**National**
Brain / CNS	n.a.	84%	n.a.	81%	n.a.	67%	n.a.	71%
Breast	82%	89%	86%	85%	66%	62%	90%	80%
Colorectal / LGT	79%	84%	76%	82%	*	54%	*	82%
Gynaecological	82%	83%	85%	79%	74%	58%	84%	77%
Haematological	79%	83%	89%	82%	60%	58%	90%	86%
Head and Neck	*	83%	*	80%	*	59%	*	79%
Lung	*	83%	*	80%	*	69%	*	84%
Prostate	84%	86%	*	83%	45%	44%	*	79%
Sarcoma	n.a.	83%	n.a.	82%	n.a.	56%	n.a.	78%
Skin	*	86%	*	82%	*	52%	*	62%
Upper Gastro	*	83%	*	80%	*	60%	*	84%
Urological	67%	74%	*	72%	*	35%	*	67%
Other	80%	80%	90%	77%	70%	55%	83%	80%
All Cancers	79%	84%	84%	81%	62%	56%	86%	80%

[$] These are unadjusted scores

Operations

	Q25. Beforehand had all the information needed about the operation		Q26. Staff explained how operation had gone in understandable way	
Cancer type	**This Trust[$]**	**National**	**This Trust[$]**	**National**
Brain / CNS	n.a.	93%	n.a.	68%
Breast	98%	97%	80%	78%
Colorectal / LGT	100%	96%	70%	83%
Gynaecological	96%	96%	84%	79%
Haematological	*	93%	*	75%
Head and Neck	*	94%	*	78%
Lung	*	97%	*	79%
Prostate	*	96%	*	77%
Sarcoma	n.a.	93%	n.a.	80%
Skin	*	96%	*	83%
Upper Gastro	*	96%	*	79%
Urological	93%	95%	54%	77%
Other	93%	95%	70%	78%
All Cancers	96%	96%	75%	79%

[$] These are unadjusted scores

Hospital care as an inpatient (Part 1 of 2)

	Q28. Groups of doctors or nurses did not talk in front of patient as if they were not there		Q29. Patient had confidence and trust in all doctors treating them		Q30. Patient's family or someone close definitely had opportunity to talk to doctor		Q31. Patient had confidence and trust in all ward nurses	
Cancer type	This Trust[$]	National	This Trust[$]	National	This Trust[$]	National	This Trust[$]	National
Brain / CNS	n.a.	74%	n.a.	79%	n.a.	61%	n.a.	66%
Breast	84%	89%	86%	86%	74%	76%	81%	76%
Colorectal / LGT	69%	76%	89%	85%	55%	72%	67%	70%
Gynaecological	83%	85%	83%	85%	72%	72%	60%	71%
Haematological	76%	81%	88%	81%	72%	73%	77%	74%
Head and Neck	*	79%	*	84%	*	74%	*	72%
Lung	*	77%	*	82%	*	73%	*	75%
Prostate	*	85%	*	88%	*	74%	*	79%
Sarcoma	n.a.	80%	n.a.	85%	n.a.	72%	n.a.	74%
Skin	*	87%	*	92%	*	80%	*	85%
Upper Gastro	*	74%	*	82%	*	73%	*	71%
Urological	79%	80%	69%	86%	52%	71%	66%	77%
Other	63%	79%	72%	81%	52%	70%	56%	71%
All Cancers	77%	82%	81%	85%	67%	73%	70%	74%

	Q32. Always / nearly always enough nurses on duty		Q33. All staff asked patient what name they preferred to be called by		Q34. Always given enough privacy when discussing condition or treatment		Q35. Patient was able to discuss worries or fears with staff during visit	
Cancer type	This Trust[$]	National	This Trust[$]	National	This Trust[$]	National	This Trust[$]	National
Brain / CNS	n.a.	59%	n.a.	65%	n.a.	76%	n.a.	38%
Breast	74%	71%	68%	61%	91%	86%	55%	54%
Colorectal / LGT	52%	62%	63%	70%	81%	84%	*	53%
Gynaecological	71%	66%	58%	65%	86%	83%	45%	50%
Haematological	44%	62%	88%	70%	88%	86%	57%	56%
Head and Neck	*	65%	*	69%	*	86%	*	54%
Lung	*	70%	*	72%	*	83%	*	50%
Prostate	*	73%	*	68%	*	89%	*	52%
Sarcoma	n.a.	71%	n.a.	71%	n.a.	88%	n.a.	53%
Skin	*	78%	*	67%	*	90%	*	62%
Upper Gastro	*	64%	*	74%	*	83%	*	50%
Urological	72%	68%	72%	72%	83%	87%	*	47%
Other	59%	62%	74%	68%	71%	83%	42%	47%
All Cancers	66%	67%	69%	68%	86%	85%	47%	52%

[$] These are unadjusted scores

Hospital care as an inpatient (Part 2 of 2)

	Q36. Hospital staff definitely did everything to help control pain		Q37. Always treated with respect and dignity by staff		Q38. Given clear written information about what should / should not do post discharge		Q39. Staff told patient who to contact if worried post discharge	
Cancer type	**This Trust[$]**	**National**	**This Trust[$]**	**National**	**This Trust[$]**	**National**	**This Trust[$]**	**National**
Brain / CNS	n.a.	79%	n.a.	79%	n.a.	76%	n.a.	91%
Breast	81%	86%	89%	88%	94%	91%	99%	96%
Colorectal / LGT	79%	84%	93%	87%	87%	84%	96%	94%
Gynaecological	75%	83%	76%	87%	69%	87%	95%	94%
Haematological	83%	83%	88%	89%	78%	80%	96%	95%
Head and Neck	*	81%	*	87%	*	85%	*	91%
Lung	*	84%	*	87%	*	81%	*	91%
Prostate	*	85%	*	91%	*	89%	*	94%
Sarcoma	n.a.	87%	n.a.	90%	n.a.	84%	n.a.	94%
Skin	*	87%	*	92%	*	89%	*	95%
Upper Gastro	*	82%	*	86%	*	82%	*	93%
Urological	68%	82%	76%	89%	75%	86%	81%	91%
Other	53%	82%	78%	86%	70%	81%	84%	93%
All Cancers	76%	84%	84%	88%	83%	86%	93%	94%

[$] These are unadjusted scores

Hospital care as a day patient / outpatient

	Q41. Patient was able to discuss worries or fears with staff during visit		Q42. Doctor had the right notes and other documentation with them		Q44. Beforehand patient had all information needed about radiotherapy treatment		Q45. Patient given understandable information about whether radiotherapy was working	
Cancer type	This Trust[$]	National	This Trust[$]	National	This Trust[$]	National	This Trust[$]	National
Brain / CNS	n.a.	63%	n.a.	95%	n.a.	86%	n.a.	58%
Breast	66%	70%	92%	96%	87%	88%	61%	60%
Colorectal / LGT	84%	72%	93%	96%	*	86%	*	58%
Gynaecological	67%	68%	91%	95%	*	85%	*	62%
Haematological	69%	74%	90%	97%	*	84%	*	64%
Head and Neck	*	71%	*	96%	*	84%	*	61%
Lung	*	70%	*	95%	*	85%	*	58%
Prostate	*	72%	92%	96%	*	89%	*	58%
Sarcoma	n.a.	72%	n.a.	97%	n.a.	89%	n.a.	69%
Skin	*	72%	*	97%	n.a.	84%	n.a.	59%
Upper Gastro	*	68%	*	94%	n.a.	86%	n.a.	57%
Urological	*	68%	96%	96%	*	81%	*	56%
Other	71%	67%	94%	95%	*	83%	*	58%
All Cancers	70%	70%	93%	96%	90%	86%	59%	60%

	Q47. Beforehand patient had all information needed about chemotherapy treatment		Q48. Patient given understandable information about whether chemotherapy was working	
Cancer type	This Trust[$]	National	This Trust[$]	National
Brain / CNS	n.a.	80%	n.a.	59%
Breast	83%	82%	63%	62%
Colorectal / LGT	76%	85%	68%	63%
Gynaecological	90%	84%	78%	66%
Haematological	85%	84%	69%	75%
Head and Neck	*	80%	*	58%
Lung	*	84%	*	68%
Prostate	*	84%	*	67%
Sarcoma	n.a.	86%	n.a.	73%
Skin	n.a.	88%	n.a.	78%
Upper Gastro	*	84%	*	64%
Urological	*	84%	*	67%
Other	88%	85%	66%	68%
All Cancers	86%	84%	71%	67%

[$] These are unadjusted scores

Home care and support

	Q49. Hospital staff gave family or someone close all the information needed to help with care at home		Q50. Patient definitely given enough support from health or social services during treatment		Q51. Patient definitely given enough support from health or social services after treatment	
Cancer type	**This Trust [$]**	**National**	**This Trust [$]**	**National**	**This Trust [$]**	**National**
Brain / CNS	n.a.	49%	n.a.	42%	n.a.	41%
Breast	60%	57%	40%	53%	24%	40%
Colorectal / LGT	53%	60%	35%	61%	*	51%
Gynaecological	58%	56%	64%	50%	59%	39%
Haematological	56%	60%	42%	51%	*	44%
Head and Neck	*	61%	*	52%	*	48%
Lung	*	57%	*	50%	*	43%
Prostate	46%	56%	*	48%	*	43%
Sarcoma	n.a.	59%	n.a.	55%	n.a.	48%
Skin	*	65%	*	57%	*	59%
Upper Gastro	*	59%	*	55%	*	48%
Urological	43%	58%	*	47%	*	43%
Other	61%	54%	54%	55%	*	48%
All Cancers	57%	58%	49%	53%	39%	45%

[$] These are unadjusted scores

Care from your general practice

	Q52. GP given enough information about patient`s condition and treatment		Q53. Practice staff definitely did everything they could to support patient	
Cancer type	**This Trust[$]**	**National**	**This Trust[$]**	**National**
Brain / CNS	n.a.	89%	n.a.	51%
Breast	97%	96%	59%	62%
Colorectal / LGT	91%	95%	48%	62%
Gynaecological	95%	95%	71%	61%
Haematological	97%	96%	39%	59%
Head and Neck	*	94%	*	59%
Lung	*	95%	*	61%
Prostate	88%	96%	*	67%
Sarcoma	n.a.	95%	n.a.	56%
Skin	*	96%	*	67%
Upper Gastro	*	94%	*	61%
Urological	83%	95%	48%	64%
Other	96%	95%	59%	59%
All Cancers	94%	95%	55%	62%

[$] These are unadjusted scores

Your overall NHS care

	Q54. Hospital and community staff always worked well together		Q55. Patient given a care plan		Q56. Overall the administration of the care was very good / good		Q57. Length of time for attending clinics and appointments was right	
Cancer type	**This Trust[$]**	**National**	**This Trust[$]**	**National**	**This Trust[$]**	**National**	**This Trust[$]**	**National**
Brain / CNS	n.a.	43%	n.a.	32%	n.a.	82%	n.a.	61%
Breast	61%	61%	36%	37%	93%	91%	62%	65%
Colorectal / LGT	42%	60%	27%	35%	85%	89%	76%	70%
Gynaecological	62%	58%	28%	30%	92%	89%	59%	66%
Haematological	57%	63%	44%	33%	91%	92%	47%	63%
Head and Neck	*	62%	*	36%	*	89%	*	69%
Lung	57%	63%	*	33%	86%	89%	*	71%
Prostate	76%	65%	55%	35%	95%	88%	84%	73%
Sarcoma	n.a.	56%	n.a.	28%	n.a.	87%	n.a.	61%
Skin	*	69%	*	39%	*	90%	*	76%
Upper Gastro	*	58%	*	34%	*	87%	*	66%
Urological	47%	63%	46%	27%	86%	87%	77%	75%
Other	52%	55%	47%	29%	86%	88%	53%	61%
All Cancers	58%	61%	39%	33%	91%	89%	61%	67%

	Q58. Taking part in cancer research discussed with patient		Q59. Patient`s average rating of care scored from very poor to very good	
Cancer type	**This Trust[$]**	**National**	**This Trust[$]**	**National**
Brain / CNS	n.a.	24%	n.a.	8.3
Breast	31%	28%	8.9	8.8
Colorectal / LGT	25%	26%	8.4	8.7
Gynaecological	40%	30%	8.8	8.7
Haematological	52%	34%	8.9	8.9
Head and Neck	*	19%	*	8.7
Lung	*	33%	8.2	8.7
Prostate	25%	34%	8.7	8.7
Sarcoma	n.a.	33%	n.a.	8.6
Skin	*	18%	*	8.9
Upper Gastro	*	33%	*	8.6
Urological	31%	15%	8.0	8.7
Other	27%	30%	8.6	8.6
All Cancers	33%	29%	8.7	8.7

[$] These are unadjusted scores

Annex

Methodology

The sample for the survey included all adult (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2016.

The patients included in the sample had relevant cancer ICD10 codes (C00-99 excluding C44 and C84, and D05) in the first diagnosis field of their patient records, applied to their patient files by the relevant NHS Trust, and were alive at the point at which fieldwork commenced. Deceased checks were undertaken on up to three occasions during fieldwork, to ensure that questionnaires were not sent to patients who had died since their treatment.

Trust samples were checked rigorously for duplicates and patient lists were also de-duplicated nationally to ensure that patients did not receive multiple copies of questionnaires.

The fieldwork for the survey was undertaken between October 2016 and March 2017.

The survey used a mixed mode methodology. Questionnaires were sent by post with two reminders where necessary, but also included an option to complete online. A Freephone helpline was available for respondents to ask questions about the survey, to enable them to complete their questionnaires over the phone, and to provide access to a translation and interpreting facility for those whose first language was not English.

The Health Research Authority supported the survey by granting Section 251 approval.

Further information

Further information on survey methodology, as well as all of the national and local reports and data, is available at www.ncpes.co.uk

Redevelopment of the 2016 survey

The following changes have been made to the National Cancer Patient Experience Survey in 2016:

- question 5 and 25 are no longer presented in a tick all that apply format and their response options have been revised. This has allowed the questions to be scored and presented in the comparability charts, data tables and tumour group tables. Because of these changes, no comparison with 2015 results is possible
- question 8 has had a response option removed. Because of this change, no comparison with 2015 results is possible.

Official Statistics

The 2016 survey data has been produced and published in line with the Code of Practice for Official Statistics.

Scoring methodologies

49 of the 50 questions relating directly to patient experience have been summarised as the score of the percentage of patients who reported a positive experience. For example:

- question 6 asks: "Overall, how did you feel about the length of time you had to wait for your test to be done?". Responses have been recorded as positive only for those patients who selected the first option ("It was about right")
- question 11 asks: "When you were told you had cancer, were you given written information about the type of cancer you had?". Responses have been recorded as positive only for those patients who selected the first option ("Yes, and it was easy to understand").

Where options do not provide any information on positive/negative patient experience (e.g. "Don't know / can't remember"), they are excluded from the score.

The other question (question 59) asks respondents to rate their overall care on a scale of 0 to 10. Scores have been given as an average on this scale.

A copy of the 2016 questionnaire, marked up with all of these scoring conventions, is available at www.ncpes.co.uk

Further details on the scoring methodology can be found in the technical document for the survey, available at www.ncpes.co.uk

Case-mix adjustment

As in 2015, case-mix adjusted findings are being presented alongside unadjusted results for Trusts. Case-mix adjustment allows us to account for the impact that differing patient populations might have on results. By using the case-mix adjusted estimates we can obtain a greater understanding of how a Trust is performing given their patient population.

The factors taken into account in this case-mix adjustment are gender, age, ethnic group, deprivation, and tumour group.

For further details on case-mix adjustment, please refer to the technical document for the survey, available at www.ncpes.co.uk

Statistical significance

In the reporting of 2016 results, appropriate statistical tests have been undertaken to identify any changes between 2015 and 2016 unadjusted scores which are ‘statistically significant’. ‘Statistically significant’ means that you can be very confident that any change between scores is real and not due to chance.

For further details on statistical significance, please refer to the technical document for the survey, available at www.ncpes.co.uk

Response Rates

	Sample Size	Excluded	Adjusted Sample	Not Returned	Blank / Refused	Completed	Response Rate
National	118,253	8,590	109,663	33,035	3,840	72,788	67%
RXK	908	58	850	324	20	506	60%

Respondents by tumour group

The tables below show the numbers of patients from each tumour group and the age and gender distribution of these patients.

Tumour Group	Number of respondents*
Brain / CNS	0
Breast	142
Gynaecological	86
Colorectal / LGT	34
Lung	21
Skin	6
Haematological	70
Upper Gastro	11
Other	58
Urological	31
Prostate	39
Sarcoma	0
Head and Neck	8

** These figures may not match the numerator for all questions in the 'Comparisons by tumour group' section of this report, because not all questions were answered by all respondents.*

Respondents by age and gender

The questionnaire asked respondents to give their year of birth. This information has been amalgamated into 8 age bands. The age and gender distribution for the Trust was as follows:

	16-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total
Male	0	1	2	11	26	63	52	7	162
Female	0	7	17	49	89	108	58	16	344
Total	0	8	19	60	115	171	110	23	506

Quality Health is a specialist health and social care survey organisation, working for public, private and not-for-profit sectors, in the UK and overseas.

Quality Health works with all acute hospitals in England, all independent providers of hospital care, and all Health Boards in Scotland, Wales and Northern Ireland.

Quality Health is an approved contractor for the Care Quality Commission's patient survey programmes, NHS England's National Staff Survey programme, and the national Patient Reported Outcome Measures (PROMs).

Further information on Quality Health is available at www.quality-health.co.uk

Further information on the National Cancer Patient Experience Survey, as well as all of the national and local reports and data, is available www.ncpes.co.uk

Sandwell and West Birmingham Hospitals NHS
NHS Trust

CLINICAL LEADERSHIP EXECUTIVE SUMMARY

Date	25 July 2017
Attendees	The Executive Group, Group Triumvirates and staff convenor
Key points of discussion relevant to the Board	• **Safety Plan, Consistency of care, DNACPR and DoLS** There is significant work being done on the safety plan and consistency of care. Both, and they relate, are showing promise in that we are beginning to be able to evidence always events in the care of inpatients. There remains work to do to ensure multi professional working in every team. The importance of DNA CPR recording on eBMS (and from Monday failure to do so will become a prima facile conduct issue) and of acting on DOLs assessments by making relevant external referrals. • **Midland Met prep work, refurbishment of the STC and BTC** The start of prep work for the move to Midland Met, and for the refurbishment of the STC and BTC. In many areas thinking is advanced and preparations are happening. There was a general enthusiasm for access to the site and digital approaches which help staff to visualise the space. From August, the estate development committee will meet in the hour before CLE to take forward matters of this type. • **Pathology proposal** We discussed the pathology proposal. It was clear that there are some unanswered questions about the clinical standards that that will offer and about the commercial structure. • **Casenote scanning** We discussed casenote scanning. The discussion illustrated collective coherence on the risks, issues and perceived risks. After the review work on this is complete late next week, we will agree with colleagues how the various concerns are best responded to. At the same time we need to recognise that the vast majority of clinical interactions are working well, and we have largely successfully redeployed our health records staff. It is not inevitable but always possible that major process changes have unintended impacts/issues. The task now is to manage out those issues at pace. • **Eye ED/UCC model evaluation** We explored again the quite significant change in how eye casualty works. This is now largely working, and complaints have fallen. The change is a positive one for patients and for care, and also helps us slightly with the forthcoming separation of BMEC and ED when we move to Midland Met.
Positive highlights of note	• Avoidable surgical cancellations have reduced • Nurse recruitment continues at scale • 58 days – no Thornbury

Matters presented for information or noting	• Procurement summit • Imaging performance and recharges • 2017/18 CIP progress and Q2 forecast • Roster compliance: Q2 • Improving medical agency spend • IPR
Decisions made	• From the 31/7 failure to record DNA CPR on eBMS will become a prima facile conduct issue and of acting on DOLs assessments by making relevant external referrals.
Matters of concern or key risks to escalate to the Board	• Imaging reporting turnaround times associated with PACs • Casenote scanning supplier issues

Toby Lewis, Chief Executive
Chair of the Clinical Leadership Executive
For the meeting of the Trust Board scheduled for 3rd August 2017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Pathology Proposal
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Terry Whalley, Project Director
DATE OF MEETING:	3rd August 2017

EXECUTIVE SUMMARY:

The Black Country Pathology Transitional Management Team has met to discuss the opportunities that could be realised by creating a single managed pathology service from the four Trust services of: Sandwell & West Birmingham Hospitals NHS Trust; Walsall Healthcare NHS Trust; The Dudley Group Foundation Trust and Royal Wolverhampton NHS Trust. The resulting proposal set out in the Outline Business Case is being presented to the Board for consideration and decision.

REPORT RECOMMENDATION:

The Trust Board is asked to consider the Outline Business Case and approve the recommendations set out in the covering paper.

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

Accept	Approve the recommendation	Discuss
	x	x

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

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

Comments:

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

PREVIOUS CONSIDERATION:

July Clinical Leadership Executive

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Public Trust Board

Pathology Proposal

Introduction

The Black Country Pathology (BCP) Transitional Management Team, formerly the BCP Steering Group, has been meeting monthly since September 2016 to discuss the opportunities that could be realised by creating a single managed pathology service from the four Trust services that are currently operating. Whilst all members understand and acknowledge the concern caused by large scale change, there has been a consistent and firm view that the creation of a unified service offers a real opportunity to address some of the critical challenges that are being faced by pathology services across the NHS. Foremost amongst these are recruitment and retention of key staff, and the ability to maintain and develop quality of service in the face of financial constraints.

While the Outline Business Case (OBC) concentrates, quite rightly, on the technical detail, it is important to view this process as a positive and exciting one, aimed at creating a new service that is strong and sustainable, focused on quality, and fit for the future. It must be a service that is attractive to high quality staff, fully integrated with all other clinical services across the locality, and set fair to move quickly to implement new scientific developments as they become available.

The success of any pathology service is dependent on the expertise and commitment of the staff, who provide far more than a simple technical 'results' function. Pathology is an integral part of all patient-facing clinical services and this close relationship must be maintained if the proposed approach is to be successful. Accordingly, we are proposing that:

- the governance arrangements facilitate equitable input from all Trusts
- a medically-led Clinical Reference Group is created to oversee service quality and the delivery against the 'no worse than now' promise and 'better than the best of us' aim.
- the next stage (production of Target Operating Model and Full Business Case) includes considerable staff and stakeholder involvement as the detail of the new service is developed and agreed

Outline Business Case (OBC)

The OBC reaffirms the finding from the Strategic Outline Case, that there are significant benefits to be achieved by creating a Black Country Pathology Service that operates from a single large hub, supported by three Emergency Service Laboratories (ESLs) on the other acute hospital sites.

The BCP would be set up as an Arms Length Organisation, hosted by one Trust but owned equitably and run jointly by the four Trusts. The senior members of the single management team, and the Chairs of the Clinical Reference and Operational Reference Groups, should be drawn from all Trusts to ensure balance, with the Clinical Reference Group playing the pivotal role in ensuring clinical service users are able to monitor and influence the quality of the services and functions provided.

The single management team will report to Trust Boards via the BCP Strategic Board that comprises of Trust Directors (one clinical and one non clinical from each trust) and an independent Chair.

The BCP will include a commitment to deliver services and meet turnaround times 'no worse than now' and an aspiration to go beyond the best among us. Detailed transitional planning will include consideration of what is done now that is valued to assure this. The preferred approach offers an estimated saving in excess of £65m against a currently projected overall pathology spend of circa £708m over the next 10 years. This incorporates and goes beyond the savings projected within the long-term financial model (£44m), many of which depend on high levels of collaboration and rationalisation of working to achieve.

Decisions required

The Boards are asked to consider the Outline Business Case, and approve the recommendations to

- Establish a Black Country Pathology Service, which will be equitably and jointly owned by all 4 Trusts.
- Commence a transition phase to create a Black Country Pathology Service based on a single hub / ESL model that is expected to be fully operational by end of 2018.
- Begin process of recruiting BCP Clinical and Operational Director roles that will drive this work forward.
- Commit to enabling expenditure for next period of activity as defined in attached summary.
- Produce a detailed Target Operating Model (TOM) and Full Business Case (FBC) that will be completed in time for consideration at Trust Board meetings in October 2017.

Mark Newbold, Chair

Terry Whalley, Programme Director

BCP Transitional Management Team

July 2017

Outline Business Case (OBC)

Report into the development of a consolidated Black Country Pathology Service

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Walsall Healthcare NHS
NHS Trust

The Dudley Group NHS
NHS Foundation Trust

The Royal Wolverhampton NHS
NHS Trust

Foreword

Review of options for an efficient and high quality Black Country Pathology Service

This is a critical time for NHS pathology services both nationally and locally.

At present almost 130 NHS Trusts and Foundation Trusts provide their own pathology services, many of which are competing for increasingly scarce staffing resource and based on outdated operating models which are in urgent need of investment in premises, IT and equipment. At a national level, NHS Improvement are looking for an increase in ambition and pace for the consolidation of pathology services across the NHS, based on strong international and NHS evidence that consolidation and modernisation of pathology services can provide strong and sustainable services that offer both increased quality and efficiency.

At a local level the four Black Country Trusts each operate their own laboratory service, and the Black Country Pathology Steering Group has been formed to examine how a single management team for the four services might achieve similar benefits locally. There is considerable commitment to working as a single service, with the aim of developing a successful and sustainable pathology service that continues to provide high quality services in the locality. Clearly there are a number of options and opportunities that require examination, and this report details the appraisal of seven operational options.

Trust Boards have committed to a service led by a single management team that is neutral with respect to site and organisation, and accountable to an Oversight Group derived from executive and non-executive directors of the four Trusts. This is a very positive step, which places the responsibility for shaping the services in the future with the existing laboratory teams, and this report provides the first piece of analysis that will inform the next steps for the management team. This Strategic Options evaluation includes strategic, economic, financial, commercial and management considerations, and utilises both the expertise of the current pathology management teams and the best data available from locations across the NHS where similar processes have been undertaken.

This report provides clear direction to the Steering Group and points to some exciting opportunities for the Black Country services. I very much look forward to progressing with the establishment of our single management team and utilising the findings in this report to develop a full business case for Trust Board consideration later in 2017.

Mark Newbold

Independent Chairman Black Country Pathology Steering Group

Content

Content

EXECUTIVE SUMMARY

Executive Summary

Introduction and Recommendations

This Outline Business Case (OBC) presents a detailed analysis of the potential benefits for patients, staff, primary care and hospital clinicians of a new operating model for pathology services across the Trusts - a single hub and spoke model, with a single operating and governance model under a hosted arrangement.

The Black Country Pathology Service (BCPS) project began 6 months ago with the development of a Strategic Outline Case (SOC), which identified four preferred options out of a long list of 8. It was decided at the end of that stage that a Hub and Spoke (essential services laboratories or ESLs) model was likely to produce the best quality, patient, operational and financial benefits. This OBC has been developed to assess the potential benefits that a consolidated model would bring to all parties involved..

This OBC follows the Treasury guidance and recommendation on developing Business Cases and brings together the potential benefits and the recommendations for approval by each Trust Board during August and September 2017. If the OBC is approved, the months of September, October and November will be spent developing a detailed transition timeline, plan, activities and gateway reviews where the Trusts would be able to assess the progress of the project.

The Executive Summary brings together:

• **The Strategic Case** for change to the current operating model;

• **The Economic Case** which sets out the results of the appraisal of the new operating options and describes, in detail, the preferred Target Operating Model and its benefits;

• **The Financial Case** which quantifies the annual revenues and costs and investment required for the Target Operating Model and shows the impact (compared to the current model) for each Trust;

• **The Commercial Case** sets out the proposed governance, managerial and commercial arrangement for the Target Operating Model and the organisational form which it could take; and

• **The Management Case** which describes the implementation planning required and the risks to be managed to move the BCPS Trusts forward, were they to agree to establish a single pathology entity in line with the new Target Operating Model.

Recommendations & approvals

Trusts are asked to consider and review this OBC and recommendations below:

i. The differential over 10 years between the preferred model (Hub and three ESLs) and its variant is only £3m derived from the lower capital required. However, from a clinical and quality point of view the single hub option would still be the preferred option. It should be noted that a financial sensitivity run on both models in relation to the capital development costs indicated that the Hub and 3 ESL option provides a marginal higher saving.

ii. It is recommended that the Trust boards approve the commencement of the transition phase with a number of gateways on the way which should be defined during August , September and October, such as: confirm access to funding, confirm appointment of management team, etc.

1. Strategic and Economic Case
   - All Trusts to confirm the need for change and unsustainability of current delivery model.
   - Confirm that all Trusts are signed up to deliver the described benefits to patients, staff and stakeholders.
   - Agree that all pathology activity under the Base Case models will be managed by the new service.
2. Financial Case
   - Support the Financial Case as presented and its assumptions for the new TOM.
   - Approve the initial recommendations for shareholder distribution methodology and the implication for sharing of risks and rewards including transition costs.
   - Approve the investment required in the next three months for the development of a detailed transition plan, HR plan, Hub design and operational design as part of Gateway 1.
   - Support the commitment to consolidate services at RWH with the extension of the Hub as preferred option.
   - Support the development of the final agreement amongst the parties over the next three months and as part of gateway 1. This would include full agreement on shares, payment mechanism, revenue treatment, downside scenarios, CCG price standardisation and other key commercial terms.

Executive Summary

Recommendations & approvals

Trusts are asked to consider and review this OBC and recommendations below:

- Commit to the principles of the pricing mechanism where each test is paid for using a consolidated list of test prices.
- Support the pricing principle where the profit margin on Private Patient income is always retained by the Trusts and the same for GP income is retained by the Trusts for the first two years after the opening of the Hub.

3. Commercial Case
   - Establish an Arms Length Organisation (ALO) to operate the BCPS hosted by RWH.
   - Support the ALO to be governed by the principles set out in the Heads of Terms (HoTs) using a Scheme of Delegation including the Reserved Matters set out in this OBC.
   - Support the commercial principles set out in the Commercial Case but reserve the right to agree the detail once the partnership agreement if fully developed for Gateway 1..
4. Management Case
   - Agree to the appointment of a Clinical and Operations Director for BCPS to lead the transition period and plan development.
   - Agree to the development of a detailed transition plan for implementation with a number of Trust Gateway reviews for approval. The plan is to be ready by the end of October 2017 so implementation can start in November 2017.

Engagement

Over the last 3 months period there has been significant engagement with a wide variety of stakeholders to take the project to this point, specifically:

- BCPS Oversight Group: Formed by the CEOs and Clinical Directors the group has met on a monthly basis to assess progress and evaluate options.
- BCPS Steering Group: Formed by three representatives from each Trust including the laboratory manager, the clinical lead and a divisional management representative, the group has met once a month to discuss the detail of the business case and have been involved in the development of analysis.
- Clinical Workshops: Workshops have been held at each hospital site with clinical leads from each laboratory to discuss solutions to key clinical risks and the requirements for the operating model.
- Directors of Finance: three workshops have been held with DoFs to discuss key commercial and financial terms.
- Finance managers: engagement with finance leads from each Trust to capture and validate financial information used for financial modelling.
- HR Leads: engagement with each HR Lead from each Trust to understand the risks and start the development of a HR Plan for BCPS.
- Suppliers – we have also engaged with key existing suppliers who have provided (informally) cost estimates for reagents, Managed Equipment Services, IT and logistics to help underpin the new Target Operating Model.

Over the next few months, until October 2017, it is recommended that the engagement continues with the groups above to finalise a detailed project implementation plan and finalise the commercial agreement. At this point, staff engagement and communications should stepped up with the support of HR Leads.

Executive Summary

Strategic Case

Since the publication of the second phase of the Carter review in 2008, “Report of the Second Phase of the Review of NHS Pathology Services in England”, limited progress had been made in the implementation of new operating models that were able to provide cash releasing savings. The creation of NHS Improvement in 2016 has seen a re-examination of the central drive for consolidation in pathology. The mounting pressure on the finances of each Trust together with the new policy for consolidation has created a climate were collaboration amongst Trusts is seen as the way forward to achieve the sustainability of pathology services.

The ability to develop a sustainable pathology service is the key drive for collaboration. Most Trusts in England are seeing increasing pressure on laboratory operations from demographic changes (having to do more with less funding – average year on year growth of at least 5%) but also from staffing levels. Recruitment of specialist technical staff and pathologists is becoming an issue that is beginning to have an impact in the turn around times of specialist services like anatomical pathology and the development of new clinically relevant services. Certain staff groups are becoming more difficult to recruit and retain, these staff tend to be attracted by those laboratories or partnerships that are more forward thinking, offer a wider test repertoire and sites, and can offer wider opportunities for training and development. Isolated pathology services are unlikely to be able to attract and retain best candidates. This is already evident in some of the vacancies that the Trusts within the BCP service have not been able to fill, including some key clinical positions.

This requires the need to accelerate the collaboration of pathology services to radically improve the efficiency and size of laboratories linked to the implementation of radical reconfiguration of services, the adoption of world class technology and the ability of the pathology services to support better preventative medicine, long term conditions management and enhanced primary care capability.

The BCP service has been created with the aim to explore how pathology services can be best delivered for the local economy from a clinical quality and financial sustainability point of view. While some areas of the country have begun to make progress towards achieving the STP and Carter objectives for pathology (these are highlighted in the Strategic Case), the Trusts within BCP currently have been operating its services independently and delivering increased activity volumes year on year, while achieving the required CIP savings imposed by the Trusts. This is an unsustainable model that given all the strategic pressures has now reached the point where something has to be done to ensure the safe continuity of the services.

Economic Case

The economic case covers the analysis of a long list of options from a qualitative point of view to produce a short list of options that were analysed financially.

To ensure the sustainability and quality of BCPS service and deliver the required level of savings a number of options were considered, during the SOC (Strategic Outline Case), as to what should be the optimal operating model from a clinical quality and financial sustainability view point. However, the key economic driver is not the actual annual savings but the long term quality and sustainability of the service and the retention of current income, including the GP Direct Access revenue.

Executive Summary

Economic Case

The SOC highlighted 4 preferred options of which the Oversight Group ruled that due to the quality and financial benefits of the Hub and Spoke this is the main option that should be explored in the OBC with an ESL+ variant and compared against the baseline.

Current "As Is" Pathology Services

The facts concerning the existing Pathology services across the BCPS Trusts confirm its significance. The combined pathology services:

- Deliver approximately 25 million tests per annum;
- Have experience in consolidation through the consolidated Cytology service across all BCPS Trusts; and
- Employ approximately 679 staff (including consultants) of which 497 are Bands 2 to 8 employed in the laboratory.

The service currently faces a number of challenges to its sustainability in the form of annual volume increases, difficulty in recruiting for certain grades and requirement to achieve annual savings. For this purpose a new Target Operating Model (TOM) has been developed.

New Target Operating Model

The following table summarises the target operating model. Key features are:

- Creation of a clinically led joint service, owned by the four Trusts and for the support of the four Trusts and its users;
- Clinical staff to work on where required by clinical activity;
- Hub and Spoke model to achieve economies of scale;
- GP collections, TATs and service quality maintained or improved through potential additional collections (costs included);

	Service Description	Turn Around Times (TATs)
Integrated Hub	• The Hub will incorporate maximum automation and an optimum workforce profile; • Work performed here is sub-acute and/or specialist and/or screening. The default position would be that all work is performed here, unless there is specific reason for it not to be – i.e.. Turn Around Times (TAT), clinical proximity, etc; • The Hub will allow opportunity for commercial development and expansion, including research and development; • Main Hub facility to be located at Royal Wolverhampton Hospital (New Cross site); and • Work performed at the Hub will include Research and training of staff with specific facilities available for this purpose, including consultant offices.	• Routine work – >4 hours • Specialist work - >6 hours
Essential Services Laboratories (ESLs)	These laboratories will service the clinical needs of local acute sites. These will be based at current laboratories which will be reconfigured. They will provide: • Tests required for acute care with TATs which cannot be serviced by the Hub, but which can be delivered from an ESL lab, e.g. CSF, frozen sections, A&E support; and • Tests on samples which cannot be transported to the Hub.	• 20 mins – 4 hours
Point of Care/Near Patient Testing	In areas within Acute Hospitals which require faster TATs than are available from laboratories.	• 5 mins – 20 mins

Executive Summary

Economic Case (continued)

- Common IT LIMS with links to other key systems within the Trusts, including a digital pathology solution to facilitate MDT support and reporting;
- Implementation of common equipment platforms. TOM takes into consideration the new MES contract at Dudley assuming no savings are derived from it;
- Hub extension at New Cross Hospital: costed extension and design for hub extension that would allow for all BCPS specialties to be consolidated, including space for consultant offices; and
- Creation of one team of consultant pathologists, that would work where clinical activity demands it, under one single clinical governance framework and leadership, providing continued support for MDTs.

Area	Benefits Required	How the TOM will deliver it	BCPS Objective
Patient Benefits (inc. Clinical Quality and Research)	• Reduced waiting times for patients for all tests including cancer and specialist diagnosis; • Consistency and speed in the way in which results are reported, via IT which are seamless with customer's systems; and • Support for R&D at the forefront of pathology Speedy access to clinicians for support and diagnosis.	• Co-location of staff from all disciplines would allow for multidisciplinary teams that would ensure relevant expert can report on the results, avoiding transport costs, delays and reducing duplication. This would also allow for speedy access to relevant expertise; and • This pool of experts has the potential to attract R&D funding and would allow for greater training opportunities for staff.	Deliver improved quality and outcomes for users of the service and patients, including improved TATs Deliver Clinical and Research excellence.
Workforce and Skill Mix	• Standardised working practices across all sites; • Centralised workforce and management; • Changes in skill mix and economies of skill and scale; • Cross skilling of staff across disciplines; and • Reduce staff costs.	• A common workforce that has the same standard processes and a common management team would allow for greater integration and support across all sites; and • A single management team will reduce management costs and increase opportunity for reinvestment.	Ensure a more effective, integrated and efficient service.
Equipment, IT Logistics and consumables	• Investment in transport and logistics; • Greater efficiency in procurement and distribution processes leveraging economies of scale; and • Opportunity to share facilities across disciplines to reduce costs.	• Integration of equipment and platforms with common suppliers will increase purchasing power and deliver economies of scale benefits; and • New common IT system would allow faster reporting to primary care and other users, including digital pathology.	Ensure a more effective, integrated and efficient service which delivers greater value for money.
Flexibility and resilience	• A Hub will be flexible enough to accommodate increased volume of work; • A dedicated Hub will be able to accommodate advances in technology/equipment; • A model based on a Hub with supporting Essential Lab sites has more resilience; and • Cost reduction to allow financial benefits to be both shared with customers and retained for investment.	• Integration would increase resilience through the use of spare capacity across sites; and • A Hub Laboratory would provide flexibility to increase capacity and manage test demand fluctuations, adapting to future needs creating a more sustainable service overall.	Ensure long term sustainability of the service.

Executive Summary

Financial Case

The financial evaluation has been carried out by assessing the impact that each cost driver would have on the overall cost of pathology to the Trusts. Savings are shown at the end of this executive summary. The analysis has confirmed the initial estimates provided in the SOC. While there has been an increase in the calculated transition/investment costs as a result of a more accurate evaluation of refurbishment and build requirements, there has been an increase in the savings derived from staff and non-pay. It should be noted that the design of the ESLs has been carried out with a conservative approach and therefore the numbers provided are achievable and could derived in greater savings during implementation.

- Staffing costs: staffing numbers required and skill mix were calculated based on hourly evaluation of volumes at the Hub and ESLs (using activity volumes submitted by the Trusts).
- Equipment costs: Total savings for equipment are achieved through economies of scale. This has taken into consideration current contracts in place and therefore no savings are applied to the costs from DGFT.
- Logistics: additional logistics costs were added to the models as required to cope with the additional sample movements.
- IT costs: It costs have been included and priced to reflect the required capital investment in a new IT LIMS with links into hospital system, ordercomms and other required links
- Transition investment: various levels of capital and non capital transition costs were considered and added to the totals during the transition period.

Summary of savings

The implementation of a new TOM would, including the investment required in transition would exceed the requirements of the Trusts for the achievement of CIPs as well as exceed the savings that have been planned in the LTFM.

The implementation of the TOM would ensure the long term sustainability of the service and support the quality improvements required.

Executive Summary

Commercial Case

The commercial case provides details of the agreements reached on key commercial terms and which will form the basis of the partnership agreement (PA). Key commercial terms agreed are:

- It is proposed that the service is set up as an Arms Length Organisation (ALO) and hosted by one organisation with the Host being the Hub (RWH) or an alternative Trust if it can provide a more effective service.
- BCPS to be subject to the list of reserved matters agreed in the Appendix 2 and the standing orders of the host Trust.
- Partnership to be managed by the BCPS Strategic Board which will be formed by two representatives from each Trust (one clinical and one executive member) with all Trusts having equal voting rights.
- Appointment of an Executive Management Team for BCPS formed by a finance director, operations director and clinical director.
- Establishment of user clinical steering committee to provide oversight on clinical quality and contract management committee to provide oversight on SLAs.
- All partners to commit to a term of 10 years to allow the recovery of investment.
- Shareholding to be calculated based on activity volumes by Trust times a price. These shares would only be recalculated once volume at one Trust changes by ±8%.
- Funding to be accessed through the application submitted to the development fund (resolution in early July) or through the ITFF as per the head of ITFF guidance.
- Staff to TUPE transfer to the Host.
- Revenues: each Trust would retain current revenues from commissioners and external sources. Each Trust would be responsible for managing their relationship with its commissioners and clients. New clients joining the partnership would do so by contracting directly with the BCPS service through the host Trust.
- Sharing of benefits an liabilities: these would be done in accordance to the shareholding at the time.

Management Case

The management case provides an overview of the next steps for the establishment of the the partnership. It is recommended that work on the transition begins in August 2017 to achieve an implementation date of December 2018. Key phases for the transition are:

1 – Appointment of Executive Management Team and selection of BCPS Strategic Board members;

2 – Gateway 1 (FBC): set up to transition plan by October 2017 with detailed HR plan, detailed finance plan and construction plan (FBC);

3 – Gateway 1 (FBC): Completion of commercial agreement and finances, including clarification on route to access capital (FBC);

4 – Gateway 2: Design of Hub and ESL layouts for construction and refurbishment, including detail quotes from builders;

5 – Gateway 3: Operational processes design: design of detailed operating processes for the Hub and the ESLs;

6 – Gateway 4: Procurements: Development of procurement documentation and running of procurement processes, including detailed procurement costs;

7 – Implementation of IT and Equipment;

8 –Validation of equipment, IT and transfer of services across sites: this would also include early transfer of activity where possible to achieve quick wins;

9 – Project implementation review and steady state: review of project implementation and official start of steady state.

STRATEGIC CASE

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At a Glance

NHS Improvement National Programme	NHSI is currently undertaking a national review of pathology services with the aim of ensuring that consolidation takes place in England. The aim of the review is to create no more than 30 hubs across England as per the recommendations of the 2008 Lord Carter review. This means that working across STPs is a necessity as well as the consolidation of services in the Hub and Spoke models. It is likely that Trusts not moving forward with this strategic aim will be forced to collaborate to achieve savings.
NHSI and NHS Five Year Forward Review - 2015	This joint paper from the NHS national leadership states that **NHS providers should achieve savings** and be more proactive in the way they engage with other NHS organisations and the private sector. NHSI have issued a number of letters to Trusts and STPs with timelines and submission requirements for consolidation plans for Pathology and Back Office.
BCP Service sustainability	A key driver for the creation of the BCP collaboration was to explore options that would ensure the sustainability of the service from a financial, clinical and operational point of view. Some of these sustainability pressures are clearly manifested on the need to realise cash releasing savings but also the difficulty of recruiting and retaining qualified staff. Over time, as large laboratory collaborations develop in England the retention of qualified staff by smaller isolated laboratories is likely to become significantly harder as employees look for the challenges and variety that large laboratories with multiple disciplines can bring.
Lord Carter Coles Report	Supporting this, Lord Carter Coles has produced a report into the efficiency of NHS Trusts in England and Wales. This report recommends that **NHS Trusts look at the operational efficiencies that can be achieved through collaborations and new models of service delivery** such as consolidation and Lean thinking.
Financial and efficiency pressures	BCP is also suffering other pressures derived from the need to deliver more tests (changes in demographics and an increase in chronic conditions are increasing the number of tests delivered every year) with less financial resources as Trusts are required to reduce cost to balance their budgets. As a result of the current worsening financial position of the Trusts, **BCP will be required to achieve a higher level of savings year on year in the future.** This is no longer sustainable in the long term without collaboration or changes to the operating model.
Best use of spare capacity	Within the BCP partnership, RWH has invested in a new fully automated hub facility and Dudley and Walsall entered new equipment contracts with suppliers. This has created spare capacity with the group of Trusts that could be utilised to achieve efficiencies and savings.
Pressure from neighboring Trusts	Currently the risk of other Trusts developing a service that could pose a threat to the sustainability of the Trusts within BCP is low as all initiatives in the Birmingham area are still at an early stage of maturity. This poses an opportunity to the BCP Trusts to lead the way in the reconfiguration of services within the STP and develop an innovative and flexible service that can secure its future sustainability.
Opportunities	The creation of the BCP collaboration would allow for the sharing of resources in a way that can favour the development of the service. Key areas of development that would benefit all BCP partners, include the development and growth of the BCP reference chemistry service and the optimisation of services in a large Hub through the use of the latest automation technology. The service would also be able to better address the challenges emerging from the STP clinical reconfiguration of services, R&D and clinical sustainability.

Strategic Case

1.1 Strategic Context

1.1.1 National Context – Department of Health (DH) strategy

Since the publication of the second phase of the Carter review in 2008, "Report of the Second Phase of the Review of NHS Pathology Services in England", Trusts have increasingly looked at their option to achieve the proposed savings and quality improvement. However, limited progress has been reported across England on Trusts in achieving the creation of the proposed Hub and Spoke models for the consolidation of services

At the time the Carter review was published, the economic downturn was just starting. The publication of the review in 2008 has been followed by 8 years of austerity and public finance restrictions where the financial position of Foundation Trusts has deteriorated but also the financial position for non-foundation Trusts.

During this period of austerity, Trusts have been required to achieve annual savings to balance the budgets, and to start looking at the alternative models for service delivery.

This has translated into pressures for pathology departments to achieve year on year savings while coping with limited investment in facilities, equipment, IT and logistics and having to deliver more tests as a result of changes in test ordering and demographics.

The NHS Chief Executive Officer published in 2014 his "NHS five year forward view" for the NHS, where he seeks to address these population and demand changes through the proposal to change the way healthcare is delivered in the UK. This report encourages Trusts to look at the scale and scope of services they deliver and how these could be best delivered, including collaborations to deliver services and new organisational forms. The report has certainly inspired changes in the way "Integrated Care" is delivered but also the opportunity to think how other services can be provided.

Following this, a number of CCGs across England have started to engage further with their pathology services providers to understand what part pathology can play in the patient pathway and how it can support essential initiatives such as admission avoidance and providing greater levels of care in the community.

In December 2014, a report from Sir David Dalton (CEO, Salford NHSFT) to Jeremy Hunt entitled "Examining new options and opportunities for providers of NHS care: the Dalton Review", noted the importance of developing new organisational forms and service models to facilitate the transformation of services and improvements in Quality and Efficiency.

NHS Improvement initiative (NHSI)

The creation of NHS Improvement through the merger of Monitor and the TDA has given pathology consolidation a new focus.

The lack of progress achieved over the last 8 years and the need for Trusts to achieve efficiencies has prompted NHSI to create a new drive for consolidation. NHSI policy is currently looking into supporting Trusts across England in their consolidation efforts.

As per the recommendation from Lord Carter, it is expected that less than 30 Hubs and Spokes will be created in England: this will clearly require consolidation of services across STPs. The new drive to encourage Trusts to collaborate will look into supporting those initiatives that have currently developed plans and made progress so savings can be realised early. On the other hand, those Trusts that have no plans or are not willing to collaborate are likely to be pushed towards a recommendation on who to consolidate with in order to achieve savings for the health economy.

Overall, the current guidance from NHSI and the Department of Health points towards greater flexibility for NHS FTs and NHS non-FTs to create new alternative organisational forms and operating models that would allow the creation of sustainable services for the community and save costs. Trusts will be supported on their consolidation efforts while Trusts without plans are likely to be put under recommendation for consolidation with neighbouring initiatives.

Strategic Case

1.1.2 Summary of UK Initiatives

The following page provides a summary of all the UK initiatives and their status, classified as per their commercial model chosen.

Organisation	Partners	Size	Scope	Model	Organisational Form	Staff	IT and Equipment
Thin Joint Venture							
SPS Facilities and SPS Analytics LLPs	iPP Facilities; iPP Analytics, Taunton and Somerset NHS FT and Yeovil District Hospital NHS FT	£15m annual turnover 6.8m tests	Whole service	External hub with consolidated 99% Microbiology, 85% Blood Sciences and Cytology 2 Essential Services laboratories (ESLs)	LLPs with customer contracts with Trusts and supply agreement with iPP	TUPE to iPP	Latest automation (tracks, Kiestra and GE digital pathology) New integrated LIMS
Pathology First Analytics and Pathology First Facilities LLPs	Basildon and Thurrock Hospital; Southend Hospital and iPP	£25m per year and 13.2m tests	Whole service including phlebotomy	External Hub and 2 ESLs same as above	LLPs same as above	TUPE to iPP	Latest automation (tracks, Kiestra and GE digital pathology) New integrated LIMS
HSL LLP	TDL; UCLH and Royal Free Hospital (as a customer)	£120m per year 62m tests	Whole service	New on site Hub and ESLs	LLP	TUPE to TDL	Plan for single integrated LIMS and latest automated platforms
Thick Joint Venture							
Christie Pathology	Christie Pathology and iPP	£6m annual turnover 2.8m tests	Whole service	One laboratory at the Christie	LLPs with customer contracts with Trusts	TUPE to JV	No change to IT or automation
Viapath	Kings Hospital; Guys and St Thomas Hospital and Serco	£80m and 35m tests	Whole service	Currently undergoing a consolidation project for a Hub and Spoke	LLP same as above	TUPE to JV	Implementing integrated LIMS and consolidation with latest automation (Track at Kings)

Strategic Case

Organisation	Partners	Size	Scope	Model	Organisational Form	Staff	IT and Equipment
Trust Led Developments and Managed Networks							
Pathlinks	Boston Hospital, Grantham Hospital, Grimsby Hospital, Lincoln Hospital and Scunthorpe Hospital	£48m and 20m tests	Whole service	Laboratories deliver all the tests for certain specialties with specialties being distributed across all Trusts	No entity created	Remain with their Trusts	Under integrated iSoft system. No consolidated automation
Gateshead	Gateshead hospital	£12m investment in new pathology building on site (NHS grant and Roche)	Whole service	Centralised consolidated Hub and ESLs as required	No entity created, division within Gateshead hospital	Remain with their Trusts	Single LIMS and equipment platforms across all sites
TPP	6 Trusts East of England + PHE	£90m and 32m tests (£5m loss – because of lack of consolidation implementation)	Whole service	2 Hubs and 6 spokes although it has recently been announced that the partnership is reviewing its form in 2017	NHS Hosted organisation. From **5th of May 2017 it has split into two separate entities**	Plan to TUPE to Cambridge and PHE	Exploring implementation of single LIMS and equipment platforms
SWL	St Georges; Croydon and Kingston Hospitals	£50m and 18m tests	Whole service	Hub at St Georges and spokes	NHS Hosted	TUPE to St Georges;	Procuring single LIMS and equipment
NWL	4 NW London Trusts	£105m and 54m tests	Whole service	External Hub and spokes	To be NHS Hosted by imperial	TUPE transfer to imperial	Exploring procurement options

These initiatives show that there are a number of successful models across the UK. The MES + option where a Trust contracts additional services (such as refurbishment of facilities) with an equipment supplier has been successfully implemented across many Trusts in the UK. The facilities management option where a private developer builds and finances a laboratory block has not been tested in pathology (other than by the private sector) but has however been tried many times in NHS programmes such as the Local Improvement Finance Trusts (LIFT) projects for Primary care.

Strategic Case

1.2 Local need for change

The Black Country Pathology (BCP) service is formed by four Trusts looking to collaborate to optimise the use of resources. These Trusts are: The Dudley Group NHS Foundation Trust (DGFT), The Royal Wolverhampton NHS Trust (RWH), Sandwell and West Birmingham Hospitals NHS Trust (SWBH) and Walsall Healthcare NHS Trust (WHT).

- **Sustainability of services and CIPs:** A key reason for the creation of the BCP Service (BCPS) is to ensure the sustainability of the service. From a financial point of view the pressures that all Trusts in England are facing will translate in to the need for pathology services to achieve ongoing savings and CIPs. In addition, NHS Improvement as highlighted in the previous section, will be looking to push for collaboration to happen in England to release cash.

- The BCPS is also facing other operational pressures such as the increase in activity volumes year on year. This is a particularly acute problem in blood sciences with increases of 5-8% year on year. Including Histopathology where the increases in difficulties in recruiting clinical staff put the ability to report within agreed targets at risk.

- However, the consideration of future sustainable models by BCPS will also bring some positive solutions for some of the current local issues affecting sustainability:

- **Recruitment**: The creation of a strong service that is attractive to new high quality recruits would ensure the ability to have the right clinical leadership over the long term. The creation of a strong service would enhance the attractiveness of employment for new technical and clinical candidates.

- **Flexibility**: the drive to create Accountable Care Organisations (ACOs) as well as to move more hospital services into the community is beginning to have an impact on the redesign of pathways and the role that diagnostics play within the pathway. Pathology departments are beginning to get asked to have greater flexibility on their delivery models to allow for increases in the amount of Point of Care Testing (PoCT) offered as well as changes in nature of the interaction with clinicians. A joined team and workforce for BCP would allow it to increase its flexibility in dealing with requests arising from the Black Country Alliance and other initiatives within the area.

- **Service quality:** while all laboratories within the BCP service provide a high level of quality and care, the operational pressures that the services are phasing, coupled with pressures from the market, especially around recruitment challenges, there are some areas of the service that are seeing quality standards at risk. These areas are likely to be at risk in the future (e.g.: histopathology) unless a new TOM is implemented to address these risks.

Strategic Case

1.3 Strategic need for Change

The plans for the long term sustainability of the BCP service have to address not just the local needs of the Trusts but also the impending demands that national strategy and drivers are likely be imposing on the service.

Driven by national policy, financial pressures and local population pressures there are a number of impending needs for change:

- **NHSI:** NHS Improvement have indicated that there will be a number of directives issued to push Trusts towards collaboration and reform of operating models in Pathology. This means that by 2017 all Trusts would be required to consider the best options for their pathology service within the STP. **STPs** are being asked to collaborate and consolidate services across the STP footprint to achieve the required level of savings. Within the Black Country area, Trust boards have asked all pathology departments of the 4 member Trusts to start developing options and plans for a collaboration.
- **Technological requirements**: RWH have developed a new dedicated laboratory facility with potentially enough capacity to deliver the routine Blood Sciences and Microbiology for the current BCP partners with minimal capital investment required (detailed capacity analysis required as view formed during initial site visit by LTS). The facility also has the option to be extended to accommodate specialist work. The equipment (automated track) has spare capacity. DGFT has recently entered into a MES contract with Roche for the replacement of their technology creating some spare capacity for routine work.
- **Facilities:** RWH opened a new laboratory block with capacity to accommodate additional work and expand for additional services. SWBH are currently updating and upgrading their laboratory facilities. DGFT and WHT currently operate from PFI facilities, this could potentially impact some of the options regarding the analysis of stranded costs.

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- **Market openness and competition:** new competitors have entered the market and created efficient consolidated service models that allows them to push the boundaries on quality and cost to gain market share. These are both from the private sector (SPS, Pathology First, HSL, Synlab) and from the public sector (Gateshead Pathology, NHS Pathology – Frimley Park). These are explored in the strategic section of this report.
- **New ISO 15879 quality requirements** the move from CPA accreditation to the new ISO standards has meant that greater pressures are put in the service in order to maintain quality standards and accreditation. This requires additional staff time focused on quality as well as a high standard for the facility and equipment.
- **Increases in demand**: changes in demographics and long term conditions are increasing demand on services on an annual basis, which requires the laboratory to be optimised to be able to do more with the same or even less when financial pressures are taken into account. Across the BCP Trusts annual activity increases of 5-10% in volume for different disciplines.
- **Savings and sustainability** the deteriorating financial situation at the Trusts requires all departments to contribute towards the financial sustainability of the Trusts. For pathology this means that there is a requirement to control costs and meet budgets.
- **Clinical Sustainability:** Recruitment of clinical staff to provide a clinically led service is likely to become more challenging for those organisations that cannot offer the variety of work to develop specialism, and the ability to work for a forward looking, dynamic and flexible organisation.

Strategic Case

1.4 Opportunities, Threats & Barriers

Threats

The current NHSI initiative, the Model Hospital and the ongoing review of hospital efficiency being developed by Lord Carter will push hospitals to rethink the way pathology and other clinical support services are delivered. The financial positions of BCP Trusts will increase pressures to rethink how services are delivered to achieve efficiencies

In addition, private providers are likely to get stronger as hospitals and CCGs continue with the tendering of pathology services, which could in the future have the potential to threaten the sustainability of local pathology services.

Opportunities

The above threats would also create an opportunity for a pathology service that is already set up and operating with efficient costs and spare capacity. Certain Trusts are likely to look for partners to support pathology. In addition, a service that can provide access to Specialist Testing may see growth opportunities in this area.

Barriers to change

- **Differing Trust objectives:** trust objectives are focused away from pathology due to the financial, cancer pathway and A&E challenges (amongst others). As such pathology is not given sufficient consideration as a way to deliver change;

- **Protectionism**: A number of Trusts fear the domino effect of losing pathology through centralisation as a precursor to reducing their wider front line clinical services;

- **Staff reluctance to change**: There is often some reluctance among staff to change to a new model of delivery of pathology services, particularly where the potential delivery model is outsourcing;

- **Resources** required to develop new models: In many pathology laboratories there is insufficient staffing, with the difference made up largely by agency staff. This, coupled with ever increasing accreditation and regulatory requirements, means that there is often insufficient time in order to effectively scope and plan for changes in service;

- **IT platforms**: Different IT platforms, and the inability of these to communicate can cause significant impediments to consolidation. There must be common IT platforms across the consolidated sites;

- **Equipment platforms**: The same can be seen with equipment platforms – through the consolidation there should be in place a process to move to common equipment platforms;

- **Lack of engagement of clinical teams** and clinical users to determine an urgent test repertoire required at each site: There is a general resistance towards moving tests off site. In many occasions this can be used as a blocker which can partly be overcome through clinical engagement;

- **Agreement on a commercial** method to maintain Trust external income: If no agreement is reached between the parties then the consolidation will not take place – external income is a significant part of the pathology service delivery;

- **Lack of local leadership and skills:** a large pathology consolidation project will require a set of specialist skills, clinical skills and senior management engagement to develop the target operating model and agree the commercial terms between the parties.

Strategic Case

1.5 Clinical and Quality Benefits

BCPS is an opportunity for staff to be part of a world class service with the potential to innovate and expand the range of services, which in turn will benefit patients. Integration has already been successfully implemented by the BCPS partnership as shown in Appendix 6.

Clinical and quality benefits can be predicted based upon the experience of other networks and the experience within the Black Country of the centralised Gynae Cytology service. The centralised gynae cytology service formed in 2013. The initial concerns of staff quickly evaporated as they realised that by sharing expertise they could create something better than any of the individual sites could previously. The service that they created is nationally recognised and has maintained excellent turn-around times always being ranked within the top 5 labs in the country.

- **For patients**

A fully accredited (ISO 15189), faster, more reliable and more cost effective service, delivered by improved logistics (increased collections from GP surgeries), less requirement to send samples to other labs, and improved IT connectivity across the Black Country enabling seamless care as patients move between providers.

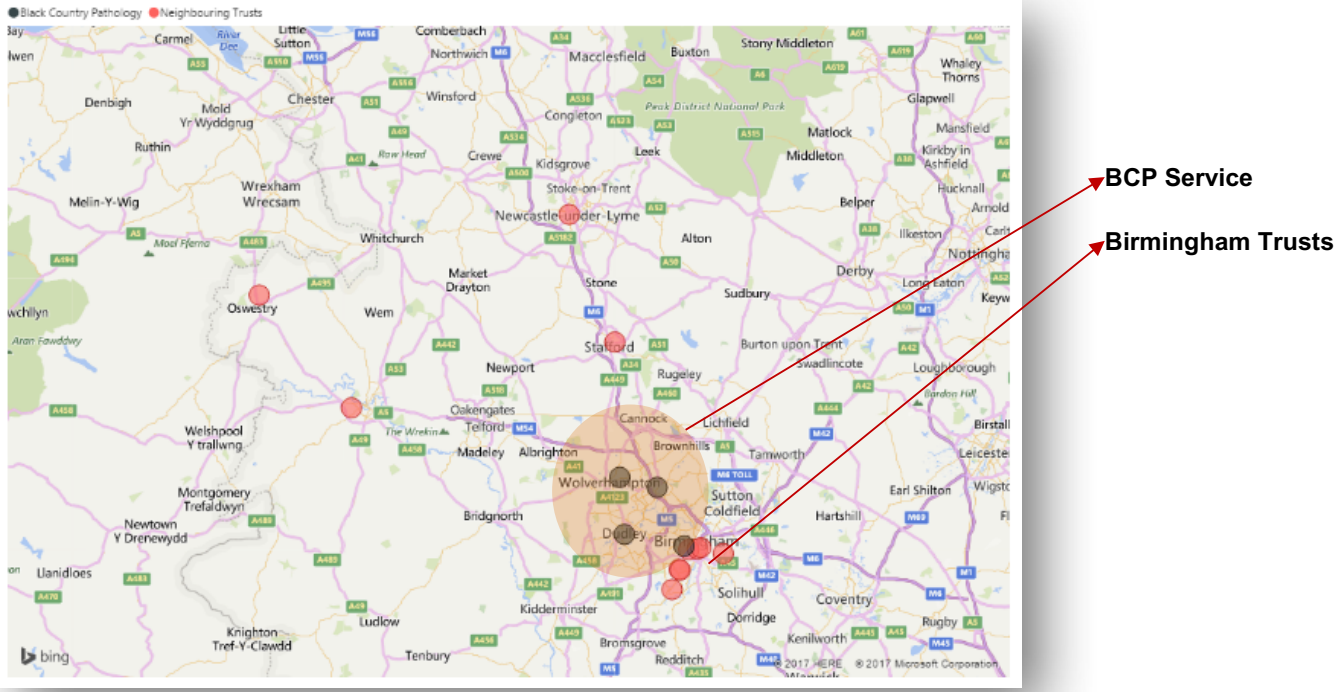
- **Staff**
  - Better utilisation of staff resources – there are currently national shortages of pathology Consultants and scientific staff,
  - Improved ability to recruit and retain staff
  - Succession planning and workforce development
    - More opportunities for development of staff
    - Improved training opportunities
  - Pooling of best practices from all sites resulting in an exemplar service
  - Staff working out of a purpose-built, state of the art building
  - Critical mass of staff enabling provision of 24/7 services for departments such as microbiology which currently cannot do this across four sites
  - Critical mass of Histopathologists enabling specialist reporting of all samples
- **Equipment**
  - Ability to always access the latest equipment and technology eg microbiology track and digital imaging for histopathology
  - Avoids duplication of equipment across sites
- **Test repertoire**
  - Larger repertoire of tests available to clinicians with resulting benefits for patients
  - Sustainability of service
  - Improved ability to recruit and retain staff
  - State of the art building
  - Latest equipment and technology
- **R&D**
  - Critical mass to enable BCPS to be at the forefront of research and development, providing better outcomes for patients.
  - Provide an opportunity to consolidate and expand other services that are of benefit to patients and users such as POCT and phlebotomy.
- **Improved user satisfaction**
  - GPs – improved number of collections per day, less chance of patients needing to be recalled for repeat tests due to samples exceeding the 4 hour delivery window,
  - Hospital users – The ESLs will be able to focus of hospital patients without the distraction of the GP work.

Strategic Case

1.6 Geography and competition

Currently BCP is surrounded by a number of Trusts and private organisations that have either created consolidated pathology models or are in the process of doing so. These organisations are looking to expand their collaborations and services. The map below shows how BCP is currently surrounded by the Birmingham Trusts to the South and a couple of isolated Trusts to the North and Northwest.

These organisations have already started to approach CCGs and other Trusts to form collaborations and gain additional activity, posing a threat (though not immediate) for the current BCP GP Direct Access revenue. The map below provides an overview of some of the hospital sites surrounding the BCP partnership



Strategic Case

1.7 Conclusions

The recommendation from National Policy, NHSI, Trust finances, initiatives in the market, changes in requirements from commissioners, changes in the way that pathology services need to be delivered and status of competitors and private providers have created a perfect storm of external threats for pathology services that are not able to adapt to the market and create a sustainable service. In addition, there are a number of internal drivers that are pushing BCP Trusts towards the need for change to address this. These are likely to have significant impact on KPIs in the future if not addressed. The pathology service is also likely to be asked to achieve increasing levels of savings in order to help the Trusts to return or maintain financially sustainable positions. The key change drivers are summarised below:

National Change Drivers

- Forward View and NHSI recommend that Trusts look at alternative ways of delivering services, increasing collaboration between Trusts and with private sector. There is growing pressure to collaborate within the local STP driven by NHS Improvement.
- Pathology services need to adapt to commissioner needs and become an integral part of the new care models such as ACOs, care closer to home, PoCT, IT connectivity and access to results, etc.
- Demand for services will continue to increase with more tests having to be delivered.
- NHS finances will continue to put pressure on pathology services to achieve large cost reductions. Doing more with less, in collaboration within STP footprints

BCP Drivers

- Service Long term Sustainability is key for each of the Trusts. All Trusts in the BCP service are currently under financial pressure which is likely to increase the demands on the pathology services to implement cash saving initiatives.
- The sustainability of the service will also be impacted by the ability to recruit the right clinical and technical staff. It has been proven around the country and in the BCP area that smaller isolated services are finding it increasingly difficult to recruit and retain staff.
- The creation of the BCP service would allow the Trusts to have access to a wider pool of resources, increasing resilience and the flexibility of the service.
- The creation of an NHS partnership may encourage other Trusts to join at a later date as well as the repatriation of send away tests and development of the service.

Market Drivers

- A number of private providers have now consolidated their positions in the UK market and will be looking for expansion of opportunities through the outsourcing of services at Trusts where pathology services cannot achieve financial sustainability.
- In the same way, a number of NHS organisations have been able to implement new operating models (Gateshead, Surrey Pathology Services), achieving savings and gaining market share through contracts with other Trusts, Mental Health Trusts, Community Services Trusts and CCGs.
- New engagement models are emerging (different types of JVs, private set ups and NHS developments) providing Trusts with the opportunity to be creative in the way that the required efficiencies can be achieved.

ECONOMIC CASE

2

At a Glance

Options evaluation and process	The BCP Steering Group during their meeting in March decided that a long list of options needed to be evaluated on a qualitative basis in order to assess the deliverability and sustainability of the service under those Target Operating Models (TOM). While this was a subjective evaluation it provided the Trusts with an opportunity to discuss the key strengths and weaknesses of each option and assess them against the proposed evaluation criteria. It was then agreed that the shortlisted options would become the subjects of further detailed financial analysis to assess their financial sustainability. It was decided that out of the 7 options in the long list, 4 would be selected for financial evaluation with the As Is used as a baseline to compare against.
Long List of Option	The Long list of options was formed by the following: 1 – Status Quo (As Is) – including required CIP savings; 2 - Joint Outsourcing – to a private sector organisation or another Trust; 3 – Distributed Network Model – creation of centres of excellence by discipline at different sites; 4 – New External Hub + five ESLs – building of a new external hub facility; 5 – One internal Hub and three ESLs – using a current Hub as a facility for all services; 6 – two Hubs and three ESLs – duplicating specialties across two Hubs based on capacity; and 7 – MES+ – Joint equipment contract for all sites by specialty.
Evaluation of the long list	The evaluation was carried out by the BCP Steering Group Trust representatives and the Chairman of the BCP group as an independent evaluator. The five evaluation scores per option were then combined into an average to provide the following results: 1 – Status Quo (As Is) – 2.70 – 7th 2 - Joint Outsourcing – 2.88 – 5th **3 – Distributed Network Model – 2.98 – 4th** 4 – New External Hub + five ESLs – 2.78 – 6th **5 – One internal Hub and three ESLs – 3.71 – 1st** **6 – two Hubs and three ESLs – 3.25 – 2nd** **7 – MES+ - 3.07 – 3rd**
Preferred Option	Following the initial evaluation of options in the Strategic Outline Case, the BCPS Strategic Board decided that the preferred option they would wish to explore in the OBC is option 5, **One Internal Hub and three ESLs**. This option would be compared against an enhanced “As Is” model that includes CIPs and a variant on option 5 where one of the ESLs hosts reference chemistry to reduce the capital investment required.

Economic Case

The economic case will provide a summary of the current services. This will be followed by a description of each option and a description of qualitative evaluation criteria to be used for the evaluation of these options to reduce the long list to a shortlist that will undergo detailed financial analysis.

A key consideration for the modelling of the different options is that any tests with a TAT of 4 hours or more can be consolidated at a centralized laboratory.

All staffing numbers in the following pages reflect total budgeted staff and not actual, which means that vacancies are not included in the numbers in the followng pages.

2.1 Description of the current service – Blood Sciences

The current services for the BCP Trusts are provided from 5 main sites. The table below provides an overview of the levels of activity for Blood Sciences and Immunology. Areas like specialist chemistry, haematology testing, coagulation, and blood transfusion have been grouped as part of the Blood Sciences. We have assumed that direct access blood sciences, which are non urgent tests that could be considered for consolidation at a centralised facility, can be centralised. In addition, we have assumed that from the remaining Inpatient and Outpatient tests, approximately 90% of the volume would also have a non-urgent TAT. It should also be noted that current immunology tests for Walsall are sent away and not delivered in house.

	Blood sciences	Chemistry	Coag.	Haematology	Immunology	Blood Transfusion
RWH	6,204,169	5,132,736	217,716	576,048	175,968	101,701
SWB	7,967,196	6,383,868	284,244	921,708	176,652	200,724
WH	3,979,500	3,778,962	88,406		33,508	78,624
DGH	5,340,748	4,452,000	161,184	443,532	196,200	87,832

Economic Case

The table below provides a summary of the staffing levels within blood sciences and the skill mix of the staff. It should be noted that the high levels of staff at SWBH, in contrast to the number of tests performed, is the result of the provision of specialist testing and services which the other Trusts do not provide. The high levels of efficiency at RWH are the result of the implementation of the new automated laboratory facility for routine activity.

Current State Blood Sciences				
Blood Sciences	WHT	RWH	DGFT	SWBH
Band 2	-	-	6.29	3.58
Band 3	9.28	16.34	10.00	11.78
Band 4	0.08	-	-	3.94
Band 5	1.63	13.00	8.00	11.49
Band 6	15.78	17.17	22.85	37.26
Band 7	6.89	10.00	8.32	15.94
Band 8a	4.14	3.00	4.33	4.80
Band 8b	-	1.00	1.00	2.38
Band 8c	-	-	-	1.00
Band 8d	-	-	1.20	-
Total	37.80	60.51	61.99	92.17

Current State Immunology				
Blood Sciences	WHT	RWH	DGFT	SWBH
Band 2	-	-	-	2.00
Band 3	1.00	2.34	1.00	1.73
Band 4	-	-	-	
Band 5	-	-	-	2.82
Band 6	1.00	2.00	2.49	3.05
Band 7	0.80	1.00	1.00	1.60
Band 8a	-	-	1.00	
Band 8b	-	-	-	0.80
Band 8c	-	-	-	
Band 8d	-	-	-	
Total	2.80	5.34	5.49	12.00

Economic Case

2.2 Description of the current service – Microbiology

Microbiology services are delivered across all four Trust members of BCP.

	Microbiology
RWH	307,068 *
SWB	433,356
WH	261,024
DGH	345,523

* Serology included within blood sciences

Current State Microbiology				
Blood Sciences	WHT	RWH	DH	SWBH
Band 2	-	5.84	6.97	14.37
Band 3	4.06	4.00	4.00	1.80
Band 4	1.23	5.00	-	1.00
Band 5	0.42	3.00	2.00	1.50
Band 6	6.62	8.67	9.00	11.83
Band 7	2.96	4.00	3.00	5.70
Band 8a	1.00	2.00	1.00	0.94
Band 8b	-	1.00	-	1.00
Band 8c	-	-	-	-
Band 8d	-	-	-	-
Total	16.29	33.51	25.97	38.14

Economic Case

2.3 Description of the current service – Cellular Path.

The cellular pathology service is currently delivered at all the Trusts. For the purpose of modelling, the figures below do not include staffing or activity for Mortuary.

	Cellular Path.
RWH	220,000
SWB	60,216
WH	84,777
DGH	84,000

Current State Cellular Pathology				
Blood Sciences	WHT	RWH	DH	SWBH
Band 2	3.41	2.00	3.10	-
Band 3	1.00	10.00	3.86	1.63
Band 4	1.76	8.62	-	2.75
Band 5	1.27	8.00	3.50	2.23
Band 6	3.02	11.30	5.78	3.74
Band 7	3.83	7.46	2.95	4.30
Band 8a	1.00	3.00	1.00	1.00
Band 8b	-	2.00	-	-
Band 8c	-	1.00	-	-
Band 8d	-	-	-	-
Total	15.29	53.38	20.19	15.65

Economic Case

2.4 Description of the current service – Equipment & IT

The following table shows the current IT Systems and equipment used across the BCP Trusts.

	WHT	RWH	DH	SWBH
IT System	**CliniSys**	**Technidata**	**CliniSys**	**CSC-iSoft**
Blood Sciences				
Central Specimen Reception			ThermoFisher	Anglia ICE/Cerner
Blood Transfusion	Biorad	Diamed	Biorad	IBG
Clinical Biochemistry / Chemical Pathology	ROCHE	Abbott and Sebia	Orthoclinical & TOSOH	Abbott, Waters, Shimadzu, Agilent, Thermo
Haematology	Beckman Coulter	Sysmex	Siemens	Sysmex, Wersen
Immunology	Euroimmune	Thermo Fisher, Werfen and Sebia	ThermoFisher	Phadia
Cellular Sciences / Anatomical Pathology				
Cytology		Hologic	Roche	Various
Histopathology	Thermo Fisher	Leica	Roche	Various
Microbiology				
Bacteriology		Biomerieux	Becton Dickenson	Biomerieux
Molecular Microbiology	Panther	Roche	Becton Dickenson/Biomerieux	Various
Serology	Cobas	Abbott & Biomerieux	Abbott Diagnostics	Abbott
Other / Not known (Microbiology)	UF100			

Economic Case

2.5 Description of the current service – Financial Baseline

2.5.1 Total laboratory costs

	RWH	SWB	WH	DGH	Total
Pay costs	8,666,970	9,305,181	5,141,895	6,375,000	29,489,046
Non-pay costs	6,204,490	9,302,643	6,144,876	8,108,026	29,760,035
Total cost of pathology	14,871,460	18,607,824	11,286,771	14,483,026	59,249,081

Current laboratory costs equal £59.2m. Alongside this, there are c.£33.5m of income for the laboratory. Therefore the Net As Is Cost for the pathology department, the true cost of providing the hospital pathology service, is c.£25.8m.

Total income for the laboratory represents 56% of the total cost base for the laboratory.

The cost information is for the financial year 2016/17.

Economic Case

2.6 Requirements for a joint BCP Service

The following are the key requirements that any option must be able to successfully address:

- A clinically led service;
- High quality pathology service that improves the provision of services to the Trust and meets its clinical pathology requirements;
- Fit in with the strategic vision and plans of the Trusts, the NHS and the Black Country STP;
- Financial sustainability;
- Ability to improve current facilities through investment and development;
- Minimise potential costs of PFI for those Trusts where pathology is in a PFI facility;
- Ability to develop areas of the service that could provide additional revenue for the Trusts;
- Additional equipment and upgrade to current analysers (note that The Dudley Group has recently signed an MES contract to renew all their equipment);
- Ability to retain staff and improve staff morale;
- Improve and facilitate recruitment of staff;
- Provide for GP Direct Access activity;
- Ensure retention of current research and other income;
- Opportunity to expand research and development activities;
- Ability to reconfigure processes and workforce to improve efficiency;
- Ability to maintain clinical contact and clinical relationships;
- Comply with NHS guidance on collaboration for pathology services and Strategic vision;
- Provide funding for development and access to capital; and
- Desirable: Ability to develop assays for the repatriation of tests to reduce costs.

Economic Case

2.7 Outline of the options

The options that have been considered are summarised below. Further information on these models is provided in this section:

- **Option 1: Status Quo** – This option involves the four Trusts to retain the current services as they are. The option includes minor reconfiguration in the form of high level collaboration on send-aways and other unsustainable areas, together with some investment on maintenance as required.

- **Option 2: Joint Outsourcing –** This option involves the full outsourcing of the service (pay and non-pay elements) to a third party provider organisation (Viapath, HSL, iPP or an NHS organisation). This model assumes that the independent sector would be responsible to invest in the creation of a Hub and reconfiguration of ESLs. This option assumes a full transfer of risk to another pathology operator (NHS or Private) and a contract management function within the Trusts.

- **Option 3: Network Collaboration model –** This model would require the Trusts to collaborate to deliver pathology provision in a service model where specialties and activities are shared across the Trusts. The specific form would depend on local agreement but be underpinned by the consolidation of areas of testing to realise efficiencies from the consolidation of volumes and skills. As a minimum, the Trust would retain an essential services laboratory (ESL) on site but could also maintain elements of additional specialist and/or discrete provision under certain circumstances. Multiple governance arrangements also exist with regard to this model with the potential ability for the Trusts to maintain direct influence over the quality and direction of future service delivery.

- **Option 4: New external Hub and 5 five Essential Services Laboratories (ESLs) –** This option involves the consolidation of all non-urgent testing within an external Hub laboratory and the creation of 4 ESLs as a minimum, within each hospital site that requires it.

- **Option 5: One Hub and 4 three ESLs –** This option is similar to the above but the Hub is located in one of the current hospital sites, therefore reducing the need for 1 ESL.

- **Option 6: Two Hubs and 3 three ESLs –** As above although this involves the creation of two distinct Hubs and therefore reducing the need for ESLs to only 3 as the Hubs would be collocated with ESLs on current hospital sites.

- **Option 7: MES+** –.This involves the collaboration between the 4 Trusts in a joint procurement for an MES+ contract that would allow for savings in equipment/reagents as well as some potential investment to invest in the current model. It does not include any consolidation of testing other than some low volume specialties.

These options are explored in further detail in the following section.

Economic Case

2.7.1 Option 1: Status quo (baseline)

This is the option of the Trusts continuing to provide the service on their own, from the current facilities, and the staff remaining in each of the Trust's employment with minor changes. Option 1 therefore provides an opportunity to develop a baseline for the comparison of other options. As such, the Trusts retain full control of the service, both in terms of management and in terms of patient care, and retain the full benefits of the profitability of the service. However, Trusts will be required to invest in the service in order to improve capacity (dealing with year on year demand increases), including investment in the estate for backlog maintenance. While this option involves minimal changes to the current provision, it is expected that initiatives such as business process reengineering and workforce and demand alignment would be implemented to assist each Trust with its own CIP targets for savings.

This option is the most common form of pathology provision in the UK, whereby Trusts continue to own and operate their pathology service. In light of the increasing financial pressure of the NHS and deteriorating financial positions of NHS Trusts, and the reports on the service, many Trusts are coming to the conclusion that continuing to operate a pathology service "on their own" is becoming increasingly unsustainable. In addition, in July 2016, the NHSI asked all Trusts in the UK to submit their plans for STP consolidation to achieve savings.

2.7.2 Option 2: Joint/single Outsourcing

This option involves the full outsourcing of the service (pay and non-pay elements) to a private sector provider organisation (Viapath, TDL, iPP, Synlab) or an NHS organisation. While this model has the potential to provide efficiencies similar to those of the Hub and ESL models (options below), the savings to be realised by the Trusts are likely to be lower as a result of the investment recovery margin and the profit margins that would be retained by the private sector. Given that there are currently no private sector providers in the region with an established Hub, this option is likely to require a significant level of capital investment in the creation of a Hub and the refurbishment of ESLs. This option would most likely lead to the centralisation of all non-urgent activity with only ESLs left on each hospital site. All specialist testing would also be consolidated at the Hub.

The key advantage of this model would be the full transfer of risk to the private sector and the access to capital. However, it is an option that is likely to face opposition from staff and consultants. This option would see the TUPE transfer of all laboratory staff while consultants would remain employed by their Trusts. The option would require the establishment of strong clinical and operational governance procedures as well as a contract management structure to monitor the delivery of services. A key risk arising from this option is scope creep and increases in cost as a result of test activity growth and price changes, areas that would need to be carefully set up in the payment mechanism of the contract.

The procurement could be run jointly by the four Trusts or as a single organization by each Trust. A joint procurement would have the advantage of economies of scale as well as the opportunity to create a Joint Venture (JV) with the private sector. A further implication that would need to be explored at a later stage is the VAT implications and the impact on the overall financials, and the impact of any competition commission assessment of the contract.

Economic Case

2.7.3 Option 3: Network Collaboration Model

Under a distributed network, each site would continue to operate an ESL (Essential Services Laboratory) in order to provide those tests that have an urgent turn-around time. For non-urgent tests, and for GP tests, these would be distributed across the sites based on discipline. Each site would specialise in certain disciplines, and would see the activity for that discipline co-located onto that site. The option assumes the creation of a joint operational management team and joint clinical governance group..

2.7.4 Option 4: New Hub and 5 ESLs

Under this model, each hospital site would operate an ESL for the purposes of undertaking the urgent TAT work. All non-urgent turnaround-time work, and all GP (Direct Access) work would then be transferred to a new laboratory off-site from the hospital locations.

While this option allows for potentially a high level of savings through the optimization of processes in the build of a new laboratory it requires a high level of investment based on the need to either build or refurbish a facility. The likely capital requirement is in the region of £8m to £16m based on current estimates for a refurbishment or a new build for a laboratory of the size required.

There would be an additional requirement for capital for the refurbishment of the ESLs, estimated at approximately £250k per ESL. Other additional costs are likely to involve the integration of IT, implementation of common equipment platforms and additional logistics costs.

2.7.5 Option 5: 1 Hub and 4 ESLs

This model is similar to the above, however, it assumes that the Hub can be collocated with one of the ESLs within a current hospital site. This would bring the advantage of sharing resources across the ESL and the Hub and therefore maximizing workforce efficiency. Pending further analysis, this option would be deliverable with the Hub located at Wolverhampton Hospital with the need to extend it at a cost of £2 m to £4 m to accommodate reference chemistry depending on the specification of the building. It is estimated that while the laboratories at Dudley and Walsall Trusts may have some spare capacity this would only be enough to accommodate a relatively small number of tests. Sandwell and West Birmingham Trust confirmed no capacity is currently available to host the full Hub.

2.7.5 Option 6: 2 Hubs and 3 ESLs

This model assumes that the activity in the Hub would split into two smaller hubs. The idea being that it is likely to require less reconfiguration in terms of the infrastructure to create the capacity for 2 Hubs. Similar costs and capital investment issues would arise for the reconfiguration of infrastructure and increase in capacity as required to accommodate the two hubs, including the implications of reconfiguring PFI buildings. While the reduction on the number of ESLs may deliver some savings these have the potential to be offset by less efficient hubs and duplication of functions like pre-analytics.

There are two variants within this model:

3.6.1 – Mirror Hubs: both hubs perform the same type of tests and activity

3.6.2 – One Hub specialises in non-urgent testing while the other hub performs all specialist testing

Economic Case

2.7.7 Option 7: MES +

This option assumes that there is no/minor reconfiguration of actual pathology activity but an active collaboration on the procurement of same equipment platforms across all Trusts through an MES. The joint procurement would provide economies of scale savings on the MES pricing and a saving of 20% on VAT. These savings could also be applied to any of the other options where a joint procurement is put into effect.

Economic Case

2.8 Trust SWOT Analysis

All Trusts were requested to submit a SWOT analysis on behalf of their Trusts for each of the options. This SWOT analysis formed part of the BCP Steering Group discussion prior to the submission of evaluation scores. The aim was to create a common view that represented the opinion of Trusts in relation to each of the options. The summary SWOT analysis is shown in the following tables.

	Strengths	Weaknesses	Opportunities	Threats
Status Quo	• Easy to achieve • No investment required • Acceptable to staff • Least disruptive	• Little potential for saving • Does not address sustainability • Lack of sufficient size to undertake major projects • Multiple platforms for work that could be centralised and done more efficiently • Politically inept. Does not align with national strategy. Unable to meet CIP. Fails to meet NHSI plan	• Joint working gives opportunity for areas of common interest to be addressed. Sharing of best practice	• Vulnerable to privatisation • Politically not seen as doing anything • Little potential for savings based on large facility model
Joint Outsourcing	• Access to capital if required • New facility not required • Greater focus on financial savings • KPIs very strong as contract in place with provider • Transfer of operational risk to provider • Externalising the change decreases the opportunity for in-house resistance • Fall back option if DIY fails	• Perceived poor track record (Toxicology in London) • Poor track record on research • Training cuts • Local innovation may be lost • Staff resistance could be very strong • Stakeholders may have very negative views • Overcoming existing long term contracts in some Trusts very difficult unless taken on by the outsourcing organisation - may actually mean little interest is shown • Trusts do not achieve full benefit of financial savings	• One brand new organisation comes in and implements change • Opportunity to improve current areas of poor performance • Commercial benefits of private organisation • Improved marketing • Robust KPIs with users established	• Risk of staff leaving for other Trusts • Consultant staff not being part of the outsourcing is a very significant risk. This would completely change the nature of the Trust's clinically driven services • Control by Trusts only as good as specification. Could cause problems with future proofing • Cost containment in meeting contracts could mean lower service • Stakeholders with much higher expectations and increased sensitivity to our services • No plan B if private sector gives notice of termination. There is a track record of private sector providers doing this (Hinchingbrooke Hospital)

Economic Case

	Strengths	Weaknesses	Opportunities	Threats
Network Model	• Acceptable to Trusts and stakeholders • Retains high level of control • Perceived that all Trusts 'win' something • Little capital investment. Gradual move to uniform ways of operating. Increased ability to discuss areas of improvement, for example when there are skill shortages	• Poor efficiency and financials: both may be worse than the status quo • Requires considerable IT investment • Increased logistics risk • Significant clinical risk with moving samples • Poorer communication between sites/disciplines • More difficult to have shared Quality Management System (governance, assurance) • Overall big things such as single governance and quality systems across the four Trusts may not be worth the return	• PFI's are utilised • Plays to different Pathology strengths across the Black Country • Some standardisation of working practices, SLAs, KPIs etc.	• Chaos. Significant risk to patient safety • Movement of staff potentially very destabilising • Potential loss of contracts due to stakeholder dissatisfaction • May cost more • IT heavy solution required probably not justified by business plan finances • Not seen to offer the NHSI/STP solution being looked for
New Hub and 5 ESLs	• New optimised and purpose-built facility – should be efficient and effective once samples arrive • Could be centrally located and collectively owned. No one Trust 'winner'	• Requires a high level of capital (£15-20M) • This capital is not available • Expensive running costs • Not aligned with NHSI guidance on use of current capacity and facilities • Divorced from clinical services • Requires an additional ESL • Increased equipment requirement • Cost of current facilities needs to be written off • Lack of contingency within the group • Significant time required to build new facility, unlikely to be achieved by end of 2018	• Could be a financially efficient model. • Optimally planned and designed • IT and equipment platforms refurbished • Easy to introduce new technology • Opportunity to design for future expansion • Combined expertise for all disciplines • Provision of 24/7 services for Microbiology and extended working day/week for Cellular Pathology • Good opportunities for R&D (and associated income for Trusts) • Opportunities for training and staff development • Repatriation of tests due to consolidation of work	• Prime target for privatisation. Business continuity • Capital may not be forthcoming • Staff may not want to work in what is perceived as a 'factory'

Economic Case

	Strengths	Weaknesses	Opportunities	Threats
1 Hub and 4 ESLs	• Most optimal and efficient model • Maximises financial savings • Capacity already available. Low capital investment • Opportunity to consolidate all routine blood sciences and microbiology at no capital cost • Stronger governance • Standardises services across the Black Country • Successful models elsewhere (St Georges London, Imperial London, Frimley Park) • Consultant recruitment easier to a single cancer centre for Cellular Pathology. Aligns with proposed cancer network reporting. Better recruitment, training and retention of staff based on experience of other single hub networks • In line with Carter report	• Requires some investment to move all services (histology and reference chemistry) • IT solutions required • Lack of contingency within the group • No mirror lab in the event of downtime • High level transport required for sample movement across an area of 150 sq. miles • Geographical issues of Birmingham centre to Wolverhampton • Perceived by 3 Trusts as negative impact on staff (however cytology services merged successfully)	• Centralise all 'cold' work. Efficient use of resources • Easy to introduce new technology • Combined expertise for all disciplines • Provision of 24/7 services for Microbiology and extended working day/week for Cellular Pathology • Good opportunities for R&D (and associated income for Trusts) • Opportunities for training and staff development • Repatriation of tests due to consolidation of work	• Business continuity • Not enough staff to run it in the single locality
2 Hubs and 3 ESLs	• Increased resilience of services • Easier to deliver than 1 hub model and more acceptable to staff and stakeholders • Staff more likely to be retained • Two Trusts are not fighting • Allows 'mirroring' of all services for risk and capacity issues • Less transport issues • Major changes can help to achieve NHSi/STP goals locally	• May not be as efficient and effective • IT solution may be increased over 1-hub model • Duplication of equipment and services • Compared with 1 Hub and 4 ESLs: Higher level of capital investment, more difficult to agree on clinical governance and quality management system (easy to split into 2 separate organisations) • This model was used in Cambridge and failed	• Some opportunities for combined expertise for all disciplines • Some ability to extend working day and week • Some opportunities for R&D (and associated income for Trusts) • Opportunities for training and staff development and ability to attract skilled staff from both ends of conurbation • Potential for some repatriation of tests due to consolidation of work • Ability to standardise across the Black Country	• Easy to become 2 separate organisations • For long term sustainability, ultimately may need to move to 1 hub • Two Trusts fighting and negative to process • More management structure needed than single hub models • May not realise savings
MES+	• Some savings over doing nothing • Standardisation of equipment • No structural changes and little local politics from staff or stakeholders	• Less cost savings • NHSI/STP goals may not be achieved • Does not address sustainability • Two trusts have already done this with long term contracts in place. So much of the savings from this approach are already achieved	• Standardised reference ranges • Business continuity resilience • Two trusts may achieve savings	• Vulnerable to privatisation • May not be seen as compliant with NHSI/STP either locally or nationally

Economic Case

2.9 Options evaluation methodology and criteria

The evaluation of options has been carried out by the members of the BCP Steering Group in representation of their Trusts. In addition, the chairman of the BCP Steering Group produced a separate and independent evaluation of options t bring an additionally element of neutrality to the process. The evaluation process has followed a two stage approach with an initial long list of options evaluated on the basis of a qualitative desktop analysis to produce a shortlist of options. The 4 options with the highest scores will proceed to the financial evaluation developed in the financial case of this SOC.

The evaluation criteria below has been developed on the basis of the pathology service requirements to assess the potential benefits of each options and how they contribute towards meeting the Trusts objectives and needs. Each option will be scored against each of the criteria by assigning a value of 1 to 5, where 1 means that the option does not meet the evaluation criteria and 5 means that the options fully meets the evaluation criteria

	Criteria	Description	Sub-Weighting	Weighting
Patients and Clinical Quality				
1	Clinical sustainability and Quality	The option provides the right level of clinical oversight to create a consultant led service with a common clinical governance structure across all sites that is sustainable and improves quality	40%	60%
2	Patient Safety and experience	The option minimises any potential risk to patient safety, e.g. The need to have some services within a certain proximity to the patient, any necessary linked between staff, consultants (MDTs) and the patient are preserved.	30%	
3	Achievability	The service addresses the emerging needs of the pathology market and would face the lowest level of resistance by stakeholders. Evidence that other organisations have successfully implemented the model without affecting quality	15%	
4	Standardisation	The model facilitates the introduction of common procedures, common ranges, KPIs and clinical reporting across sites	15%	

Economic Case

	Criteria	Description	Sub-Weighting	Weighting
General, Financial and Governance Requirement				
5	Strategic Fit, innovation and clinical sustainability	The option would provide the greatest chance for BCP to become a sustainable organisation supporting it on the retention of current revenues and supporting the development of the service to meet the future needs of the market and service.	15%	40%
6	Potential affordability	The option would provide the best opportunity to access funding and is likely to provide a high return on investment. Capital requirements are low and therefore achievable.	25%	
7	Potential VfM	The option would provide the greatest level of savings over the long term through economies of scale	30%	
8	Facilities, IT and Eqmt Systems	The options allows the introduction of a common IT LIMS that would link all sites and common equipment platforms across all sites. Availability of estates for development of pathology	15%	
9	Control and Governance	The option would allow BCP to operate with an autonomous governance structure allowing to operate in the market and effectively respond to market forces	15%	

Economic Case

2.10 Options' evaluation results

The following table provides a summary of the evaluation scores as awarded by each Trust to provide a ranking of the options. As can be seen from the data, the preferred options for further analysis are options 5 (Hub on a current site with 4 ESLs), 6 (two hubs on current sites with 3 ESLs), 7 (MES+ contract) and 3 (network collaboration model).

Out of the 4 options shortlisted for financial analysis the single hub option with 4 ESLs is the preferred overall. It should be noted that it would be expected that the saving derived from Option 7 (MES+) would also be achieved under any of the other options by increasing the purchasing power of the BCP Trusts through a joint procurement. At this point in time, Option 2 (joint outsourcing) and option 4 (construction of a new Hub on a greenfield site) have been rejected.

The following page provides a summary of the commentary provided by each Trust with regards of each of the options.

	Weighted Score						
	1	2	3	4	5	6	7
	Status Quo	Joint Outsourcing	Network Model	New Hub 5 ESLs	Single Hub and 4 ESLs	2 Hubs and 3 ESLs	MES+
The Dudley Group NHS Foundation Trust	3.48	2.27	4.52	1.66	2.66	2.54	4.01
The Royal Wolverhampton NHS Trust	1.92	3.44	2.7	3.79	4.82	3.9	2.37
Sandwell and West Birmingham Hospitals NHS Trust	2.6	3.53	1.87	2.62	2.53	2.93	2.75
Walsall Healthcare NHS Trust	3.39	3.17	4.11	3.53	3.96	3.09	4.01
BCP Chair	2.09	1.99	1.71	2.28	4.6	3.81	2.2
Average	2.696	2.88	2.982	2.776	3.714	3.254	3.068
Rank	7	5	4	6	1	2	3

Economic Case

		Comments
1	Status Quo	• This does not deliver the change agenda • This offers a low risk model with some greater degree of coming together. Overall it is low risk with regard to clinical issues as currently they are felt to be reasonably covered. Of course it does not address future pressures in any way - for example one or more Trusts not attracting key staff e.g. Consultant Histopathologists or specialist Clinical Scientists
2	Joint Outsourcing	• Effectively privatising with risks and uncertainty around delivering service • There is no private sector presence in the Midlands and therefore they would need to build or refurbish a building for a central laboratory function. This would not be within the decision timeline • The key potentially positive aspect of this approach is externally driven change. A big risk is that Consultants are not taken into the new organisation, due to the very real issues of negotiating with the BMA etc. This scenario would totally change the nature of the SWBH service
3	Network Model	• The logistic risks are common to most of the options. The least logistic risk is in the status quo and the network • Poorest consolidation model • Overall this will need capital investment at local sites and also substantial IT infrastructure. Sample splitting to various sites could potentially be very inefficient and disruptive
4	New Hub and 5 ESLs	• There is no clarity on where or how the hubs will work and why 5 or 4 ESL's are needed as there are only 4 acute IP sites in total • Too costly and doesn't meet the timelines • The biggest model like this was the Leeds 'factory style' centralised pathology set-up in the 1990s which failed. We do not have the capital for this approach
5	1 Hub and 4 ESLs	• Query around capacity detailed in proposal document, where the hub will be and how it will work • Consolidation model which is closest to the national expectation and maximises savings • This model offers relatively low capital investment. Key issues are the practicalities of one hub for our geographical area
6	2 Hubs and 3 ESLs	• Query around capacity detailed in proposal document, where the hub will be and how it will work • Scored assuming a mirrored hub model. There may be some modifications to this model in that it is not necessary that the two hubs are an equal size • This offers a lower risk model
7	MES+	• Stepping stone to the other models • The MES approach suggests some working together has been achieved but in reality is it enough to keep the BCP idea afloat in the longer term?

Economic Case

2.11 Evaluation outcomes and preferred option

The evaluation from the Trust members of the BCP Steering Group and the chairman of the BCP indicated that the following models should be considered for financial evaluation. These options were assessed in the financial case in the SOC, with the result in the table below:

- As Is + model to be used as baseline;
- 1 – One Hub and three ESLs;
- 2 – Distributed Network collaboration;
- 3 – Two Hubs and three ESLs; and
- 4 – MES+.

In May 2017, the BCPS Strategic Board agreed that the **preferred option**, as per the evaluation carried out and described above would be the **One Hub and three ESL option**. This option is to be developed into an OBC that would allow the the BCPS Strategic Board in July to produce a recommendation for their respective Trust boards. The BCPS Strategic Board concluded that the one Hub and three ESL option would provide:

- Greatest level of standardization and quality for the service;
- Highest level of savings and economies of scale;
- Best opportunity to develop an integrated clinically led service with consultant resources supporting all the Trusts;
- Consolidated option provides the best opportunity to increase quality of the service for the long term;
- Creation of an integrated pathology service for the benefit of all Trusts.

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Economic Case

2.12 Description of preferred Target Operating Model

As per the evaluation in the previous sections, the preferred target operating model is the **single hub with three ESLs**. This model is described in the next few pages of this document. There is a scenario on this model being assessed where reference chemistry services remain at SWBH to minimise the capital requirements on the project, through the avoidance of building an extension to the RWH Hub. However, this variant would still incur capital as the services currently at City Hospital would have to be moved to a refurbished part of Sandwell Hospital.

The target operating model assumes that all tests from all disciplines that have a TAT of greater than 4 hours can be moved to the central hub facility. As such, the facility would need to extended to accommodate services and certain areas refurbished to expand their capacity. Each site would then have an Essential Services Laboratory (ESL), of which a standard description is provided. Staffing numbers have been calculated using the hourly throughput through each of the laboratories. Because of the inefficient nature of ESLs, where the focus is on rapid delivery of results, there is additional capacity at each ESL to deliver additional tests without increasing the staffing numbers. This allows for detailed scoping and adaptation of ESL requirements during the implementation phase.

Key assumptions for the implementation of the TOM are:

- **Common IT system**: implementation of a common Laboratory Information System (LIMS) to ensure the connectivity of all laboratories. This requirement has been developed with IT suppliers to understand the cost. The costs, including investment, are part of the financial evaluation. These costs provided by suppliers are the highest expected cost and likely to reduce during scoping and procurement. It system and costs include:
    - Implementation of a common LIMS at all sites;
    - Digital histopathology solution to facilitate MDTs and shared reporting;
    - Provision of bi-directional links and links with Trust systems;
    - Hub with circa 150 concurrent users and the 3 ESL with BHI and BT only and with 20 concurrent users in each ESL; and
    - Hardware required and upgrades for sites and the Hub.

As explained in the financial section all of these costs are included in the financial model as an investment or recurring annual fee. The implementation of a common IT is key for the success of the project as demonstrated by the successes of SW London pathology, SPS, Pathology First, etc and the failures of TPP and empath.

- **Common equipment platforms:** for the success of the partnership is essential the implementation of common equipment platforms. The cost of equipment has been assumed using the lowest common denominator cost per discipline to normalise equipment costs to the most efficient contract in the partnership. RWH and DGFT have recently entered into new equipment contracts and therefore the impact of savings on those Trusts has not been taken into account. It is not expected that the DGFT contract would be terminated although the cold volumes going through the analyzers maybe reduced. There are no savings expected from this contract in the financial model;

Economic Case

- **Quality**: The future service will have as a standard a requirement to be fully accredited under ISO 15189. All sites currently have their own established TAT requirements and service levels for GPs. The key assumption made on the target operating model is that the quality service levels currently provided to each user will be maintained. During the transition period these will be reviewed and target service levels set for all disciplines and users to ensure that the quality of the service is improved;
- **Sustainability and Resilience** is to be maintained at the ESLs to process and result tests 24 hours a day, seven days a week. The primary function of the ESL is to cover the BT service and urgent AE samples, as well as include frozen sections for histology and screening blood cultures for bacteriology;
- **Research and Development:** support and provision of support for R&D at the Hub based, including potential to allocate office space if required;
- **Training:** staff to be trained as multidisciplinary teams with access to a wider variety of tests and disciplines;
- **Consultant Staff:** consultants to transfer to the BCP service to work under a single clinical governance structure with office space provided at the Hub. Some consultants to work from current sites and continue to support colleagues and MDTs;
- **MDTs**: provision of MDT support at each site as required with allowance for consultant travel time built into the financial model. Introduction of digital histopathology to support MDTs;
- **Technical Staff**: laboratory staff to TUPE transfer to the BCP service;
- **Hub extension**: extension to the Hub to be built to accommodate all services, including Cellular Pathology and office space for reporting;
- **Logistics:** logistics routes to maintain current services with additional routes added to move samples to the Hub from sites and for additional GP collections where required. Additional cost of £400k per annum added to the model;
- **Point of Care Testing**: while this function is currently excluded from the business case, including this at a later stage would provide an opportunity for savings and the creation of a PoCT management team that can monitor quality and accreditation; and
- **Contingency fund**: contingency fund has been added to the model to allow for unforeseen costs.

Other financial assumptions are included in the financial case and would account for capital investment, transition team support , etc. the following pages provide a description of the TOM from a test perspective.

A detailed description of the ESL can be seen in Appendix 3

It should be note that though the TOM does not represent a radical solution (in terms of the market), it does represent an ambitious option for the Trust. The single hub solution is not new to the market, though it represents significant consolidation for the Trusts, and a radical departure from the existing model of provision for the Trusts.

Economic Case

- **Quality Baseline:**

General assumption made is that the new model will guarantee a “no worse than now” service provision and TATs. The service will continue to comply with guidance and standards set by the Royal College of Pathologists (RCPath), NEQAS, EQA schemes, ISO 15189 accreditation, NHSBT, HTA, Cancer reporting times and other relevant bodies.

The Clinical Reference Group, once established, would be responsible for overseeing this function and determining what the right levels of service should be for each clinical user. Currently all Trusts operate under slightly different quality standards which the clinical steering group will seek to standardised use the best in class amongst the Trusts as the initial standard to evaluate appropriateness for clinical care.

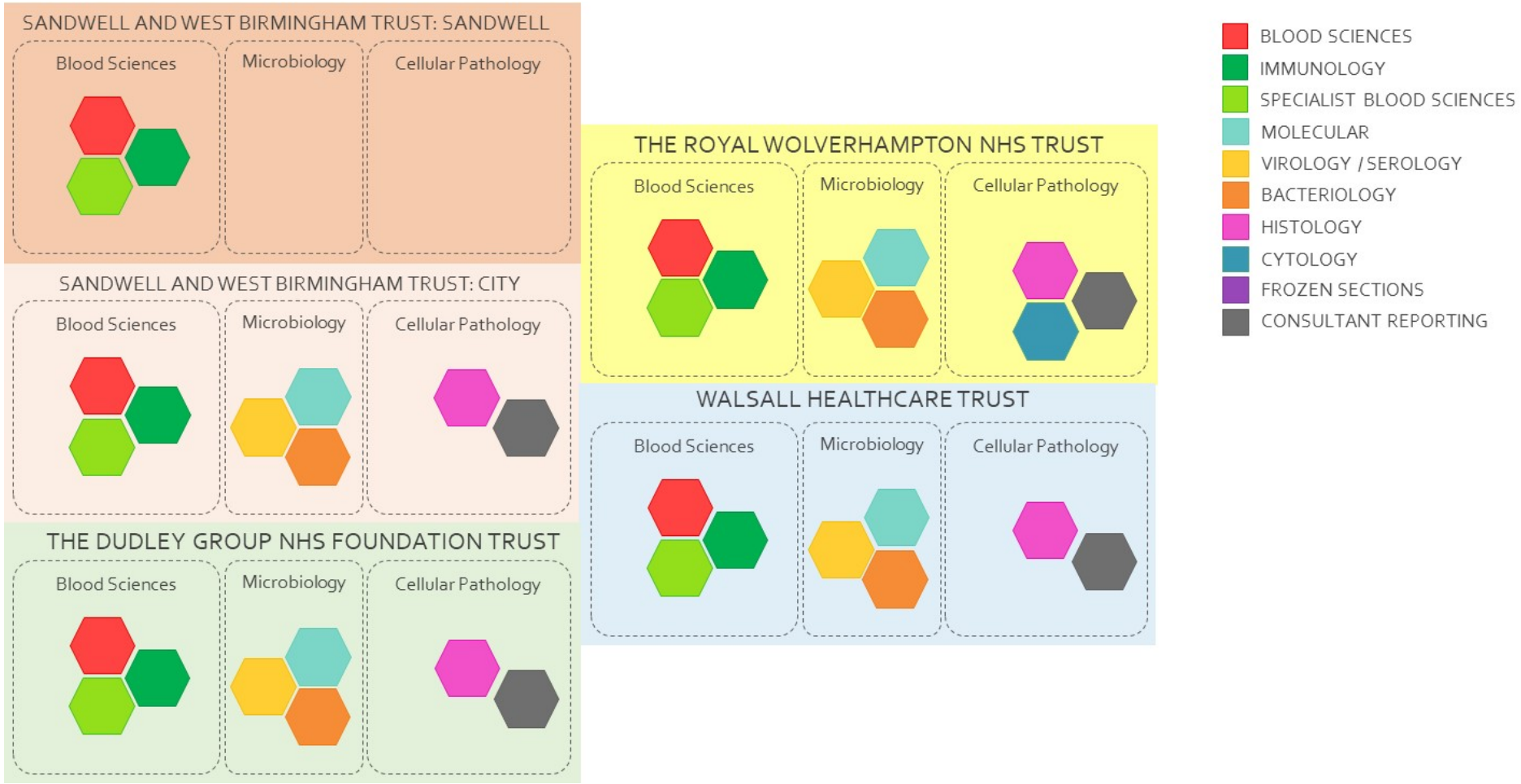
Currently all Trusts measure a range of KPIs for normal TAT reporting, complex cases and different users of the service. These KPIs are measured on a monthly basis and included within the pathology performance reporting governance. Additional quality standards such as protocols for reflex testing, further investigations, reporting of complex cases, out of hours reporting, etc, are registered within the laboratory quality manuals and handbooks and form part of the accreditation process. Examples of these KPIs are:

KPI	Trust 1	Trust 2	Trust 3
Biochemestry urgent (troponin)	RCPath 60min	60 min	60 min
Biochemistry routine (GPs)	24 hours	24 hours	24 hours
FBC urgent	RCPath 60 min	90 mins	90 mins
FBC routine	90 min	120 mins	120 mins
Histology non biopsy	RCPath 10 days	10 days	7 days
Breast biopsy	5 days	5 days	<7 days
Immunology TTG	10 days	3 days	
Anti-GBM antibodies	5 days	5 days	
MRSA screening	48 hours	48 hours	
C diff	24 hours	24 hours	
Microbiology Urines	72 hours	48 hours	
Staff mandatory training	95%		95%
Sickness absence	<5%		<3.39%
A&E TAT	90%	95%	95%
6 week wait target	0	0	0

An example of current TATs achieved and the promise that these will be maintained, improved or adjusted for best clinical outcomes and service, is available in appendix 7. It is the expectation that once the IT systems are in place, the BCPS operations and clinical directors would be able to produce a consolidated report with the quality performance of the service on a monthly basis. The following table provides an example of TATs for different users:

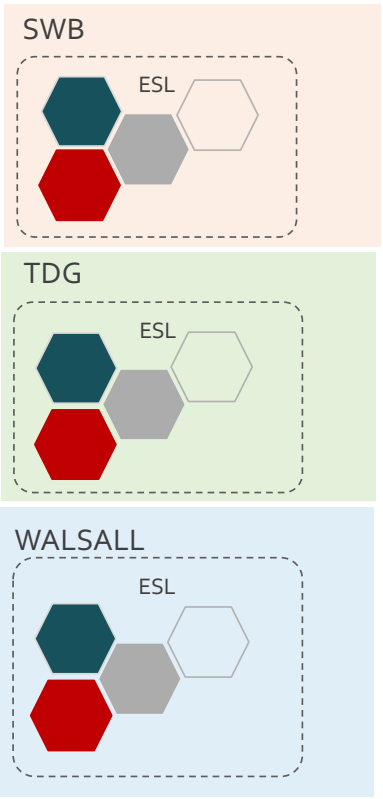
Economic Case

Current Operating Model

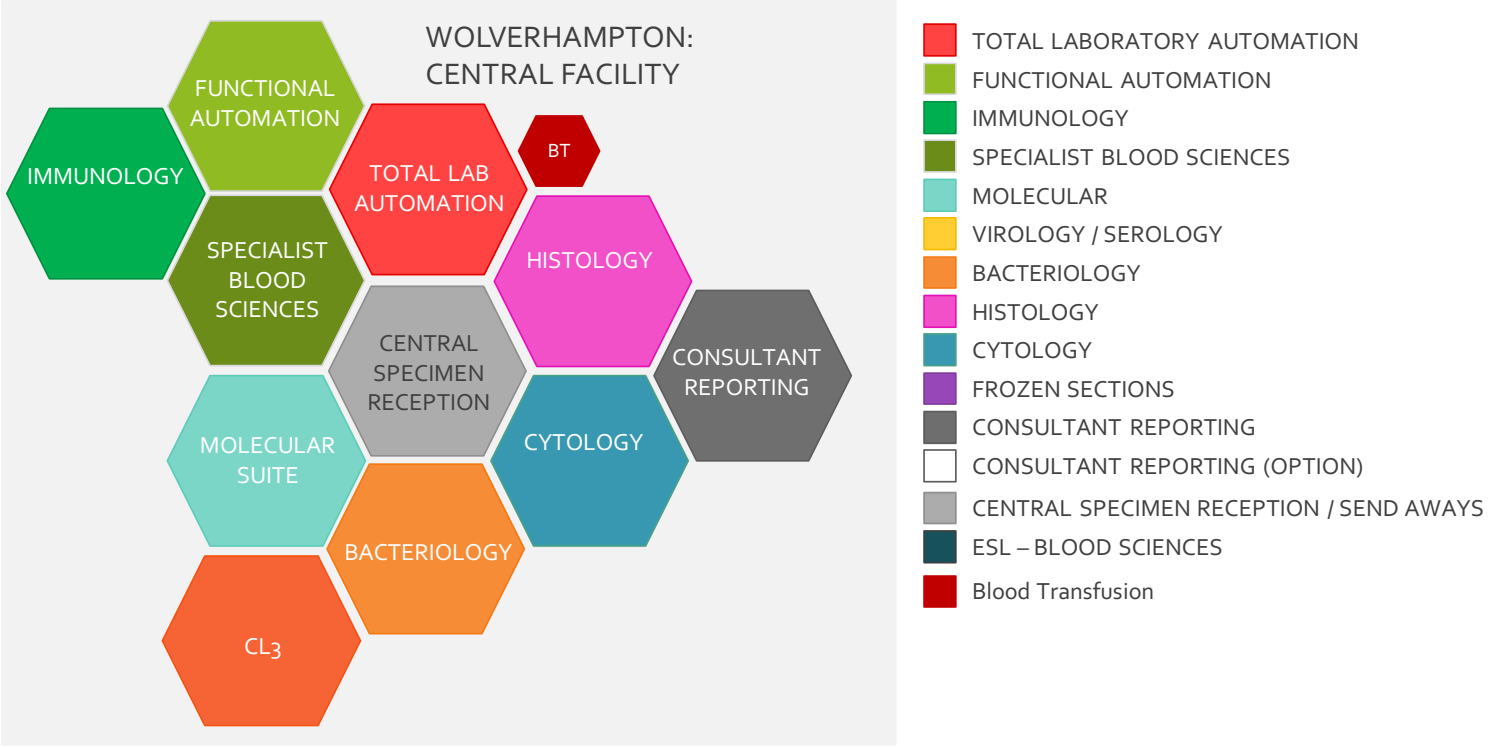


Economic Case

Single Hub and three ESLs Operating Model



Senior staff including at ESL to provide Frozen section, CSF and other urgent services

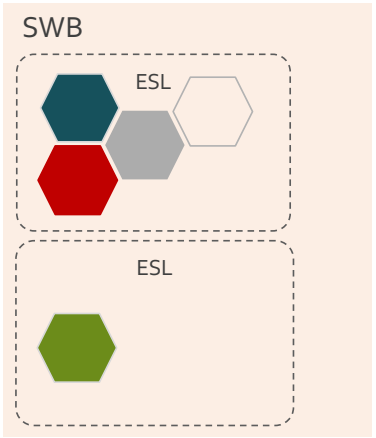


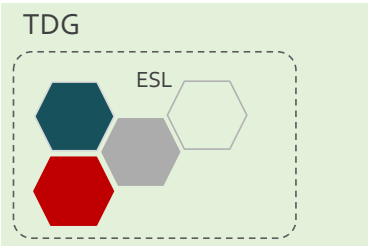
The Central Facility is currently reviewed at being at the New Cross Hospital in Wolverhampton. It would accommodate all functions across SWB, TDG and Walsall.

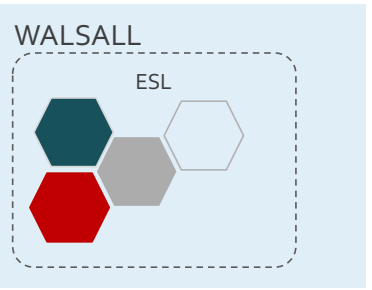
The ESL sites would consist of processing urgent blood sciences and all Blood Transfusion work. An option is to retain consultant reporting for histology at all existing sites. However, the Central Facility is currently being reviewed to have adequate space for all consultant reporting across the 4 trusts with the extension to be built.

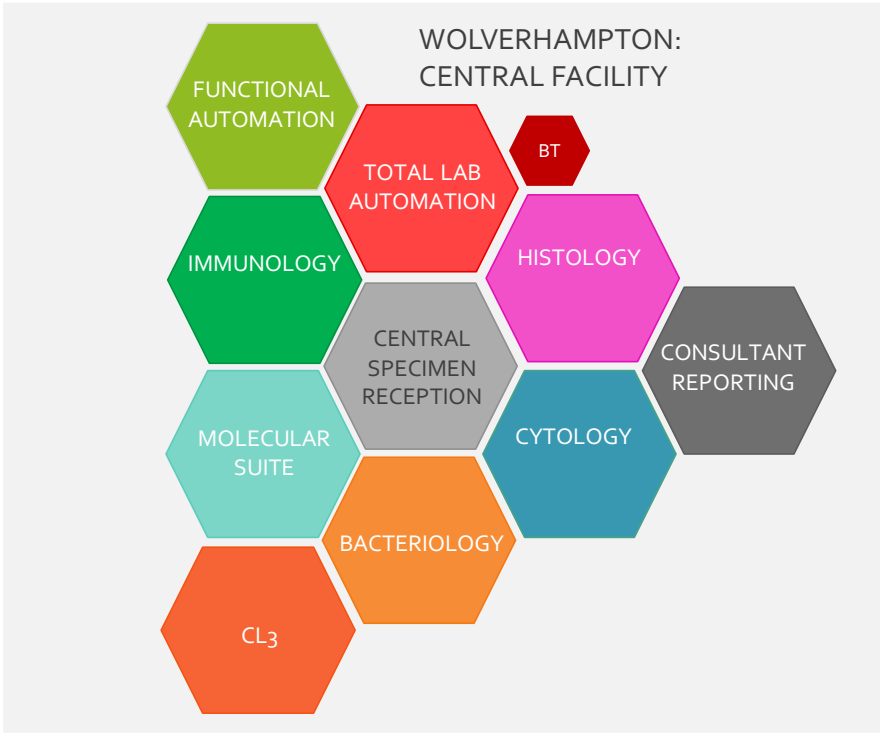
Economic Case

Single Hub Operating Model - ESL+ Reference Chemistry









Senior staff including at ESL to provide Frozen section, CSF and other urgent services

Economic Case

Central Hub Facility –Review

Based on the latest information and discussions with the architect, all activity can be centralised at RWH if the extension is to be built.

The following slides will elaborate on the below:

- The ground floor would require *medium* refurbishment to extend the automated areas
- The first floor would require *minimum* refurbishment with the addition of an additional automated line
- The second floor would require the *most* refurbishment to accommodate for the growth of histology
- The extension has been reviewed to be able to accommodate all the additional specialist blood sciences, any additional immunology, all of cytology, any additional molecular areas (if these cannot be catered into the first floor wing), as well as histology consultant offices.

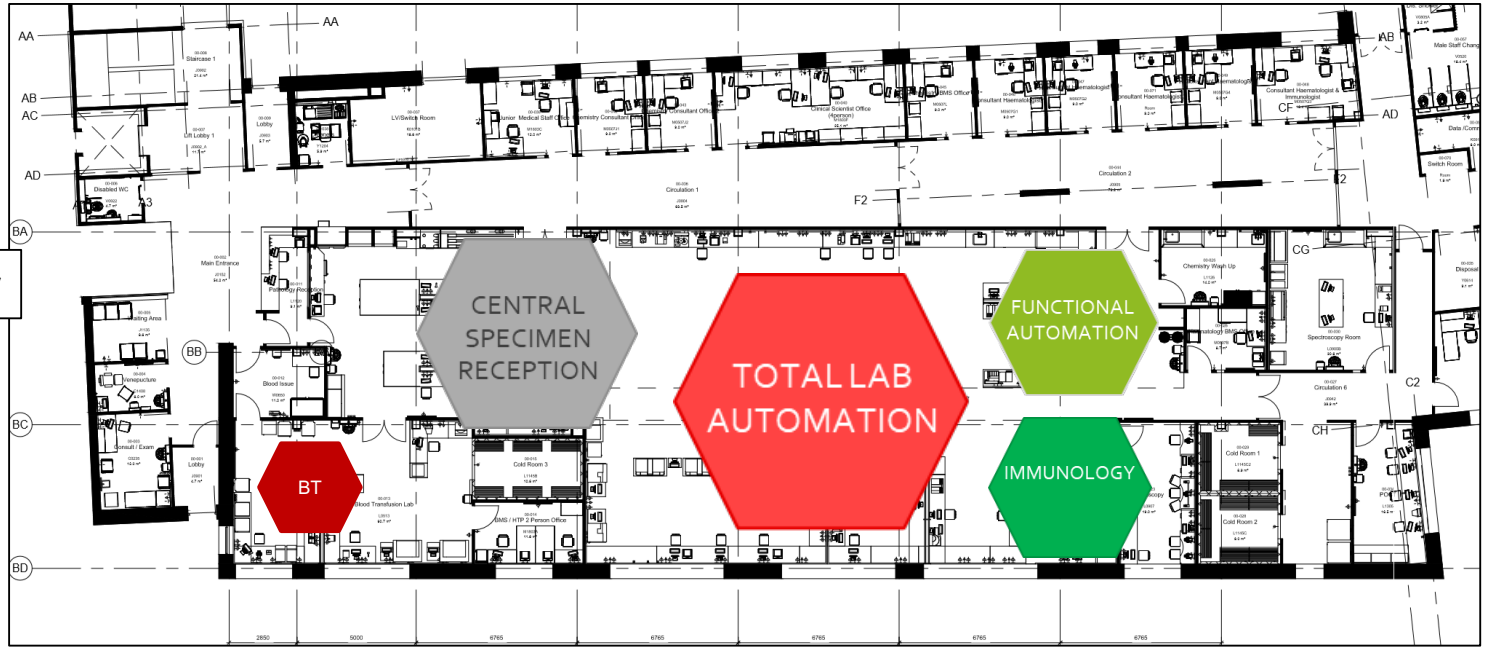
Note: The above is based on housing the required functions with regards to square meters. A detailed design would result in additional decreases in space and further accuracy for the central facility. A detailed design review could also be facilitated with the wider group of staff in engagement workshops to assure buy-in for the future service.

Economic Case

Central Hub Facility – Ground Floor Review

The Ground floor would retain its existing CSR, BT, Automation and Immunology areas. The CSR and main automated area would need to be extended. Also, the immunology area would need to be clarified further to assess the impact of growth. Any additional space for immunology or specialist chemistry is accommodated for in the extension.

Ground Floor



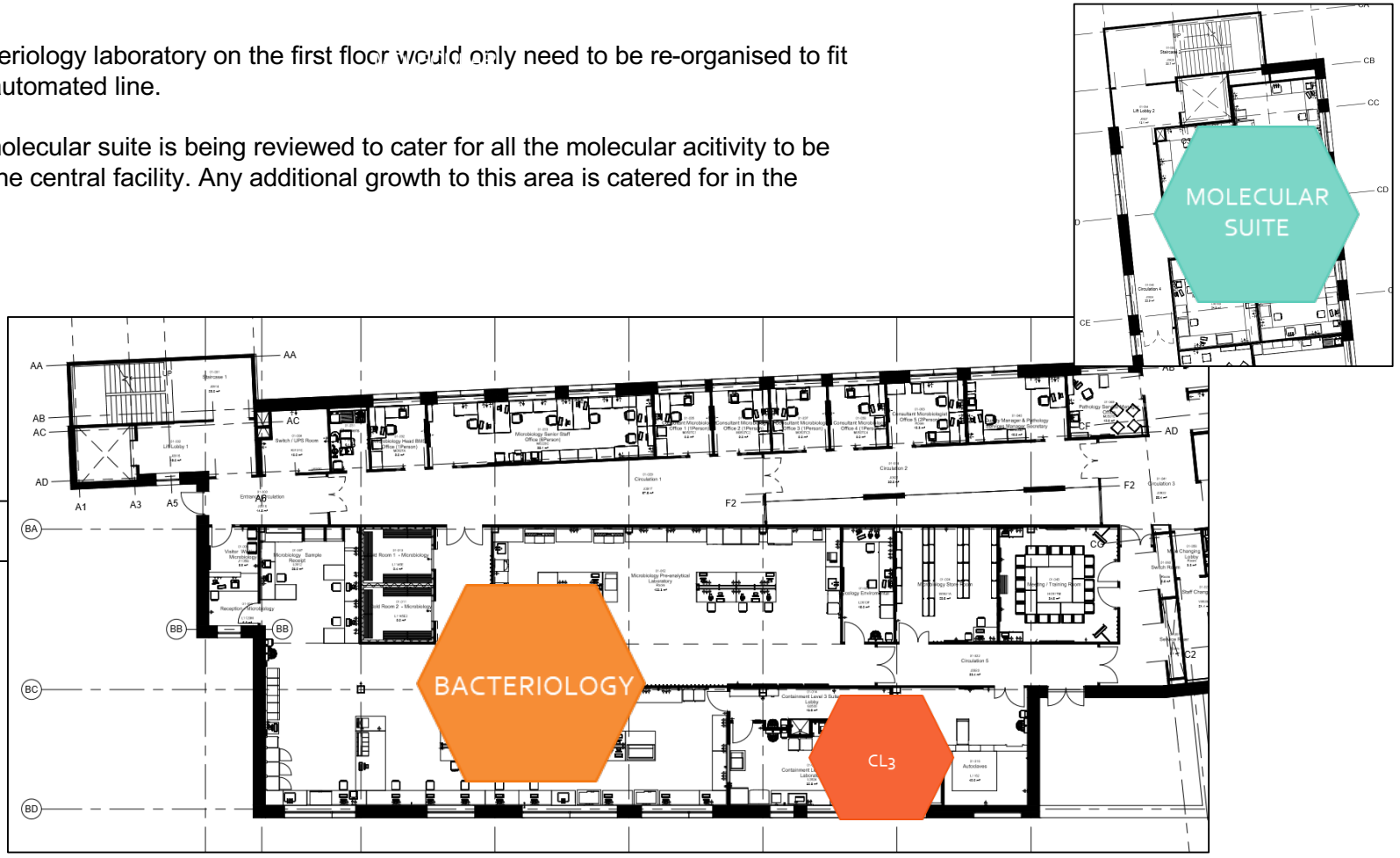
Economic Case

Central Hub Facility – First Floor Review

The main bacteriology laboratory on the first floor would only need to be re-organised to fit an additional automated line.

The existing molecular suite is being reviewed to cater for all the molecular acitivity to be processed in the central facility. Any additional growth to this area is catered for in the extension.

First Floor

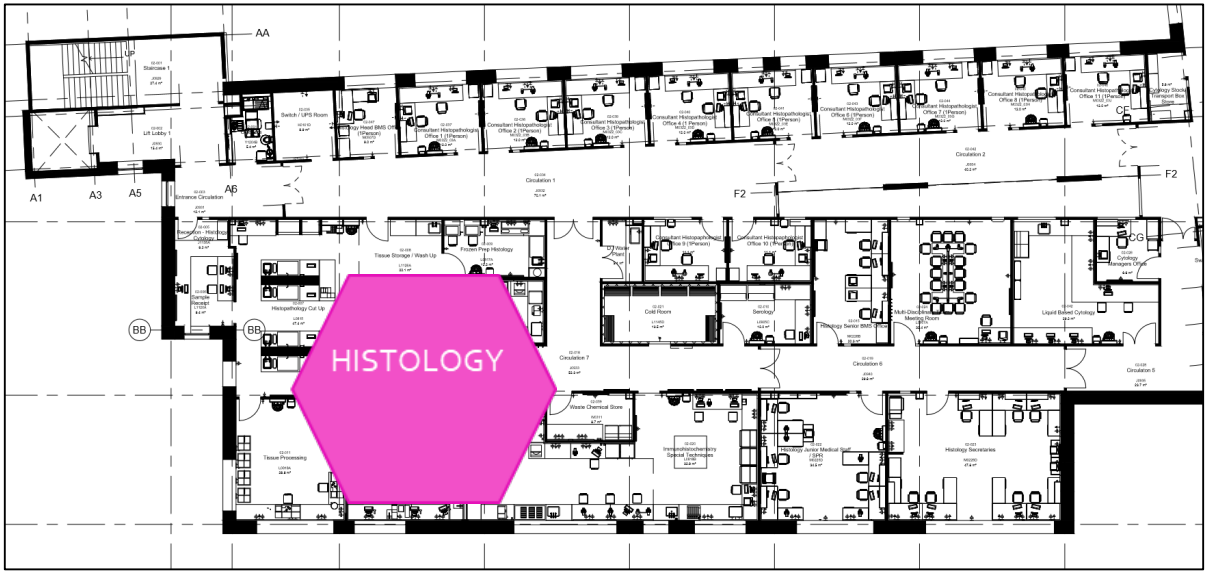


Economic Case

Central Hub Facility – Second Floor Review

The second floor would require the most refurbishment to increase the core histology area and accommodate more staining equipment. The existing space is sufficient for this. However, additional Consultant offices and Cytology may need to be moved into the extension.

Second Floor



Economic Case

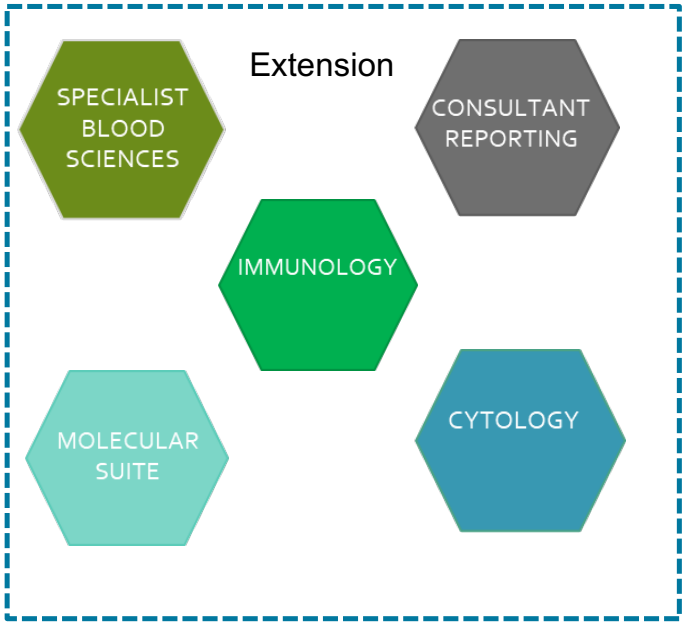
Central Hub Facility – Extension Review

The extension would have enough space for the required SQM to accommodate all additional departments and their activity. However, a detailed designed would benefit in a more optimal layout (ie. all of immunology within vicinity of the main blood science area).

If the extension would not be built, then the following would need to be considered:

- Consultant reporting to remain at existing sites
- Specialist Blood Sciences (Toxicology, Trace Metals, TPMT) to be excluded from Central Facility
- Full consolidation of Molecular work requires detailed review with Laboratory Managers

The hub extension is designed to accommodate all histology consultants and consultants for non-duplicate departments to be potentially moved to the hub. If the extension for the for the hub will not be built, then consultants would need to remain on their current site due to office space requirements.

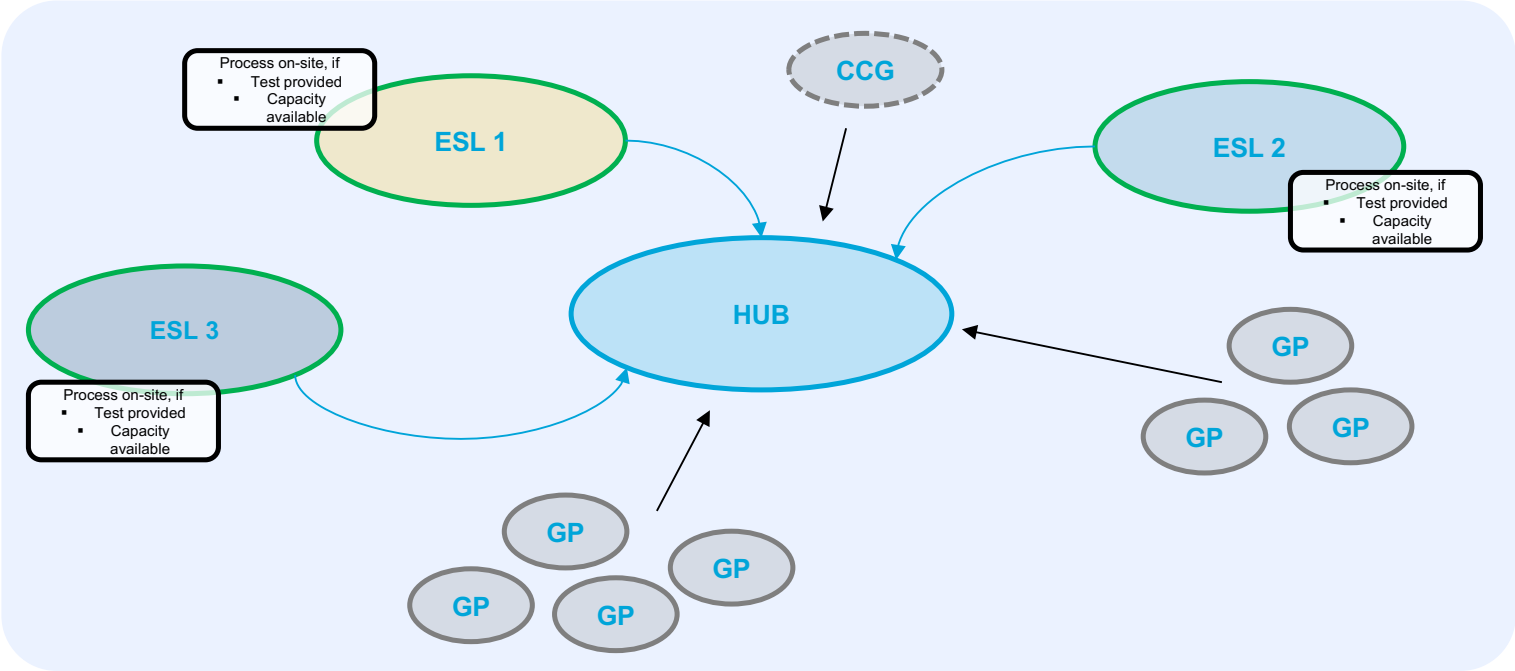


Economic Case
Logistics

The operating model is designed for all GP samples to go directly to the hub. The costs of logistics in the operating model have been increased by the cost of the trunk routes necessary to move samples from sites to the Hub. This assumes a minimum of one collection every 2 hours with the allowance for collections every hour as required. Additional contingency costs have been added in case 1 hour collections are required throughout the day from all sites. The ESL's are designed to process volume's with the following rules:

- A&E- urgent routine blood sciences sample
- Process non-urgent chemistry, haematology and coagulation *if*:
  - Test is provided within test menu
  - If capacity available to process

This allows for the efficient use of ESL resources on a 24 hour basis. The risk of processing only urgent A&E samples is under utilisation of ESL staff having to cover a 24-hour working day.



Economic Case
LIMS

The operating model envisages a single LIMS for the collaboration. This is viewed as vital for the effective operation of a single service. A single LIMS ensures that all sites are able to share data with regards to samples effectively, and will enable digital pathology, including digital histopathology, which will reduce the travel burden on staffing.

There have been a number of high-profile LIMS failures recently, and these have crippled laboratory operations. These include the decision of TPP (a recently failed pathology joint venture) to operate two LIMS concurrently. This had a significant impact on the cost of the operation and the ability to make changes. In addition, sites operating older LIMS have recently seen complete failures of their systems, including at Leeds Teaching Hospital.

In addition, the recent cyber attack on the NHS left a number of pathology services crippled, and reliant on paper for the operations of their laboratories – significantly slowing down the process, and making some testing no longer viable. As such a modern, secure, single LIMS is deemed vital for the collaboration.

FINANCIAL CASE

3

Financial Case

3.1 Introduction

The following section provides a detailed analysis of the preferred option and compares it against the baseline. Given the investment required for the expansion of the current hub facility, a new scenario has been run where all the reference chemistry activity remains at SWBH. While this scenario may avoid investing in capital it provides a higher level of clinical risk, lower quality and the option will still require capital investment as the service would need to be moved from City Hospital to Sandwell site.

These comparisons against the baseline involve measuring the cost of implementation versus the ongoing improvement in the 'run-rate' of the laboratory – annual savings that can be realised. The baseline used for comparison was based on the current costs of the laboratory as provided by the finance teams at each Trust with the application of savings and CIPs based on the long term financial models for each Trust.

For the following financial assessments, a start date of 01/08/2017 was assumed for the new service for all models.

The savings highlighted are predicted to be conservative estimates of the savings as not all non-pay cost items have been benchmarked.

The financial assessment includes a detailed evaluation and calculation of stranded costs (including the impact that changes to PFI areas may have), overheads and other non-pay areas.

The potential cost of contract terminations has been calculated, however, a termination cost would only be added when it is essential to terminate the contract and no other option, such as letting contract run to term, novation, etc., is available.

No savings are assumed for any of the options the cost of PFIs for those Trusts that have one.

Financial Case

3.2 Capital Investment and funding options

The transition period will require a <£10m capital investment requirement for the extension of Hub, refurbishment of ESLs and other transition costs. These can be obtained through:

- Application to the Carter pathology transformation fund;
- Application to the ITFF for working capital to facilitate the initial implementation of the project: it is expected that given the level of savings that BCPS would generate, the application would be successful;
- Private sector funding: cost of IT implementation could be rolled into the main IT contract to be tendered. The remaining cost for the building of the Hub extension could be obtained through the equipment suppliers or commercial borrowing/partnering.
- Trust capital programme: Allocation of costs from the Trusts' capital programmes.

ITFF funding option

A conversation with the head of the ITFF, confirmed the following aspects:

- Under normal circumstances, funding should be available, but only to the Trusts involved, not to the underlying project. So Trusts would need to downstream the funding;
- There needs to be a business case to justify the use of capital. Any loans to Trusts need to be affordable to the Trust itself. Affordability can be supported by savings, but the case needs to demonstrate this;
- Interest rates: depend on the investment and whether it's capital or not. Rough indication is equipment over 10 years at 0.5%pa and land and buildings up to 25 years at around 1%pa. Loan term is based on asset life, so a refurb might not warrant 25 years. Underlying contracts/commitments might also have an influence;
- Working capital facilities are only available to Trusts in distress, not for short term funding of a project of this nature. If the savings kick in quickly, and capital costs are already covered, ITFF could possibly look at a short term working capital loan repaid over 2 - 5 years to cover interim costs if that is more appropriate. We would need to consider how that might be split 4 ways, and whether repayment is tied in to the project or individual Trust affordability.

Financial Case

3.3 Financial modelling assumptions

For each of the main cost items in the laboratory, through our experience, and soft-market testing, we have been able to put together the following assumptions for the financial modelling. These will define the scope for cost savings, or increases, in the scenarios.

3.3.1 Cost assumptions

The following cost assumptions are applied to all the models.

3.3.1.1 Inflation

Inflation assumptions are based upon the current guidance from NHS Improvement. These are provided below:

Element	2017/18	2018/19	2019/20	2020/21
Pay costs	2.0%	1.6%	1.6%	2.9%
Non-pay costs	1.8%	2.1%	1.9%	2.0%
Corporate overheads	3.2%	3.2%	3.1%	3.1%

Source: NHS Improvement

3.3.1.2 CIP rates

Throughout the model a CIP level of 3% has been assumed on all costs. In most years, this is greater than the inflation assumption applied.

In addition, a sensitivity to the As Is position has been applied. Trusts have provided their current CIP plans for the forthcoming years. The As Is scenario, and the other scenarios prior to implementation, have been aligned to these savings to indicate the level of savings predicted through current plans. The CIP information provided by each Trust has been identified below. Where no CIP was provided, the 3% general assumption has been applied for that period.

It should be noted that the scale of the CIP savings suggest that they may be unlikely for some Trusts in the long-term without consolidation of activity between providers.

This alignment has been undertaken for the first two years until the predicted implementation date of the collaboration. CIP savings are assumed to be run-rate savings, as opposed in in-year savings. Where no pay/non-pay breakdown has bee provided, savings have been assumed to be incurred 50/50 between the categories. Non-pay savings have bee aggregated and applied as a total saving to all non-pay costs. Please note for WH the CIP on Blood Products is not included as Blood Products are not modelled as part of the combined service.

Financial Case

3.3.2 Volume growth

Activity levels have consistently risen, particularly in recent years, representing the increasing use of healthcare services in the UK, and the increasing reliance of healthcare decisions on pathology outputs.

Costs in the financial model can be classified as fixed, semi-variable, or variable, in relation to activity growth rates. Variable costs are predicted to grow at the rate activity growth (in addition to inflation and CIP growth rates). This is as their use increases directly with increases in activity. Semi-variable costs grow at a slower rate than activity growth, as they only increase partially as activity increases. Fixed costs do not increase with activity. The table below summarises the assumed variability of costs in the model.

Cost	Variability
Pay costs	Semi-variable
Reagent costs	Variable
Consumables cost	Variable
New equipment, reagent, and consumables cost	Semi-variable

3.3.3 Pay Costs

For the revised service, an new operating model has been produced to reflect the transfer of all ‘cold’ activity to a central hub facility. Based on this operating model, and the levels of activity that will subsequently be undertaken on each site, a new staffing model has been developed. The change presented is against staffing figures provided by pathology finance teams at each Trust. No change has been modelled to non-clinical AfC banded staffing.

Overall, the TOM shows reduction in staffing against the base case. It should be noted, however, that the actual financial saving is greater than this due to the model adjusting the overall grade-mix to a lower levels – thus realising additional savings. Changes in staffing levels have been modelled over a transition period where natural turnover rates, retirements and vacancies have been taken into account.

Financial Case
Single Hub Scenario

3.3.4 Non-pay Costs

Equipment, maintenance, reagents, and consumables

Similarly to pay costs, equipment, maintenance, reagents, and consumables represent one of the largest cost areas in the laboratory, and one of the largest areas for savings in collaborations. In the last few 7-10 years, market prices have fallen by around 10%. In addition, further savings can be expected in a collaboration model through lower duplication of equipment. This additional saving has been benchmarked at 15.5%. This reflects the savings on Trust contracts, where a Trust has a long term contract in place for equipment, no savings have been modelled for that contract for the remaining life of the agreement.

This saving has been confirmed through analysis of the current cost per test for the Trusts, per discipline, for their combined equipment, maintenance, reagent, and consumables cost, and predicted harmonisation of contracts to the lowest cost per test, excluding outliers.

Estates

For WH and DGH, the concern here is over the treatment of the PFI builds. As the options under consideration represent no increase in space in these labs, and only a decrease, there is no one-off change in the PFI costs assigned to the laboratory. This is as it is unclear at this stage whether the space can be re-used, and as such is assumed to still be occupied by the laboratory.

Existing estates costs are transferred to the collaboration, and recharged to the Trusts in-line with the recharge mechanism. No one-off change is assumed in these costs.

Logistics

Logistics represents the transport of samples between customers and the Trust. Under the new collaboration model there will be a new requirement to transfer samples between the hospital sites, in addition to the current transport requirements.

The model proposes no alteration to the current logistics solutions for the Trusts, and instead proposes supplementing them with additional routes for GPs and to move samples from sites to the Hub. Additional investment that more than doubles the current costs of logistics have been factored into the model.

Financial Case
Single Hub Scenario

3.3.3 Non-pay Costs cont'd

LIMS

The current LIMS providers for the organisations are summarised in the table on the right.

Two options exist for the LIMS requirement of the new pathology organisation. One option is for the combined pathology service to look to connect the existing LIMS through a middleware solution. The pathology steering group recognised that this is less than optimal, and a failure to consolidate into a single LIMS has contributed to the failure of similar collaborations, including TPP (the pathology partnership). It is also the case that this represents the highest risk solution as it presents the opportunity for the middleware to fail, as well as significant chance for the existing, and older, LIMS solutions to fail.

As such, the pathology steering group decided that the most suitable route for the collaboration would be to adopt a single LIMS that would include the implementation of a digital histopathology solution. Though likely to be the more expensive solution, it is predicted to provide the greater level of stability and interoperability for BCPS.

The capital cost of implementation includes software licences, training, and full implementation of the solution.

As such, soft market testing was undertaken for the implementation of a single LIMS for the providers. This assumes each spoke site is set at 30 concurrent users, and essential blood science and blood transfusion service only.

This value was then benchmarked against the cost of implementation of similar solutions at other providers. These indicated that the predicted annual cost was within 4% of this value, and with the capital cost 10% of the indicated value. Assumptions:

- Excludes VAT – and that any contract implementing the solution is VAT efficient.
- The capital includes spend on additional or replacement hardware for the sites.

For the financial model, the capital cost has been converted into revenue in-line with the interest assumptions provided by the ITFF. As such, for an assumed 10 year contract, the annual revenue charge has been calculated for modelling.

It is predicted that the collaboration can move 'at speed' with the procurement of the single LIMS provider given that it is possible to procure the LIMS through existing framework agreements.

Financial Case
Single Hub Scenario

3.3.3 Non-pay Costs cont'd

Tests referred out

Tests referred out are those tests which are sent outside of the Trust, and usual focus on specialist activity. For the purpose of this activity, the cost to each Trust of tests referred out to other Trusts within the BCPS group has been ignored. This is to prevent the double counting of costs – as the cost of provision of these tests is already included within the Trust that undertakes the activity.

For reference, the cost of tests referred out within BCPS, and external to BCPS are identified by Trusts in the table below:

	RWH	SWB	WH	DGH
External to BCP	£459,490	£403,462	£433,902	£516,000
Internal to BCP	£73,530	£0	£183,210	£98,031

No additional saving have been included for the tests referred out, however, savings can be expected once detailed analysis is carried out on whether tests can be repatriated or commissioned jointly.

Financial Case
Single Hub Scenario

3.3.4 Capital and Investment costs

Moving and double running costs

Under the proposed model, a new installation of equipment across both sites results in a minimal requirement for the moving of equipment. Given the transformation of the service is largely within a single laboratory site, double running and decant costs have been assessed and included, based on experience of similar movements at other laboratories. These costs are predicted to be incurred during the early part of the transition period.

Estates investment

RWH have engaged with architects Keppie Design. Keppie have been working with the Trust, in partnership with LTS, to produce a schedule of accommodation for the new single hub at New Cross Hospital, via an extension to the existing laboratory, along with a re-organisation of the existing layout of the laboratory. Through this work, the Trust will be able to identify the level of refurbishment, as well as the nature of the extension to the laboratory required.

This work remains ongoing, and a revised draft of the schedule of accommodation, with the next phase requiring the appointment of quantity surveyors to evaluate costs. This will further refine the cost input for the model, however the current assessment is, and will remain at, a high-level.

Ahead of this, RWH have provided an indicative value for the cost of the refurbishment, and the construction of the extension. For the financial modelling, we have estimated that this value is split evenly over the four semi-annual periods from 01/04/2018 to 31/03/2020 to reflect the work being undertaken.

The work undertaken has assessed the future operating model and levels of activity. This has shown that it is practical to provide the consolidated model within one central hub facility. In order to undertake this the extension to the existing laboratory will be required, alongside refurbishment of the existing laboratory. This refurbishment is included in the price, and is estimated at light refurbishment work for 250sq.m on the New Cross Site.

Project management

For the transition of the laboratories, significant project management expertise will be required to develop the governance models, transition plans, and the legal framework for the partners. Based on experience of similar collaboration projects, we estimate this cost to be £400,000 for the partners. These have been evenly profiled across the semi-annual periods from 01/10/2017 to 30/09/2019.

Financial Case
Single Hub Scenario

3.3.4 Capital and Investment costs cont'd

Central management recruitment costs

For the new collaborative service, there will be a requirement to put in place a central management team for the service. The cost of recruitment of the senior staff is estimated at £40,000 through soft-market testing. This is predicted to be incurred in the semi-annual period 01/10/2018 to 31/03/2019.

HR Support

Given the change in services, there will be a requirement to TUPE transfer staff between the sites.

In light of this, there is likely to be significant HR support required. As such, it is assumed the support requirement from the host organisation will be two FTE senior HR staff employed full-time for a year. This cost is £133,500. This is predicted to be incurred in the two semi-annual periods from 01/10/2018 to 31/09/2019.

Contingency

In addition, a contingency fund of £400,000 per annum has been included to cover unforeseen costs.

3.3.4 Costs for the ESL+ option

These costs have been calculated following the exact same methodology as the main option. Key different between the two TOMs lies on the capital requirement for refurbishment and building of the ESL+. Initial estimates indicate that these costs are slightly lower than those of the preferred option.

Financial Case

3.4 Financial Summary of Options

3.4.1 Summary of the options

Each of the shortlisted options was modelled over a 10-year period from 2016/17 using the assumptions discussed on the previous pages. This produced a 10-year forecast for the cost of the laboratory under each of the options. The As Is model is deemed the 'base case' for the model, and the variance from this model is also presented for each of the options for easy identification as to whether the option saves money against the base case, or indeed costs more.

Presented below is the annual summary of the total cost base for the laboratory for each year modelled as well as the cost difference for each year, against the "As Is" scenario modelled. When looking at the financial outputs it should be noted that these do not reflect qualitative differences. Therefore, models that cost more may indeed result in significant qualitative improvements which justify the increase in cost.

Compared against the As Is model, it is clear that, from a purely cost perspective, all models represent a saving to the As Is Model. (a negative value in the difference equals a cost saving compared to the As Is model). Financial statements for each of the options were developed to show the profile of costs and savings.

As a result of the analysis the options that provide the largest savings are:

1 – Hub and ESL+

2 – Hub and 3 ESLs

3 – LTFM plans

4 – "As Is" with CIPs

It should be noted that the difference in savings between the Hub and ESL+ and the Hub and 3 ESLs is negligible which is likely to reduce further once the hub extension costs are fully developed by a quantity surveyor. Initial analysis through a sensitivity run on the model would indicate that the single hub and 3 ESL options may provide a higher level of savings overall if the cost of the extension remains at £2,700sqm and after value engineering principles are applied to the design. Initial estimates by LTS indicate that the price per sqm for the extension, as provided by the Trusts (£4,000 sqm), are high in comparison to benchmarks (£2,500 - £2,700 sqm).

Given there is limited difference between the annual and total cost of the One Hub and ESL+ Scenarios, it is recommended that the Trusts consider the best operating model based on the following aspects:

1. Availability of capital
2. Quality considerations – The impact on quality of a split service should be considered, and whether it is more clinically and operational preferable to have the service located on a single site.

COMMERCIAL CASE

This sets out the potential governance and management arrangements as described in the BCPS partnership agreement (PA)

4

Commercial and governance principles for a potential BCPS partnership model

4.1 Introduction

The following sections contains a summary of the proposed position for commercial terms, organisational structure and governance of the new pathology partnership. These principles have been discussed and agreed by the Directors of Finance of all the organisations in the project and/or their representatives during phone meetings and email correspondence. These terms have also been presented for review and comment to the members of the BCPS Transitional Management Team.

All organisations have agreed that at this stage they do not wish to set up a separate legal entity to establish the BCPS partnership. Therefore, the model chosen is that of an Arms Length Organisation hosted by one of the Trusts. This is the model developed in this section and all the commercial terms are arranged around this model.

A Partnership Agreement (PA)is enclosed with this OBC. This will form the basis of the agreement to be signed by the four Trusts.

This section considers the organisation and commercial principles required to to establish a potential BCPS collaborative pathology model. These have then been developed into a draft set of Heads of Terms for such a model which are divided into four sections.

1. Outline Commercial Model;
2. Governance;
3. Ownership;
4. Relationship with Customers; and
5. Organisational Form, Staffing and Corporate Services.

Each commercial principle contains initial considerations and agreed approach which was developed in discussions with the Directors of Finance. Where the agreed approach has more than one options it highlights a requirement for further discussions to complete the agreement.

The initial term proposed for the partnership is 10 years so it aligns with equipment contracts and the realisation of savings.

4.2 Outline Commercial Model

This section covers the potential commercial model for the new pathology organisation.

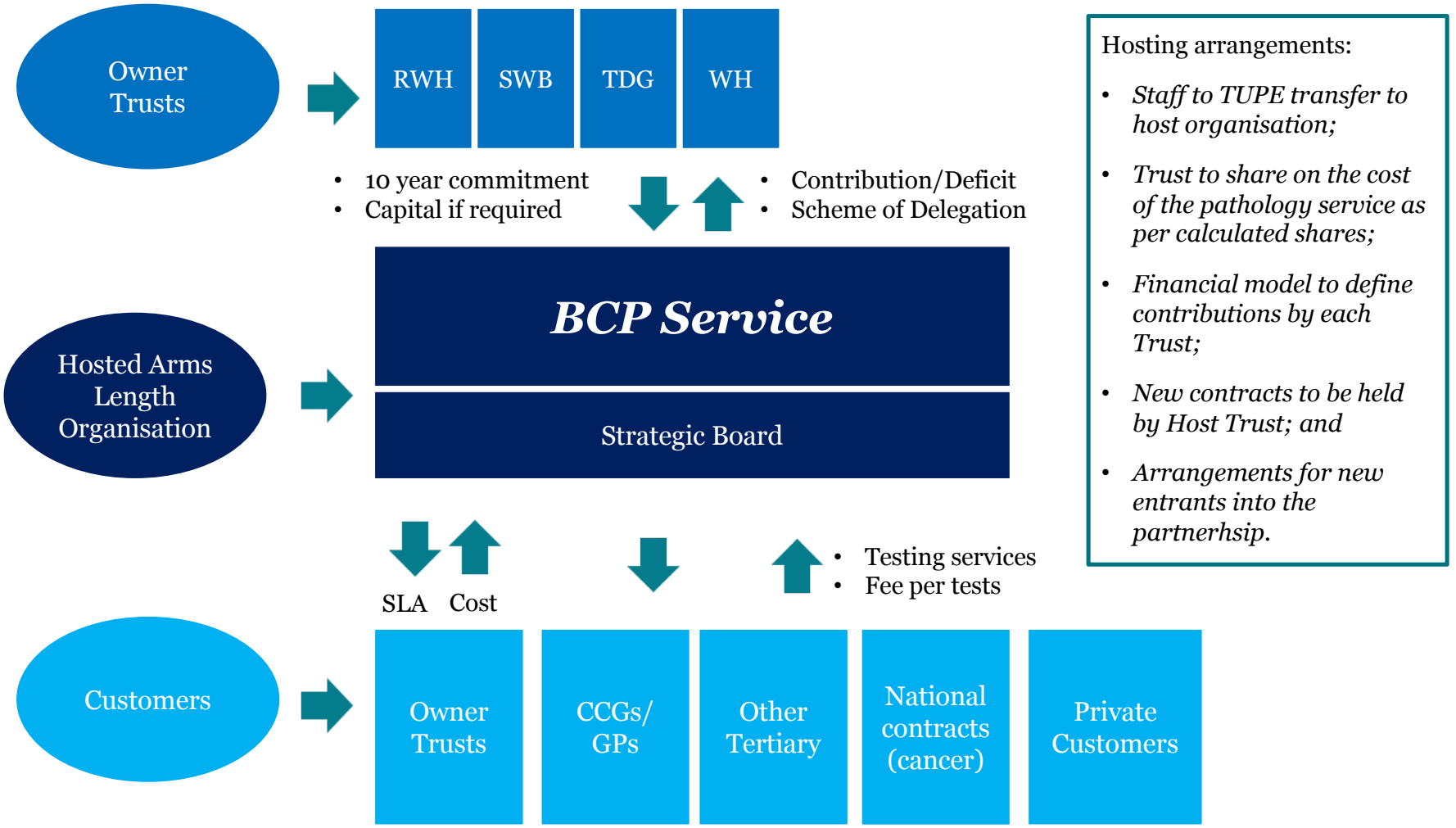
4.2.1 Operating Arrangements

The diagram in the following page summarises the operating basis for the BCPS new pathology service when fully established. It is proposed that given the complexities of setting up a new entity between NHS Foundation Trusts and non foundation Trusts, pension arrangements and costs, the partnership is set up as an arms length organisation hosted by one of the Trusts.

The entity will operate under its own Board and Executive Team, who will be accountable to the Owner Trust boards for the operation of the pathology service. It is assumed at this stage that BCP Service will not be established as a separate legal entity.

As such BCPS will have its own identity and operating flexibility which will be distinctly different for the way that pathology services are managed as part of each Trust's existing divisional management structure. It is considered important to create a new identity and operating model for BCPS because:

- This is a transformation of the pathology operations of the Trusts under a seamless management and governance structure with a single management team;
- Operationally BCPS will serve all the Trusts equally providing first class pathology services and as such needs to have its distinct identity and arms length separation from the Trusts;
- Staff will be equally and significantly engaged (in a challenging transformation) if they can identify a common loyalty to a BCPS "brand" and operational management structure which is distinct from existing arrangements within their individual Trusts;
- BCPS requires a degree of operational flexibility to set and execute its own priorities if it is to grow as a sustainable business which it is unlikely to get as part of the Trusts' divisions; and
- BCPS would be required to operate with a degree of autonomy under the standing order and scheme of delegation of the host Trust.



Hosting arrangements:

- *Staff to TUPE transfer to host organisation;*
- *Trust to share on the cost of the pathology service as per calculated shares;*
- *Financial model to define contributions by each Trust;*
- *New contracts to be held by Host Trust; and*
- *Arrangements for new entrants into the partnerhsip.*

4.3 Governance

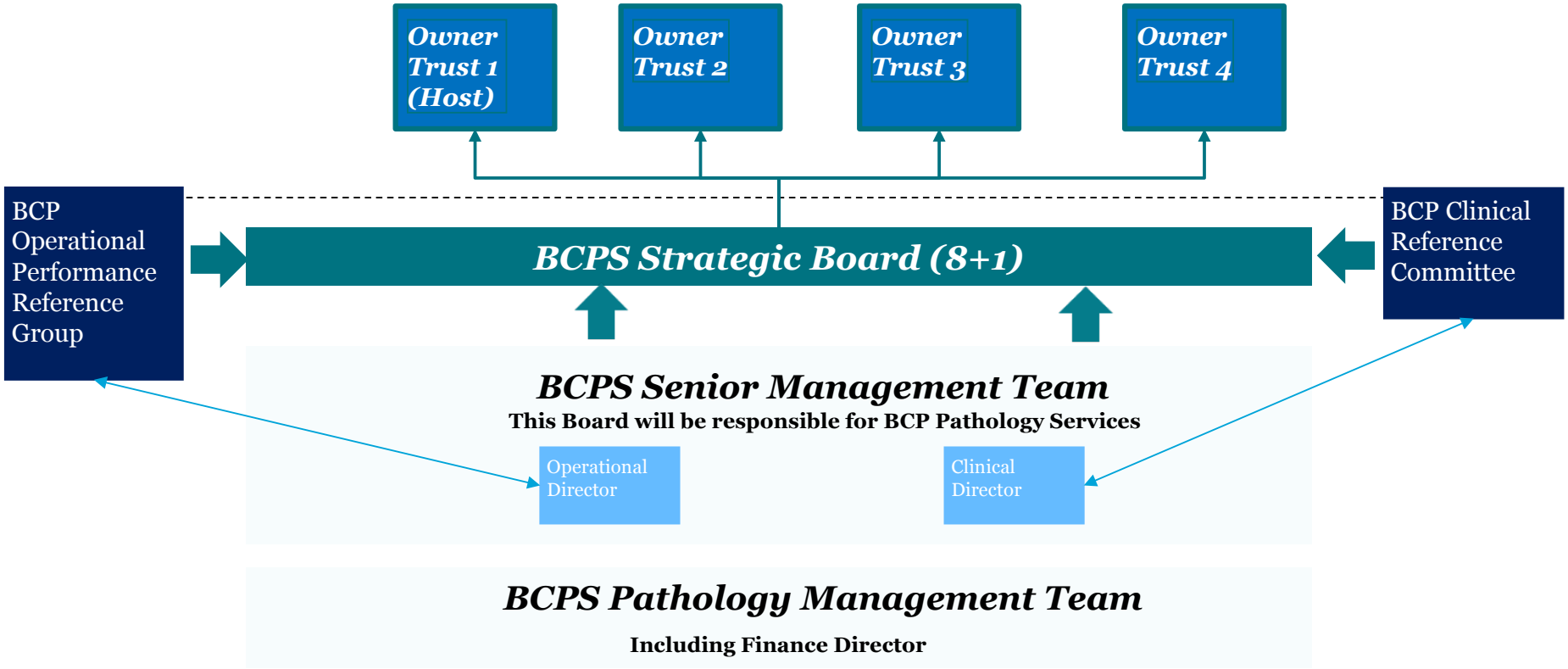
This section highlights the day to day management and control of the new organisation. The principle for the new pathology organisation is to have enough independence to make key decisions. Each owner Trust will need a level of control to assure their Board that they can strategically manage their ownership benefits and risks.

HoTs	Initial Considerations	Agreed Approach
1. ***BCPS Strategic Board***	• Initial considerations will focus on the Board role and its composition, such as: – Representation on BCPS Board; – Creation of an Executive and Non Executive team; – Management of a large business and staff responsible for finance, operational, commercial and clinical initiatives; – Size of business will require a mechanism for transparently and effectively reporting performance; – Appointment of Board members and future Board members (internal and external); – Chair appointment; and – Appointment process for independent members.	• The management remit of the BCPS Strategic Board will be in accordance with the Scheme of Delegation and reserved matters. • Trusts to appoint an independent Chair who should be independent of all Partners. Alternatively, each Trust can take it in turns to chair the board. • Unanimous agreement required for the appointment of the Chair, if no candidate available the role will rotate within the four partner Trusts. • The BCPS Strategic Board will be formed by two members of each Trust, of which at least one per Trust will be an Executive Board members of their Trust and the other will have a relevant clinical background. • Current BCP Transition Management Team to interview Directors for the BCPS Executive Management Team. • The total composition of the Board will be 9 (Chair and 2 representatives from each Trust). • Each member of the board, apart from the chair, shall have one vote. The Strategic Board will have a total of 8 votes, two from each Trust.
2. ***BCPS Executive Management Team***		• The BCPS Management Team will have responsibility for the day to day operation of the service. • The BCPS Management Team will comprise of an Operational Director and a Clinical Director (2 Executive Directors). • The Strategy, Finance and HR Directors will not need to be part of the Board, but their roles should be included in the structure of BCPS pathology. These are likely to be provided by the Host Trust. • The BCP Executive Management Team will ensure the delivery of the BCPS obligations under the SLA agreements with each Trust. • Each Trust will have an obligation to provide certain services to BCPS such facilities management, access to essential services laboratory, utilities, etc. • The Host Trust will also be responsible fro providing other support to host the organisation such as payroll, IT support and procurement and finance support.

4.3.1 Governance Principles

The diagram below illustrates the governance principles for the BCPS, The new entity will have its own board responsible for the management of the pathology service and the day to day running to the entity. The BCPS Management Board will be responsible for producing an annual business plan that will include investment requirements. This plan will then be submitted to the BCPS Strategic Board for approval and to all the Trusts for information and approval where the delegated powers are excided and confirmation from owner Trusts is required.

The BCPS Strategic Board will include a Chair and GP as non-voting members.



HoTs	Initial Considerations	Agreed Approach
3. Voting rights for Reserved Matters by the Owner Trusts	• Initial consideration will focus on the mechanism for which reserved matters are decided upon between the Owner Trusts.	• All Trusts have equal voting rights on the BCPS Strategic Board • The following is proposed: – Unanimous voting may be required for a small number of the Reserved Matters, which should be strategic in nature and not relate to operational matters; – Some Reserved Matters will be decided by Majority Voting, such a majority will be based on the agreement of at least 3 Owners or 70% of the share holding; This will ensure that no single Trust will have the majority vote or right of veto in relation to operational matters. – The final form of the Majority Voting will be determined once Ownership Shares are approved and ratified; and – The proposals as to whether a reserved matter belongs to majority or minority voting is provided in the "Reserved Matters" (See Appendix 2).
4. Scheme of Delegation	• The Owner Trusts need to 'Reserve Matters' for their own unanimous or majority decision making and the need for Trust board approval • These Reserved Matters should be critical to protecting their Owner interests and not issues of day to day operations. *Refer to Reserved Matters in Appendix 2*	• The Reserved Matters are likely to include: – Approval of the annual Business Plan and budget if it deviates from original business case by more than 5%; – Material deviation from the Business Plan or budget within the financial year; – Requests for new investment above delegated limit; – Taking on long term liabilities (e.g. large service contracts); – The appointment or dismissal of any of the executive directors of the Board; – Approving the annual clinical governance report/appraisal; – The admission of new Owners; and – Material amendments to the Partnership Agreement.

- For detailed description of reserved matters please refer to Appendix 2 of this document and the BCPS Partnership Agreement.

HoTs	Initial Considerations	Agreed Approach
5. Clinical Governance	• Initial considerations for an effective system: – The Clinical Director will have ultimate responsibility for Clinical Governance but the whole Board is responsible for effective Clinical Governance; – With BCPS hosted by a NHS Trust the Clinical Director will have to report to the Medical Director of the host Trust to ensure there is seamless, sustainable, clinical governance; and – The clinical director will also be part of the user clinical steering group.	• The Clinical Director will be responsible for clinical governance across pathology services working in collaboration with all the Trusts. • The Clinical Director will be responsible for all clinical arrangements for BCPS. • Each active laboratory will continue to receive national accreditation under the auspices of the appropriate body (CPA/ISO). • The Clinical Director should produce an annual clinical governance report for review and approval by partners. • There will be a user clinical steering committee set up who would monitor the clinical issues of the pathology service (clinical performance, clinical SOPs, introduction of new tests, etc.) • The Clinical Steering Committee will be formed by 1 clinical lead from each Trust who will be responsible for consulting with its Trusts' users. • The preferred Clinical Governance model has been discussed with the medical directors of Trusts who have confirmed that the appointment of Clinical Director is an essential requisite to achieve accreditation. This Clinical Director will then be responsible for setting up the clinical governance processes for the new entity and will also have a formal role within the Host Trust Clinical Governance processes ensuring there is regular reporting and monitoring back to the Host Trust.
6. Contact management (SLA monitoring)	• Principles for the management and monitoring of SLAs	• While the BCPS Executive Management team will be responsible for the management of BCPS a separate arrangement should be put into place to monitor SLA performance and operational remediation when required. • The contract management group will monitor SLA performance on a monthly basis and report to the BCPS Strategic Board once a month. • The contract management group will be formed by one contract manager from each Trust and the COO of BCPS • SLA KPIs and metrics will be agreed as part of the SLA development

4.4 Ownership

This section addresses the potential ownership obligations for each owner Trust which enters into a partnership to establish BCPS Pathology.
It is envisaged that a combined BCPS pathology entity will be owned by its sponsoring Trusts. A methodology needs to be agreed between the Trusts to allocate proportionate ownership "shares" between them to allow for the future distribution of surplus and losses and the sharing of start up costs (transition) and future capital calls.

HoTs	Initial Considerations	Agreed Approach
7. Obligations of Owners	• These shares will represent the proportional liability of partner Trusts. They are not equivalent to real shares as no new separate legal entity is being established. Owner shares which will be used to apportion the risks, rewards and control between the partner Trusts.	• Owner Trusts who are shareholders will take responsibility for the share of the funding and liabilities of the organisation. • There will only be a single class (type) of "share".
8. Methodology for valuing ownership "shares"	• The methodology selected to determine ownership "shares" needs to be demonstrably fair, straightforward to calculate and explain to wider stakeholders. • Conventional methods for valuing shareholders would look at the relative value or contribution that each organisation is making to the new entity. This is usually quantified as the contribution they will be giving up to the new entity.	• Income base: based on the calculation of the total income that each Trust brings to the partnership. The calculation is performed by multiplying current annual activity volumes by a set price per test (or by discipline). It has the risk of incentivising those Trusts with higher complex volumes or poor demand management and control. • Examples of the calculation are available in the "Cost Shares Methodology", Appendix 4 • Directors of Finance have proposed that the income based methodology based on activity is used. • Appendix 4 indicates the estimated current volume of shares for confirmation at Gateway 1.

HoTs	Initial Considerations	Agreed Approach
9. Commitment from owner partners and partnership term	• Entering into the Partnership Agreement will have a number of implications that all Trusts are committing to.	– The partnership is based on the creation of a joint service for the benefit of all Trusts and in which all trusts have equal say. The hosting of the BCPS and/or the location of services will be dealt with as operational matters (best value for money) and all Trusts will have an egalitarian share on the benefits created by the service. – The term of the partnership agreement will be 10 years. – At the end of the 10 year period an owner will be required to provide 12 months notice to exit the partnership. – Partners existing at the end of the term will be allowed to remain customers of the partnership. A full exit will have implications in terms of exit costs which are explored in the exit costs section. – All Trusts commit to providing the required support to BCPS, both financially and operationally. – Commitment to maintain all activity volumes within the partnership.
10. Selection criteria for the Host organisation	• Considerations for the selection of the Host organisation	– The selection of the Host organisation should be on the basis of the most advantageous set up for BCPS that would best enable the reconfiguration of services. – Key consideration should be the capacity of the Host Trust to enable and support the accounting and management of an ALO within its structure. – It should be considered the disruption to staff with TUPE transfer. This would favour the Trust with the largest numbers of staff to become the host organisation, reducing the cost and risk of TUPE transfer consultation and proceedings. – The selection of the Host organisation should be a unanimous decision by partner Trusts. – Directors of Finance have proposed that to make the management of BCPS and the provision of support better, the Hub should be the Hub at RWH. This would minimise TUPE transfer issues and ensure quick access to support services like finance and IT when needed.

HoTs	Initial Considerations	Agreed Approach
11. Exit Arrangements	• Initial considerations on the methodology and implications if an Owner wishes to leave the collaboration. Considerations include: – Owners locked in for at least [10] years Owners will not be able to trade or sell shares until end of term or break clause [if available]; – [1] year notification period for Owners who wish to exit partnership; – Penalty for an Owner for early exit; – If one Owner leaves the others have pre-emption rights to acquire their shares; and – Exit costs to be covered by the exiting party.	• Owners locked in for at least [10] years: – Owners will not be able to trade or sell shares until break clause; and – Owners who choose to terminate prior to the [6] year break clause would lose the investment and pick up any costs that are associated to early exit. • Possible exit arrangements include: – The remaining Trusts have the pre emption right to acquire the leavers share (at an agreed valuation); and – If more than [X] exit then: o If an Owner chooses to exit BCPS an equal proportion of shares will be allocated to all remaining Owners; o An Owner may increase their shareholding proportion if the other Owners do not wish to purchase additional shares; o If remaining Owners choose not to take on remaining shares a third party may be chosen to purchase the shares (majority voting will be needed); and o BCPS is wound up and its staff, assets and liabilities are divided up and transferred back to the respective Owners; or a new third party shareholder is sought [this is to avoid an unsustainable concentration of ownership. o A risk premium may be payable by any partner leaving the partnership based on the calculation in clause 6.11 in the partnership agreement. o This calculation is based on a full 12 month service fee offset by cost reductions in terms of staff transferring back to the Trust and other cost being removed from the partnership.
12. Dispute Resolution	• Dealing with poor operational performance	• Should the contract management group identify areas of non-performance, these will be notified to the BCPS Executive Management team • BCPS will put a remediation in place with the aim to rectify the problem within 3 months. • Should the problem not be rectified this will be escalated to the BCPS Strategic Board for consideration. • Following a decision of the BCPS Strategic Board, BCPS will have three further months to rectify and correct the issue. • Should the issue not be resolved it would then be escalated as per the dispute resolution procedure in clause 16 of the Partnership Agreement

HoTs	Initial Considerations	Agreed Approach
13. Annual recharges	• Consideration on how payments to the BCPS are made by each Trust to cover the operating costs.	• Prices paid by each Trust to be based on shareholding proportion of the agreed annual budget for the service (calculation based on volumes x price per test). • Shareholding to be rebased/recalculated when the volumes from one single Trust change over the course of 12 months by ±[8%] • Should volume change be within the cap and collar, then the BCPS Strategic Board has the option to agree repricing every two years.
14. Profit and Loss	• Initial considerations on the agreement on how to deal with any profit and/or losses.	• Annualised profits to be shared between Owner Trusts in proportion to their ownership share. • Losses underwritten by the Owner Trusts in proportion to their Ownership Shares.

15. Transition Costs	• Initial consideration of how implementation and transition costs are shared between the Owners. Such as:
	– Capital;
	– IT;
	– Assets;
	– Staff costs; and
	– Equipment.
		• Transition costs are shared in accordance to shares of the new entity.
		• Once the new entity is implemented any further redundancies during the transition will be shared by Owners (if they cannot be financed from the business cash flows).
		• Equipment:
		  • Transition costs will be dependent on the existing Managing Equipment Services (MES) timing of the contracts from old to new; and
		  • Owners who exit the partnership may incur costs pertaining to the termination of the equipment contracts.

16. Other transition costs	• As above	• As above

HoTs	Initial Considerations	Agreed Approach
17. Capital investment	• Considerations will be related to the Scheme of Delegation. Arrangement for investment and provision of capital, to include: – Funding obligations; – Approach to approval of investments; – Limits above which Owner Trust Board approval will be required; – Arrangements for Owners who are unable to afford the required investment; and – Ownership of new assets if the entity is a hosted arms length organisation (i.e.. still within the public sector).	• Owner Trusts to have equal investment obligations (proportionate to ownership shares). • As the entity is hosted by a Trust then all existing capital assets acquired will be owned by the acquiring Trust (Host) and in accounting terms will be consolidated between the Owner Trusts according to the shareholding. • Any capital investment, above an agreed value, will require approval from the Owners. • Investment contributions can be made in a mutually agreed form (e.g. loan with a fixed tenor, coupon and repayment period which will be the first call on operating profits before any dividend payment). • If any Owner is unable to meet its investment obligation then the other Owners will have the first right to step in and take up that investment obligation (they will probably need an adjustment to be made to shareholding to reflect the revised concentration of loss and reward) or alternative may be a loan to the new entity with agreed as fixed terms.
18. Transfer of assets	• Consideration to the treatment of currently owned assets and whether these would transfer to the partnership (BCPS) and therefore the host Trust	• All assets (equipment) that impact directly on the delivery of the pathology service will transfer to the Host at a nominal cost to be agreed with the Trust. This can then be taken into account on the share calculation methodology. • Alternatively assets can remain in the ownership of the Trust and depreciation charges consolidated as part of the cost base for BCPS • New assets and contracts will be entered into by the Host on behalf of the other Trusts.
19. Exclusivity	• Initial considerations on the exclusivity clause with partner Trusts	• Partner Trusts should enter into an exclusive pathology contact with the for a minimum of a [10] year contract. • Partner Trusts would not buy pathology services from other Trusts unless the service required is not available • New pathology contracts with new customers, national screening programmes, private sector organisations, etc. will be entered into by BCPS on behalf of all the Trusts • Entering into new contracts would require BCPS Strategic Board approval and full assement on the income and expenditure account.

4.5 Relationship with customers

This section highlights BCPS' proposed relationship with customers to secure services and revenue to the new organisation. The commercial terms for the relationship between BCPS and potential customers will be largely determined by the extent of their exclusivity and the longevity of the contract period.

HoTs	Initial Considerations	Agreed Approach
20. Customer Contracts	• Supply of services to Owner Trusts to be monitored by the Contract Management Group • Considerations include: – Methodology on how to agree on Key Performance Indicators (KPIs) in relation to internal customers (Trusts) and External (GPs and other organisations); and – Charging on commercial basis of services which could be in sourced	• As part of the preferred operating model a comprehensive set of KPIs should be set in accordance with all customer requirements and which will form part of the Trust SLAs • Charging methodologies could be: • a cost per test basis (but will need to have a demand management with customers). • Cost base contribution basis • Methodology for charging to be agreed by all Trusts
21. Customer Terms	• Initial considerations will be how to determine and define a customer. Considerations include: – Level of acceptable risk and rewards to customer; – Terms of commitment of contract with the entity (the earlier the commitment the potential greater the reward); and – Longer commitment or sharing of risk will lead to better pricing.	• Risks and rewards to be determined by the extent of the customers exclusivity and the longevity of the contract period (and whether they have contributed to any of the transitional costs). • Presume the contract will be for both on site and off site (send away) services. • Will customers provide Owners with a minimum activity guarantee for a period of time? • Negotiated levels of performance to be agreed with BCPS. • Need to determine whether reward be expressed as a "customer" discount or a share of potential future profits.

HoTs	Initial Considerations	Agreed Approach
22. Acceptance of a new Customer	• Initial considerations on the process to allocate costs to new customers. Such as: – Transition; – TUPE; – Staff changes; – Additional logistics; and – Additional IM&T and assets.	• TUPE to apply to the customer's pathology staff. • BCPS will incur additional employee liabilities. • Any staff change costs incurred as a result can either be: – Met by a new customer; and – Paid by the Owners and recovered over the contract period from the customer. • New customers coming into the new organisation will need to cover the following incremental costs (as an additional levy to their agreed test prices): – Logistics; – IT ; and – Transition.

4.6 Organisational Form, Staffing and Corporate Services

This section highlights the legal framework which will allow the delivery of the organisational model and Heads of Terms for the new organisation.

HoTs	Initial Considerations	Agreed Approach
23. Organisational form	Initial considerations on the features of the model which best fits the collaborative principles agreed by the Trust partners.	• ***Arms Length Organisation (ALO):*** this is a model that would allow non Foundation Trusts to have direct ownership of the organisation. The BCPS Pathology organisation would be set up as an ALO hosted by one of the Trusts. It would operate under a quasi autonomous regime with its own Management Board with reporting requirements to the Owners Trusts. These reporting requirements would be defined by an approved Scheme of Delegation that would be part of a contractual Joint Venture Agreement between the parties. The contract under this model can be set up in a way that would allow for the creation of new legal entity once all Owner Trusts become Foundation Trusts. NHS Trusts who are party to a Joint Venture or partnership agreement would fall under section 9 of the NHS Act and would not be legally enforceable in common law although would be enforceable under the NHS resolutions regime. An NHS Foundation Trust who is party to a NHS Joint Venture or partnership agreement can enforce its legal rights against an NHS Trust and an NHS Foundation Trust under common law. • ***Private Joint Venture:*** this model would see the creation of a separate standalone legal entity with its own Management Board. The rights of the Owners Trusts would be limited to those of share holders and as defined on the Joint Venture Agreement. Only Foundation Trusts can have direct share ownership in such a new entity, however legal advice should be sought as to whether a Foundation Trust could "hold" the share of a NHS Trust (via legal agreement) until that NHS Trust became a Foundation Trust. Such Joint Venture Agreement is enforceable under common law • ***Having considered the implications above, it is recommended that given the mix of Trusts and Foundation Trusts an Arms Length Organisation is considered which is hosted by one of the four partners.***

HoTs	Initial Considerations	Agreed Approach
24. Staff transfer and recruitment	• Initial consideration to agree approach for appointing staff to a new organisation. Such as: – Staff to remain employed by own Trust or transferred to new entity; – Approach to timing of transition of staff transfers; and – Staff TUPE transfer consultation period, including consultants. – Treatment of new recruits into BCPS	• During transition period each Trust continues to employ its own pathology staff until immediately after the new organisation becomes fully operational, with arrangements being agreed to allocate responsibility between the Trusts for matters such as: – Employment of "cross cutting" staff; – Consultation; – Interim and transitional management; – Agreement of third party contracts; – Capital expenditure; and – This reflects that until the new Hub opens it will be a largely "as is" operating model. • All pathology staff will be employed and managed by the BCPS once steady state commences. Consultant staff will transfer to the new entity to achieve the benefits of collaboration and integration. Where consultant staff have non clinical Pas these will be subject to either dual contracts of employment or SLAs with the organisation that requires the consultant support (research organisations, training institutions, etc). • During the transition period, consultant staff will remain employed by current Trusts while any new staff will be recruited under the new entity. • All staff will remain part of the NHS and in the NHS pension scheme. • All new recruits will be recruited by the Host on behalf of the Trusts with the liabilities accounted for as part of the annual budget setting and approvals process.
25. Corporate services	• Initial considerations on the corporate support needs of the new entity. Such as: – Services which should be provided by SLAs; and – Approach to recharging services.	• Owners to decide which corporate services will be provided by the entity and/or Owners Trusts. • How will on site and off site support services be provided. • Calculation of recharges by each Trust for the provision of services to enable the operation of a pathology laboratory (Hub or ESL from each site)
26. Accounting principles	• Initial considerations for the responsibility for producing trading accounts and then regularity. Such as: – Approval for accounts, budgets and forecasts financial and performance reporting. • Trusts to understand how their commitments to the entity should be consolidated.	• BCPS to produce trading accounts and financial support during transition period and steady state. • The format of the financial (and wider management) reporting to be agreed by and approved by the Owners (and capture in any future Partnership Agreement). • Accounts to be consolidated by the Host and reported to all Trusts through the BCPS Strategic Board. • As a minimum, each Trust should receive on annual basis the expected net cost of pathology to the Trust.

HoTs	Initial Considerations	Agreed Approach
27. Assets (Equipment and IM&T)	• Initial considerations on the treatment of assets, including equipment and IM&T for new organisation. Trusts should discuss: – Assets to be committed by each Trust to use by the entity; – Value and remaining life of those assets; – Party to be responsible for the replacement of obsolete assets; – Use of Managed Equipment service contracts;	• The management team of the new entity will be responsible for the management of the equipment. • Investment in equipment to be identified on the annual BCPS business plan and approved by Owner Trusts.
	– Current situation at each Trust in terms of MES; – Other contracts, leases and rentals; – Approach to determining IM&T requirements;	• During the transitional period each Owner will retain any existing MES contracts but will explore the possibility of adding the other Owners as an additional party to extend MES contracts to encompass the other Trust's equipment.
	– Investment principles for IM&T; and – Management of IM&T external contracts and maintenance.	• IM&T requirements to be determined by entity and form part of transitions/implementation plan. Responsibility for contracts and maintenance to be delegated to BCPS and host Trust.
28. Intellectual Property	• Considerations on dealing with IP during the life of the Partnership Agreement	• Any IP currently in possession of any of the Partner Trusts will remain property of the partner Trust • Any IP that is developed as part of the research and development activities of BCPS will be owned by all the Trusts. • Exploitation of new IP will be part of the responsibility of the BCPS Executive Management team and the benefits will be shared across all Trusts proportionally in accordance with their ownership shares. • At the end of the 10 year term the IP will remain property of the BCPS Trusts. Should one Trust leave the partnership it would lose the right to use the IP. Should the partnership cease to exist all together then the rights to exploit the IP will be given equally to all the partner Trusts.

Heads of Terms	NHS Arms Length Organisation	Private Joint Venture
Tax	• Normal NHS rules apply	• Capital allowances may be available. • Gift Aid can provide Owner Trusts with an opportunity to receive a tax exemption by allocating all profits (100%) to other Trusts as a charitable investment (a review needs to be conducted to understand if this is a possibility due to changing policy).
VAT	• VAT position will depend on the legal status of the arms length organisation (ALO) (i.e.. whether it has a similar VAT status to NHS Trusts or whether its legal status means that it falls to be treated under the normal VAT rules).	• Establishment of private entity will be subject to normal VAT rules. • JV would need to become registered for VAT in order to charge and account for VAT and to be able to recover any VAT on its related costs. • Trusts that make any supplies into the JV (e.g. Supplies of staff, IT, other facilities), they are likely to be required to charge and account for VAT on such supplies. • Future disposals of interest/exit by Owner Trusts can incur VAT costs (e.g. whether an exempt sale of shares) as well as in relation to any transfer of assets and/or property. • If the Owner Trusts receive any payments as a result of their interest in the JV (e.g. as a profit share/dividend) then the VAT accounting treatment will need further consideration.

Management Case

5

Management Case

5.1 Deliverability

There are a number of consolidated hubs in the UK that have managed to successfully implement a hub and spoke model. As an example, Pathology First, Southwest Pathology, Southwest London Pathology, Frimley Park and HSL are a few examples. In fact, there is expertise within BCPS in the consolidation and transfer of services albeit at a smaller scale (cytology service).

The key features learned from the successful consolidation and the lessons from those that have not been successful (TPP, Kent, Sussex, Solent) are:

- Ability to agree equitable and fair commercial arrangements;
- Clinically led service;
- Implementation of common IT systems;
- Implementation of common equipment platform;
- Refurbishment of facilities/adequate laboratory space;
- Investment in clinical engagement; and
- Investment in staff engagement and support.

5.1.1 Transition programme

To achieve the above a number of steps need to be implemented during the transition to achieve the steady state. These steps will involve:

- The establishment of governance structures
- Appointment of key transition and management personnel;
- Detailed operations modelling and site design;
- Staff and clinical engagement programme;
- Developing of funding and access to capital;
- Procurement of IT and equipment;
- Procurement and building of extension;
- Consolidation of activity to achieve early savings; and
- Transfer of staff.

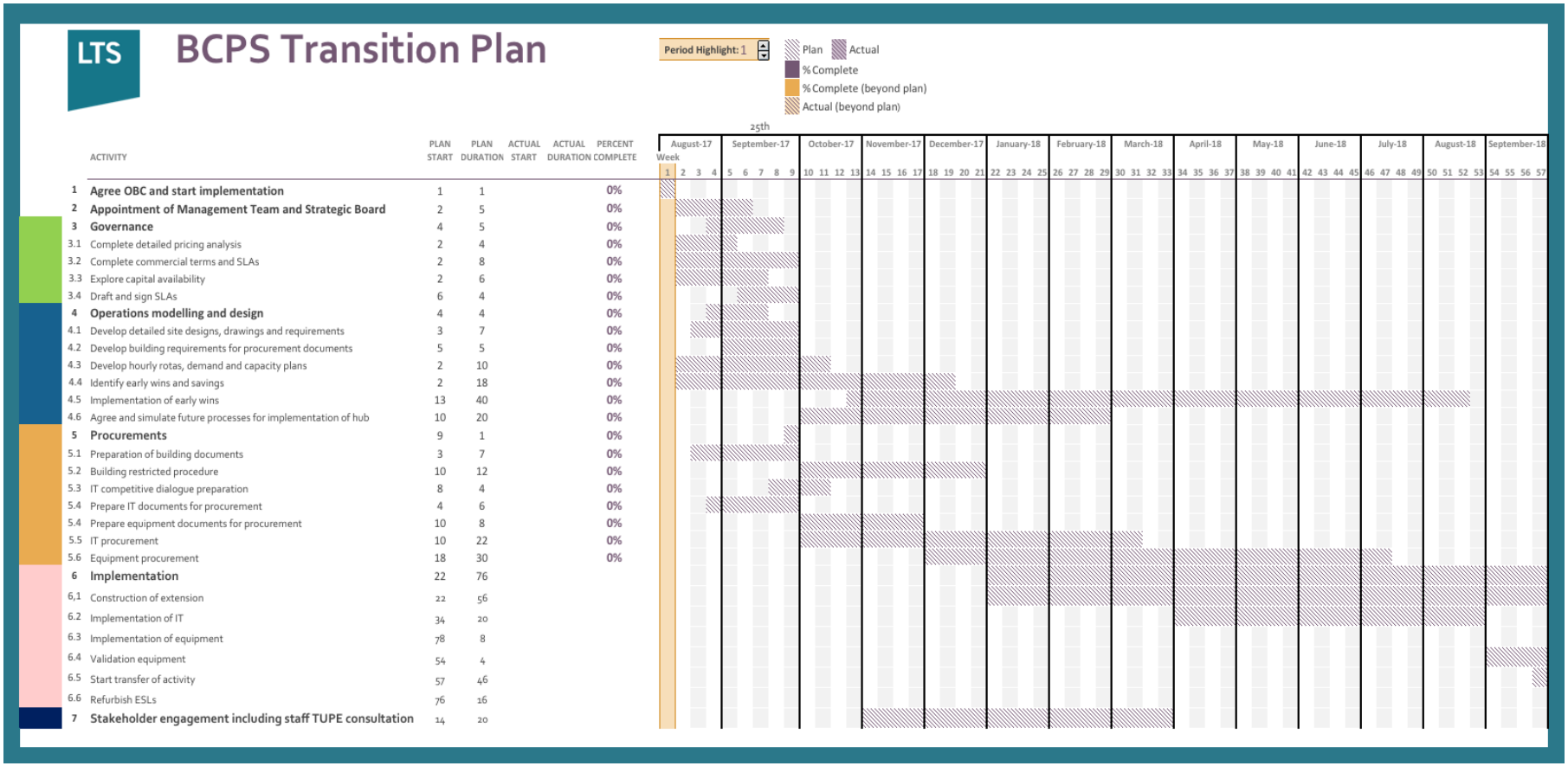
Should the Trust boards approve the OBC during July 2017 it is then expected that the implementation can start in August with the finalisation of the SLAs and agreement between the parties. At the same time, during August and September, there would be preparations for the procurements required, with expectations that the hub works can commence in second quarter of 2018. It is expected that steady state will be achieved in the first half of 2019.

5.1.2 Procurements

It is expected that three procurements will be required:

- Hub extension building works: OJEU with restricted procedure expected to start in October and finish in December 2017.
- IT Infrastructure: OJEU competitive dialogue with only one phase of dialogue. Common IT platforms and system to manage the laboratory and flow of information. Expected to start in October and finish in March 2018.
- Equipment: OJEU competitive dialogue with only one phase of dialogue Procurement to start in December 2017 and finish in July 2018. This is likely to be run as separate procurements for each pathology discipline to be able to align services and contracts across all the Trusts.

Management Case – Transition Programme



	ACTIVITY	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
1	**Agree OBC and start implementation**	1	1			0%
2	**Appointment of Management Team and Strategic Board**	2	5			0%
3	**Governance**	4	5			0%
3.1	Complete detailed pricing analysis	2	4			0%
3.2	Complete commercial terms and SLAs	2	8			0%
3.3	Explore capital availability	2	6			0%
3.4	Draft and sign SLAs	6	4			0%
4	**Operations modelling and design**	4	4			0%
4.1	Develop detailed site designs, drawings and requirements	3	7			0%
4.2	Develop building requirements for procurement documents	5	5			0%
4.3	Develop hourly rotas, demand and capacity plans	2	10			0%
4.4	Identify early wins and savings	2	18			0%
4.5	Implementation of early wins	13	40			0%
4.6	Agree and simulate future processes for implementation of hub	10	20			0%
5	**Procurements**	9	1			0%
5.1	Preparation of building documents	3	7			0%
5.2	Building restricted procedure	10	12			0%
5.3	IT competitive dialogue preparation	8	4			0%
5.4	Prepare IT documents for procurement	4	6			0%
5.4	Prepare equipment documents for procurement	10	8			0%
5.5	IT procurement	10	22			0%
5.6	Equipment procurement	18	30			0%
6	**Implementation**	22	76			
6,1	Construction of extension	22	56			
6.2	Implementation of IT	34	20			
6.3	Implementation of equipment	78	8			
6.4	Validation equipment	54	4			
6.5	Start transfer of activity	57	46			
6.6	Refurbish ESLs	76	16			
7	**Stakeholder engagement including staff TUPE consultation**	14	20			

- It is expected that transition planning will commence in August 2017.
- Construction of the Hub extension would commence in January 2018 and last a period of 12 months including equipment installation and validation.
- Implementation of IT and Equipment would start in the second half of 2018 and completed once the Hub extension is completed. Equipment validations for accreditation may continue into early 2019 if not fully completed by December 2018.
- **Hub extension to be completed by December 2018. Current Hub to start delivery of routine services during 2018 with hub being fully operational towards the end of 2018. Detailed contingency and business continuity plans being developed as part of gateway 1**

Management Case

5.2 Project transition resources

The implementation of the transition activities will be carried out by a dedicated team under the above management structure and direct supervision by the BCPS Transition Team. It is expected that the resources required for the project from each Trust would be as follows (these are costs already included in the transition investment):

- Appointment of the BCPS Executive Management Team (2 posts);
- Financial: 1 person from the finance department to dedicate 1 day a week for three weeks to capture and validate data;
- Hub and ESL Layout design: Architect and consulting support;
- Operational process design: creation of operational processes and homogenization of processes across sites;
- Completion of of key SLAs and agreement: access to senior Trust staff and BCPS Transition Management team. Additional consulting and legal support.
- Development of IT and equipment plans, including support for potential procurements;
- Development of HR plans and engagement including support to HR departments: HR departments to allocate personnel to consultation process and analysis (1 or 2 people full time in total). Support for HR analysis and engagement;
- Total transition external support costs were included within the financial models.

5.3 Project phases

The project will involve a number of sequential and concurrent phases for the implementation of the Hub and ESL model. The following phases are expected to be part of the core programme and have dedicated management resources for implementation:

1 – Appointment of Executive Management Team and selection of BCPS Strategic Board members;

2 – Gateway 1 (FBC): set up to transition plan by October 2017 with detailed HR plan, detailed finance plan and construction plan (FBC);

3 – Gateway 1 (FBC): Completion of commercial agreement and finances, including clarification on route to access capital (FBC);

4 – Gateway 2: Design of Hub and ESL layouts for construction and refurbishment, including detail quotes from builders;

5 – Gateway 3: Operational processes design: design of detailed operating processes for the Hub and the ESLs;

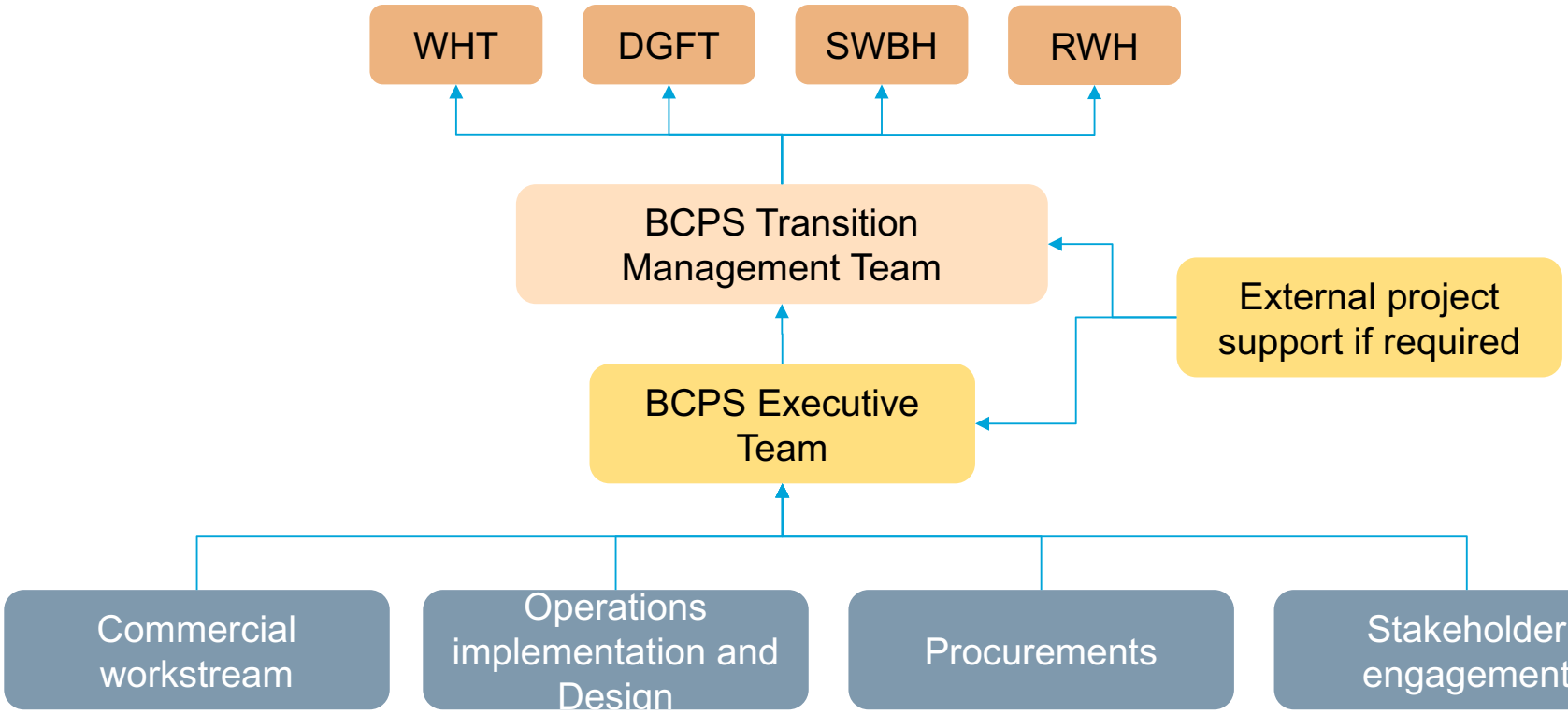
6 – Gateway 4: Procurements: Development of procurement documentation and running of procurement processes, including detailed procurement costs;

7 – Implementation of IT and Equipment;

8 –Validation of equipment, IT and transfer of services across sites: this would also include early transfer of activity where possible to achieve quick wins;

9 – Project implementation review and steady state: review of project implementation and official start of steady state.

Management Case – Transition Plan Management



- Agree governance
- Agree SLAs and KPIs
- Agree detailed pricing shareholding analysis
- Agree procurements and procurement requirements
- Identify funding

- Design facility layouts
- Design processes for Hub and ESLs
- Agree rotas and shift patterns
- Identify early wins and savings
- Develop technical requirements for procurements
- Implementation of changes

- Collect procurement information
- Equipment requirements
- Facility layouts
- IT requirements
- Manage procurement processes and negotiations

- Clinical engagement
- Technical laboratory staff engagement
- TUPE consultations
- Service user engagement
- Commissioner engagement

Management Case

5.4 Key project risks

The following table provides a summary of the key risks identified for the next stage of the project. A risk and issues register will be developed for the next phase and updated regularly for review by the BCP Steering Committee

	Description of risk(s)	Impact description	Mitigation / controls in place
1	The principles of a consolidated operating model based on arms' length governance and effective commercial partnerships are not accepted and the collaboration model continues	Lack of credibility for effective market engagement results in deferral of investments in transition, IT, equipment and logistics Staff lose confidence that genuine transformation will be delivered	OBC based on strong evidence and engagement Effective senior engagement to ensure design and delivery of governance and commercial partnerships are successful
2	Resources are not mobilised to support the workstreams and development of the TOM and associated governance and commercial arrangements. Transformation is not ring-fenced from the management of current day to day operations	Development of the TOM is high level and not bottom-up, losing credibility with technical and clinical staff Commercial agreements cannot be reached as a result of lack of key senior staff engagement	Resources identified within the Management Case. Next phase can commence immediately on approval of the OBC. Trusts to commit and nominate resources
4	Risks of legacy equipment and IT systems at each Trust aren't mitigated. Pathology and IT staff aren't engaged to review impact of current IT and equipment contracts	Loss of pathology IT service and consequent impact on hospital and GP patient services Quality and efficiency of current service compromised	Need to develop a clear understanding of current IT and equipment contracts and developed a detailed transition plan highlighting how these will be adapted to the new TOM requirements over time
5	Staff are not supportive or engaged in change	The design and implementation of the new TOM is delayed and/or compromised	Wide range of staff were engaged in the development of the target operating model Organisational Development resource to support next phase Clear and open communication with staff
6	Timeline to December 2018 is not achieved	Delay on having all services operating at the Hub by December 2018 which might impact Midlands Met hospital development	Move at pace now to commission building work and achieve timelines BCP to develop detailed contingency plan for affected services by October 2017, explore use of current facilities to accommodate specialist services and ensure business continuity

Management Case

5.5 HR Management

Management of the staffing, both in terms of legal requirements of consultation, but also in terms of staffing communication will be key. The steering group have regularly discussed staff communication, and some articles to date have been agreed and released.

In terms of the statutory requirements relating to TUPE, the HR teams have started conversations to understand and agree the route forward. This includes the collection of all policies from the Trusts around changes to staff conditions, so that a master list can be collected for formulating the consultation process.

In addition, the HR lead for Sandwell and West Birmingham has proposed the following in terms of staff support going forward, and the ongoing management of this. This is an example of the plan that all HR leads of the Trusts will be working together for Gateway review 1.

Support Programme for Pathology staff in response to proposal for 1 hub model Staff Group	Issues	Support
Medical Staff		1:1 Coaching Dealing with Change Workshop
Healthcare Scientists		1:1 Coaching Dealing with Change Workshop Team meetings to discuss developments and address concerns Access to HR support via monthly clinic
Additional Clinical Services		Dealing with Change Workshop Team meetings to discuss developments and address concerns Access to HR support via monthly clinic
Nursing		Dealing with Change Workshop Team meetings to discuss developments and address concerns Access to HR support via monthly clinic
Admin and Clerical		Dealing with Change Workshop Team meetings to discuss developments and address concerns Access to HR support via monthly clinic

Appendices

Financial Modelling Assumptions

A.1

Reserved Matters will be categorised by those which need:

- Unanimous voting: all Owner Trusts will need to be in agreement; and
- Majority voting: by a mechanism agreed by the Owners.

Unanimous vote (all Owners)	Majority voting
Admitting a new Owner into the new entity	Formally adopting the annual Business Plan for the new entity in respect of each Financial Year [Unanimous voting will be needed for the first 3 years of operation]
Altering the name of the new entity	Participating in any partnership or joint venture (whether incorporated or not)
Amending the Partnership Agreement or the Support Services Agreements	Entering into any contract or arrangement that is not on an arm's length basis or which is outside the ordinary course of business [Unanimous voting will be needed for the first 3 years of operation]
Allowing the new entity to cease (or propose to cease) to carry on its business	Dismissing any director or senior employee [in circumstances in which the new entity incurs or agrees to bear redundancy or other costs in excess of £[ ] in total]
Materially amending the Business Plan, or taking any actions which either (a) are not in accordance with the Business Plan, and/or (b) will cause the Partnership to [materially] depart from the annual budget included within the Business Plan	Making any material changes to the new entity's "Investment Guidance" policy [it is assumed the JV will be required to adopt an Investment Guidance policy which is consistent with the Founders Trusts' own equivalent policies and that any material changes to this policy would require the approval of the Founders Trusts]
Acquiring the whole (or part) of any business (more than a certain value e.g. £[1]m pa) or undertaking of any other person	Change in the pricing policy will occur if prices need to be adjusted by inflation. [Unanimous voting will be needed if the price is to be set above inflation]

Reserved Matters will be categorised by those which need:

- Unanimous voting: all Owner Trusts will need to be in agreement; and
- Majority voting: by a mechanism agreed by the Owners.

Unanimous vote (all Owners)	Majority voting
Admitting a new Owner into the new entity	Formally adopting the annual Business Plan for the new entity in respect of each Financial Year [Unanimous voting will be needed for the first 3 years of operation]
Altering the name of the new entity	Participating in any partnership or joint venture (whether incorporated or not)
Amending the Partnership Agreement or the Support Services Agreements	Entering into any contract or arrangement that is not on an arm's length basis or which is outside the ordinary course of business [Unanimous voting will be needed for the first 3 years of operation]
Allowing the new entity to cease (or propose to cease) to carry on its business	Dismissing any director or senior employee [in circumstances in which the new entity incurs or agrees to bear redundancy or other costs in excess of £[ ] in total]
Materially amending the Business Plan, or taking any actions which either (a) are not in accordance with the Business Plan, and/or (b) will cause the Partnership to [materially] depart from the annual budget included within the Business Plan	Making any material changes to the new entity's "Investment Guidance" policy [it is assumed the JV will be required to adopt an Investment Guidance policy which is consistent with the Founders Trusts' own equivalent policies and that any material changes to this policy would require the approval of the Founders Trusts]
Acquiring the whole (or part) of any business (more than a certain value e.g. £[1]m pa) or undertaking of any other person	Change in the pricing policy will occur if prices need to be adjusted by inflation. [Unanimous voting will be needed if the price is to be set above inflation]

Unanimous vote (all Owners)	Majority voting
Changing the nature of the Partnership's business or commencing any new business which is not ancillary or incidental to the existing business. [NB The entities business can be defined in the Joint Venture Agreement, for example: "the provision of pathology services and activities which are ancillary or incidental thereto"]	Creating or granting any Encumbrance over the whole or any part of the business, undertaking or assets of the new entity
[incurring any indebtedness or borrowings with the Owners except in accordance with the Annual Business Plan]	Making or proposing to make any material changes to the terms of employment of any employee or group of employees of the new entity which either (i) does not comply with applicable NHS policies and guidelines (e.g. Agenda for Change) or (ii) will result in the new entity exceeding its agreed staff costs budget as set out in the annual budget included within the Business Plan
[selling any significant asset or group of similar assets except in accordance with the Business Plan]	Entering into any leases or other forms of long term commitment which are material in the context of the new entity's business [except in accordance with the Business Plan]
[incurring any capital expenditure on any one item, or series of related items, which either (i) exceeds the host Trust's delegated capital expenditure cap or (ii) is not in accordance with the Business Plan and the new entity "Investment Guidance"] policy	Giving notice of termination of any arrangements, contracts or transactions which are material in the context of the new entity's business, or materially varying any such arrangements, contracts or transactions [except in accordance with the Business Plan]

Unanimous vote (all Owners)	Majority voting
Appointing or dismissing the [Chair and Managing Director of the Joint Venture], or [materially] varying the terms of employment or engagement of any such person	Instituting, settling or compromising any material legal proceedings (other than debt recovery proceedings in the ordinary course of business) instituted or threatened against the new entity or submitting to arbitration or alternative dispute resolution any dispute involving the new entity [Voting will be dependent on the legal structure. If there is any shareholding liability unanimous voting will be needed]
Disposing of the whole (or part) of the business (more than a certain value e.g. £1m pa) of the Partnership to any person	Independent assurances over financial reporting and or/ appointment of auditors
Distributing any [trading profits / surpluses] to the parent Trusts except in accordance with the agreed distribution policy set out in Partnership Agreement, or making any change to the agreed distribution policy	Working Capital Investment Limits [limits are [£X]]
	Granting any rights (by licence or otherwise) in or over any intellectual property owned or used by the new entity [scale of intellectual property is needed [£X]]
Definition of Materiality Levels	
If liability/requirement has a value of 0-3% of new entity's revenues then it will be considered non-material and the decision will rest with the Management Board	
If liability/requirement has a value of greater than 3-9% then it will be a reserved matter requiring majority voting	
If liability/requirement has a value of greater than 9% then unanimous voting will be required	

ESL Description

A.2

ESL detailed draft description

1. Biochemistry

Equipment required:

Main chemistry and immunoassay analysers

Osmometer

Blood POCT Blood gas analysers

Blood glucose/ketone meters

Tests:

Alanine Transaminase (ALT)

Albumin

Alkaline Phosphatase

[Ammonia - ideally if paediatric inpatients]

Amylase

Bilirubin (total and conjugated)

Bicarbonate

Calcium

[Chloride]

[Cortisol]

C-Reactive Protein

Creatine Kinase (CK)

Creatine Kinase (CK)

Creatinine

Digoxin

[Ethanol/Alcohol]

Gentamicin

Glucose [fluoride oxalate plasma]

Human Chorionic Gonadotrophin

Lactate Dehydrogenase (LDH)

Lithium

Magnesium

Osmolality – serum

Paracetamol

Phosphate

Salicylate

Theophylline

Total Protein

Troponin (I/T)

[Thyroid Function (free T4 & TSH)]

Urate

Urea

Desirable as high volume tests

Haematinics: Ferritin, Folate, Vitamin B12

Lipids: Cholesterol (total/HDL), Triglycerides

Carboxyhaemoglobin

Lactate

Cerebrospinal fluid (CSF)

Glucose, Total Protein

Urine

Sodium

Potassium

Urea

Creatinine

Osmolality – urine

2. Immunology services would not be required at the ESL.

3. Haematology/Blood Transfusion

FBC

Retics

PT

APTT

FIB

DD

Malaria Screen

Sickle Screen

G-6-P-D

ESR

G+S

X-match

Full provision of blood products

Kleihauer

DAT

4. Central specimen reception (small) for work sent to Hub

ESL detailed draft description

5. On-site clinics

Lipid clinics

Clinical haematology

Anticoagulation clinics

Lactose/glucose tolerance tests

Short synacthen tests

Skin prick test service

6. Other visits

Visits to support teaching & grand rounds at WHT

Visits to support service, Quality, UKAS, POCT.

Visits to support Research (ISBOS)

7. Microbiology

Blood culture analyser, plus gram and setting up sensitivities

Film array (poct to be located either in ae or bloodsciences.

8. **Frozen section facilities**

Consider Cryostat/staining facilities with ability for scanned images to be sent to Hub lab

Cryostat/staining facilities/microscope in ESL. Hub sending BMS/Path to ESL for test

Dr Deshpande raised issue of mdt's- not for an ESL

Financial data collection and excluded areas

A.3

Financial data collection and excluded areas

A financial data collection as undertaken with financial representative of the pathology departments. This financial data collection included cost, staffing, and income.

Following discussion with these individuals, the below areas were excluded from the financial data collection:

- Junior Doctors
- Phlebotomy
- Mortuary
- PoCT
- Externally funded regional trainees
- Cost of GP tubes (where a pass-through cost).

BCPS Consolidation of Services

A.4

BCPS previous experience in the consolidation of services

Background

In November 2012, The Royal Wolverhampton NHS Trust was asked to provide Black Country Single-site Gynae Cytology services from June 2013.

Cytology laboratories affected:

The Royal Wolverhampton Hospital Trust (RWT)

Walsall Healthcare NHS Trust (WHT)

The Dudley Group NHS Foundation Trust (DGFT)

Sandwell and City Hospitals NHS Trust (SCHT)

Project Structure & Reporting

An Integration Board chaired by the Director of Planning and Contracting was established, and comprised of senior decision-makers representing each organisation. Board members were charged with reporting back into existing structures within their own organisation ensuring that each organisation was engaged in the process and that local Policies and legal legislation were adhered to.

The Board was supported by various work streams covering all aspects of the new service with high level representation from the screening programme, commissioners and all Trusts including staff side representatives and unions.

A Project Manager was appointed to keep the project on track, control risks and to ensure good communication links between the work streams and the Board were maintained.

Transferring staff were kept well informed by regular feedback and in order to smooth the transition of staff into the new service a member of the RWT Human Resources Department and laboratory regularly attended each hospital to address concerns and complete the documentation required for pre-employment checks and payroll.

Post merger

Operational functioning

The service benefitted from the number of senior staff transferring into the new service this enabled the formation of smaller teams drawn from across the four organisations.

Each team included a member of RWT staff – ensuring that staff had immediate access to an experienced person from the for guidance on protocols, reporting codes, IT, workflows and the day to day working of the laboratory.

Access to, and liaison with, senior staff ensured that everyone had a named person to provide support and, from a management perspective, enabled close supervision during the transition phase.

The Cytology Manager operated an ‘open door’ policy to support staff on a range of aspects from travel, sickness policies, annual leave entitlements and work

BCPS previous experience in the consolidation of services

Access to, and liaison with, senior staff ensured that everyone had a named person to provide support and, from a management perspective, enabled close supervision during the transition phase.

The Cytology Manager operated an ‘open door’ policy to support staff on a range of aspects from travel, sickness policies, annual leave entitlements and work practices.

Senior staff were allocated areas of responsibility based on their roles at their former laboratories and they were tasked with ensuring day to day management of workflow.

As expected there was an initial minimal drop in KPI’s for the first 6 months mostly due to the requirement to honour existing staff leave commitments. This compares favourably with other cytology integrations where KPI’s generally fall off for around 2 years. KPI’s quickly recovered and the laboratory has since been able to support other organisations with their activity.

Challenges

TUPE regulations dictated that communications with affected staff should happen via their Trade Union Representatives, practically, this led to some staff feeling that the host trust were avoiding issues and being secretive. In order to allay this concern a Monthly Project Update was issued after each Integration Board; this was cascaded via board members to relevant staff. The lab held several open days for staff to have the opportunity to visit the department and ask questions.

For the host trust, uncertainty (due to TUPE regulations) around the number of staff transferring to the service until two weeks before ‘go-live’ meant that there was a potential to over provide accommodation.

There were no pre-existing IT interfaces between each of the four organisations; the development of which enabled the host to access patient histories and suggest appropriate patient management according to NHSCSP guidance.

Where are we now?

There was an expected minimal dip in meeting Turnaround Times during the first 6 months following integration due to the requirement to honour pre-existing annual leave bookings. Since this period RWT cytology has continually been in the top 10% of areas in the National performance tables (consistently achieving the 14 day TAT) and has achieved good results in CPA, UKAS and local QA visits. No patient result or management of was adversely affected.

Summary

By adopting a structured approach to the integration, and employing dedicated project management support, the move to a single-site Black Country Gynae Cytology service was achieved with no down-time, no staff turnover, minimal short term increase in turnaround times, (achieving commissioners’ targets by December 2013) and with no reduction in the quality of the service provided.

Positive feedback has been received from numerous GP practices and local colposcopy units - we have exceeded their expectations and allayed their concerns.

Quality and Performance Standards

A.5

Current Quality standards and KPIs

The following is a summary of the KPIs currently recorded by Trust. Full files are available with a full disclosure of KPIs at test level and discipline level.

June 2017

May Data - rolling 12 month

Directorates	Head Count	CPA	TOTAL KPI TATs %	Mandatory Training %*	PDR %	Sickness\ Absence %	Overall status (1-9)
BIOCHEMISTRY DEPARTMENT	(123)		83 ↑	90 ↑	92 ↑	5 ↑	8 ↑
HAEMATOLOGY DEPARTMENT	(56)		89 ↓	89 ↓	98 ↓	3 ↑	6 ↓
HISTOPATHOLOGY	(35)		74 ↓	93 ↓	91 ↓	4 ↑	7 ↔
IMMUNOLOGY DEPARTMENT	(26)		96 ↓	99 ↓	92 ↓	3 ↓	4 ↔
MICROBIOLOGY	(60)		86 ↓	91 ↑	92 ↑	3 ↑	6
GROUP MANAGEMENT/GENERAL	(7)			94 ↑	86 ↓	4 ↑	7
PHLEBOTOMY	(47)			86 ↑	94 ↓	in group ↑	7

↑ Improving ↔ No change ↓declining

Pathology KPIs	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17
AE Turnaround Targets(%)	90	90	91	92	92	92
Request Intervention Req	2100	2621	2506	2297	2560	2969
Never Events(Blood Trans, Mortuary)	0	0	0	0	0	0
MEDIAN GP courier transport Turnaround(mins)	240	222	241	250	237	258
Potassium affect(%)		6.4	5.4	5.9	5.5	4.5
6 week Waits (all test\investigations)	0	29	23	20	42	44

Discipline	Test Name	Location	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Chemistry	Albumin	ED	97%	97%	96%	91%	94%
Chemistry	Alkaline Phosphatase	ED	96%	96%	96%	90%	92%
Chemistry	ALT	ED	95%	96%	96%	92%	93%
Chemistry	Calcium	ED	95%	96%	96%	85%	92%
Chemistry	Creatinine	ED	96%	96%	95%	92%	92%
Chemistry	Potassium	ED	96%	97%	96%	93%	93%
Chemistry	Sodium	ED	96%	97%	96%	93%	93%
Chemistry	Total Bilirubin	ED	96%	96%	96%	92%	93%
Chemistry	Total Protein	ED	96%	96%	96%	92%	93%
Chemistry	Troponin I	ED	90%	86%	89%	76%	88%
Chemistry	Urea	ED	96%	96%	96%	92%	93%
Haematology	Full Blood Count	ED	95%	97%	96%	96%	95%
Haematology	D-Dimers	ED	84%	82%	83%	69%	78%

Clinical Support Services -PATHOLOGY		Baseline ()	Traj.	Quarter One (April-June)		
Governance				APRIL	MAY	JUNE
Pathology Services Group meeting		Monthly	Green Compliant,red non compliant			
Number of Formal Complaints				0	0	0
Number of Grade 4/5 Clinical Incidents				0	0	0
Number of Grade 1-3 Clinical Incidents				11	21	55
Near Misses				2	4	8
Number of SUI				0	0	0
Outstanding documents on Ipassport			Green Compliant,red non compliant			
Blood Sciences		85%			86%	56.70%
Histopathology		85%				87%
Microbiology		85%				91%
Accreditation status/Inspection bodies		Monthly	Green Compliant, amber awaiting report, red non compliant			
Blood Sciences CPA		Accredited	Accredited			
Histopathology CPA		Accredited	Accredited			
Microbiology CPA		Accredited	Accredited			
Blood Sciences UKAS ISO15189		Accredited	Accredited			
Histopathology UKAS ISO15189		Accredited	Accredited			
Microbiology UKAS ISO15189		Accredited	Accredited			
HTA license		License granted	License granted			
MHRA assessment		Current				
Turnaround Performance						
A/E (90% within 1 hour)		Target 90% within 60 Minutes. Green 90% and above, Amber 85-89%, Red below 85%				
FBC	Local target set more challenging than KPI			99	98.9	98.9
U&E				95.7	94.8	96.2
Troponin				89.3	89.6	92.4
INR				95.3	94.5	95.1
LFT				96	95.8	96.9
Inpatient	(90% within 2 hours)	Target 90% within 120 mins. Green 90%and over, Amber 85-89%, Red below 85%				
FBC				95.4	98.9	99.3
U&E				92.8	92.2	95.1
Troponin				94.7	95.6	96.9
INR				99.1	99.5	99.5
LFT				93.8	93	94.8
Histopathology						
% of all Histology reported in 7 calender days		80%	Green compliant, Red non compliant	47%	59%	55%
% of all Histology reported in 10 calender days		90%		72%	71%	74%
% of all Histology reported in 14 days		95%		86%	90%	91%
Number of cases reported after 20 days				70	43	57
Non-Gynae	80% within 7 days			88%	92%	77%
Non-Gynae	90% within 10 days			97%	96%	92%
Non-Gynae	95% within 14 days			100%		
Andrology	80% within 7 days			92%	96%	91%
Andrology	90% within 10 days			95%	96%	91%
Andrology	95% within 14 days			100%	100%	93%
No. of pregnancy remains stored for greater than 3 months		None to be stored for greater than 3 months	Green compliant, Red non compliant	0	0	0%
No. of products cremated before 1 month		None to be cremated within a month	Green compliant, Red non compliant	0%	0	0
No. of cadaver stored more than 4 weeks		None to be stored greater than 4 weeks	Green compliant, Red non compliant	1	3	3
Routine antenatal screening tests for HepB, HIV		90%	Local KPI			
Late presentation antenatal screening tests		97%				
Blood Culture contamination rates				2.88%	4.31%	3.36%
Chlamydia (molecular)		100% @10 days		100.00%	100.00%	100.00%
GC culture		100% @10 days		100.00%	100.00%	100.00%
GC (molecular)		100% @10 days		100.00%	100.00%	100.00%
Genital micros & Culture		100% @10 days		100.00%	100.00%	100.00%
Screening Programme KPI	Green KPI Met, Amber KPI parially met, Red immediate action required					
Chmalydia screening programme						
All Result Available Within 2 days				76.64%	92.95%	77.22
Positive Result Available Within 7 days				100.00%	100.00%	100%
Negative Result Available Within 7 days				100.00%	100.00%	100%
Negative Result Available Within 10 days				100.00%	100.00%	100%
Result reported as Invalid				0.33%	0.43%	0.70%
Results Reported as Equivocal				0.00%	0.00%	0.00%
Samples Not Processed (Zapped)				0.33%	0.00%	0.35%
Pathology managed aappointments						
LTT wait for appoitnment		<6 weeks is green, over 6 weeks red				
SST wait for appoitmn		<6 weeks is green, over 6 weeks red				
Skin prick test		<6 weeks is green, over 6 weeks red				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	NHSE Emergency Preparedness, Response and Recovery Core Standards
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Barlow Chief Operating Officer
AUTHOR:	Caroline Rennalls Head of Operations and Resilience
DATE OF MEETING:	3rd August 2017

EXECUTIVE SUMMARY:

The Emergency Planning, response and Recovery (EPRR) Core Standards Assurance is Annual National process lead by NHS England. The Trust is a category 1 responder under the Civil Contingency Act 2004 and as such have 4 main domains to respond to in this year's core standards as well as a portfolio of specific evidence to provide.

Each year NHSE send out the core standards with supportive guidance to the Accountable Executive Officer (AEO) in our organisation this is the Chief Operating Officer. We are expected to submit to NHSE the portfolio of documentation by 15th September 2017. The AEO provides organisational assurance with a quality check before authorisation for release.

Areas of assessment this year include:

- EPRR Core Standards
- Training and exercising
- Governance
- Duty to assess risk
- Duty to maintain plans and Business continuity
- Command and control
- Duty to community care with the public
- Information sharing/cooperation

- Governance
- HAZMAT CBRN Core Standards (decontamination)
- HAZMAT CBRN - Equipment List

We anticipate compliance at this stage across the assessment criteria. The assessment will be presented to the Trust Board in September.

REPORT RECOMMENDATION:

Note content of assessment and timeline for completeness

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

Accept	Approve the recommendation	Discuss
		x

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Safe high quality care, emergency preparedness

PREVIOUS CONSIDERATION:
Business continuity planning July Trust Board Previous annual assessments reported to Trust Board

NHSE Emergency Preparedness, Response and Recovery Core Standards

1. Introduction

The Emergency Planning, response and Recovery (EPRR) Core Standards Assurance is Annual National process lead by NHS England. Category 1 and 2 responders from Health are expected to complete a self-assessment against specified domains. SWBH has an acute Trust is a category 1 responder under the Civil Contingency Act 2004 and as such have 4 main domains to respond to this year's core standards and provide the 10 supportive documents requested.

Each year NHSE send out the core standards with supportive guidance to the Accountable Executive Officer (AEO) in our organisation this is the Chief Operating Officer. We are expected to submit to NHSE the portfolio of documentation by 15th September 2017 (appendix 1 submission cascade) The AEO provides organisational assurance with a quality check before authorisation for release.

2. Background

In 2016/17 SWBH submission was substantial improvement on the previous year's outcome standard of partial. We had no Red domains across the themes with seven ambers (see table 1). We anticipate being fully compliant, the highest standard, for 17/18 submission with the appointment of the Emergency Planning Officer and the progress made establishing the Business Continuity Management programme approach.

	Amber returns 2016/17	2017/18 position
1	Organisation has an overarching framework or policy that set out expectations for emergency preparedness	- EPPR Board sets out overarching plan - BCM programme ensures all departments have BCP and BIA - Valid MIP & BCP – review cycle in EPRR policy meeting
2	Ensure all plans are prepared in line with current guidance and current good practice	- Compliant
3	Those on call must meet identified competences and key knowledge skills	Competencies supported by training include: - On call training pack for strategic and tactical senior managers on-call designed/issued - Training on how to set up and close down an Incident Control Centre in place - How to log to the good practice standards in place

4	All incident commanders (on call directors and Managers) maintain a continuous personal development portfolio	- On call directors and managers personal folders provided core documents/ material on which they can build in any new developments - On call directors and on call managers have requested personal training to meet individual needs – training delivered - Ongoing development programme scheduled
5	HAZMAT /CBRN risk assessments in place	- 100% compliance with WMAS annual audit – following a designated work programme - Review of all PPE available on site - Walk though EDs with ED clinical/managerial team - Training programmes and standards reviewed to meet current guidance
6	Preventative programme of maintenance (PPM) - Suits - Tents - Pumps - RAM GENE (radiation monitor)	 - In date and correct - New tend purchased and staff trained in use – SGH - New inner lining, drainage and electrics in place at sandwell as part of the CBRN work programme - Maintenance standards for static Unit City and sell life extension in place. - Operational and present
7	Staff that are most likely to come into first line contact with decontaminated patients understand the requirements to isolate to stop the spread of contamination	- IOR standards located in ED reception areas - Staff have been trained with teams under the CBRN work programme

Table 1 – EPRR Amber Core standards returns of 2016/17

3. Domains and Themes

This year there are 4 domains of assessment with subthemes

- EPRR Core Standards – 52 Questions, (reflects the responsibilities of a Cat 1 responder)
  - Training and exercising
  - Governance
  - Duty to assess risk
  - Duty to maintain plans and Business continuity
  - Command and control
  - Duty to community care with the public
  - Information sharing/cooperation

- Governance - 6 Questions _ this year's deep dive section

- HAZMAT CBRN Core Standards – 13 Questions
  - Preparedness
  - Decontamination equipment
  - Training
- HAZMAT CBRN - Equipment List 27 Questions
  - Inflatable mobile structures – sandwell
  - Rigid structures
  - PPE for Chemical, biological incidence
  - Ancillary enabling factors
  - Radiation

Other supportive documents necessary for submission include

- Copy of last exercise reports
- Board reports and board minutes 2014,2015,2016, demonstrating a report on compliance has been taken to public board
- Copy of the Annual report(s) for 2014-2016 detailing over all EPRR preparedness
- Copy of risk register covering EPRR for 2014-2017
- Copy of internal Governance structure showing the EPRR governance structure (internal committee, meetings and no executive director involvement)
- Yearly work programme 2016-2017
- Forward training and exercise schedule 2017/18
- Training records for 2014-to the 31st August 2017 covering the incident management team

Summary

This year it is anticipated that we will be fully compliant with the core standards including the deep dive into governance. There is an ongoing programme of work that will strengthen the embedding of business continuity management, training and responsiveness of core clinical and non-clinical staff.

Appendix 1

Table 1- submission cascade -	**Completion Date**
Complete a self-assessment against EPRR Core Standards and have Executive/Board approval	By 15 September 2017
Participate in Local Health Resilience Partnership peer review, confirm and challenge meetings and provide NHS England local DCO teams with a local assurance picture	By 27 October 2017
NHS England Regional Office and local DCO teams participate in a peer review, confirm and challenge meeting and provide a NHS England Midlands & East assurance picture	By 27 October 2017
NHS England local DCO teams provide NHS England Regional Office with a local area consolidate assurance picture	By 31 October 2017
Regional Strategic Asset assurance reviews completed	By 31 October 2017
NHS England Regional Office provide regional assurance to Regional Executive Team	By 30 November 2017
NHS England Regional Office to submit a regional assurance summary to NHS England National EPRR team	By 31 December 2017
NHS England Regional Office to participate in national-regional peer review, confirm and challenge meetings	By 28 February 2018
NHS England Board submission	By 1 April 2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Staff Inclusion and Diversity Pledges – Progress
SPONSOR (EXECUTIVE DIRECTOR):	Raffaela Goodby – Director of Organisation Development
AUTHOR:	Raffaela Goodby – Director of Organisation Development
DATE OF MEETING:	3rd August 2017

EXECUTIVE SUMMARY:

The Trust's People Plan, theme 2, outlines a number of commitments and targets to increase the diversity of our staff population, and become more inclusive in terms of our offer to staff, including increasing the number of BME staff at Band 8a and above by 7.5% in the coming 2.5 years.

The attached report sets out the agreed 'Inclusion and Diversity Pledges' that were agreed earlier in 2017, and sets out the progress to date. It highlights where progress is lacking, e.g. on developing a robust WRES action plan and on developing a focussed approach to BME Leadership Development. These will be addressed in the coming quarter.

REPORT RECOMMENDATION:

The Trust Board note the progress to date on the 10 staff inclusion and diversity pledges
The Trust Board receive an update on the WRES action plan in November 17

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

Accept	Approve the recommendation	Discuss

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

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

Comments:

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

PREVIOUS CONSIDERATION:

Inclusion and Diversity. Proposed Pledges for 2017/18

1	**Increase recognition and knowledge of the value of inclusion within the leader and manager population** • Develop training module, using an interactive story telling approach, through e-learning platform. • Deliver one QIHD corporate learning module on Inclusion and diversity • Develop module of 'SWBH Chartered Line Manager' on inclusion and diversity • Design and deliver a managers development workshop on inclusive leadership, as part of the 2017/19 leadership development offer. • Executive team and board development on inclusion to be delivered • Develop a photo exhibition / poster campaign to celebrate and acknowledge the diversity of staff and role model diverse leadership at different levels	**Progress at August 2017** • Accredited Manager Programme (ACP) is being developed with inclusion as a core thread • Training developed for recruitment panels • Executive and Board will receive development from Stonewall / BME in Q4 • Board members attending staff networks and contributing to key speakers
2	**Review and redesign recruitment and selection processes** • Inclusion and diversity to be included as a key aspect of all recruitment and selection training • Deliver unconscious bias training for recruiting managers • Run CV and interview skills workshops for staff groups with protected characteristics • Implement diverse recruitment panels (gender and ethnicity) • Work closely with external recruitment partners stating Trust values on inclusion and diversity • Monitor data of applicants through the WRES • Intensive training for Organisation Development team	**Progress at August 2017** • Specific training being developed (e learning and face to face) for recruitment panels • Inclusive panellists launched in May, with 44 applicants so far • Developed partnership with NHSE, NHS Employers and ENEI • Developing action plan with BME network on WRES response

Inclusion and Diversity. Proposed Pledges for 2017/18

	• Monitor protected characteristics data of PDR completion and scoring	
3	**Develop and support Staff Network Groups** • Support newly established staff networks, including executive sponsorship • Support network chairs and vice chairs and others involved with time, efforts, events and communicating outcomes • Executive sponsor meet with network at least 4 times a year • Support each network in terms of personal development, mentorship • Support networks for campaigning, networking, education, advocacy or social purposes	**Progress at August 2017** • Networks progressing positively. Disability and Long Term Conditions network relaunched with Kam Dhami as executive sponsor. • Executive support regularly in place for network chair leads • Support being offered through external experts, Stonewall, key contacts, for networks • BME Network held 2 events so far, with another planned for weekend of 5th August • LGBT network attended PRIDE
4	**Creating a culture where it is safe to be 'out' at SWBH as a staff member or a patient** • Raise awareness and support LGBT network • Attend Birmingham Pride 2017 for recruitment and awareness raising • Join Stonewall and take part in regional conferences and workshops • Train staff in supporting LGBT patients sensitively and appropriately • Create a 'Safe Space' for LGBT colleagues • Work with Birmingham LGBT and other external partners to ensure best practice is being implemented • Work with Staffside, to support LGBT staff at work • Celebrate LGBT History Month with events and support in Feb 2018	**Progress at August 2017** • Communications campaign including LGBT History Month, support through social media and internal communications. Vice chair to be appointed • First meeting with Stonewall taken place, entering WEI for first time in Q3 • Safe Space identified for LGBT colleagues and currently being refurbished • 3 LGBT colleagues attending Birmingham LGBT Leadership Programme • Close working with Staffside, Chris Rickards attended PRIDE and went to London to receive ENEI award • Planning for LGBT events in 2018

Inclusion and Diversity. Proposed Pledges for 2017/18

	• Implement 'Allies' programme for non LGBT staff communicated and visible • Increase sexual orientation declaration to at least 20% in two years • Independent review and audit by Stonewall UK of Trust, ready to enter 'Top 100' in 2018	• Allies programme being planned • Lanyards and posters well received • Review from Stonewall being planned currently
5	**To ensure a safe and inclusive environment for transgender people.** • Support clinical groups with clear guidance on the implementation of the public sector Equality Duty, which includes gender reassignment as one of the pc's. • Work with members of SWBH staff to develop a programme to raise awareness of the challenges transgender people may face. • Develop and re-launch trans policy • Develop and launch supportive guidance for staff on welcoming trans patients • Celebrate national Trans Day of remembrance in November 2017	**Progress at August 2017** • Revised policy being planned – plan for November launch on trans rememberance day • Progress behind on trans
6	**Review the use of EDS 2 and develop and implement a 'Trust EDS'** **EDS measures 1) Better Health Outcomes 2) Improved Patient Access and Experience 3) A representative & inclusive workforce 4) Inclusive Leadership** • Senior support of EDS action plans in hot spot areas • Deliver 2 work programmes (TBC) to improve patient access and experience and better health outcomes	**Progress at August 2017** • Relaunched Local Interest Group with quarterly meetings planned with expanded attendees • Committed to corporate EDS reporting, rather than directorate. Replaced by WRES and other national reporting

Inclusion and Diversity. Proposed Pledges for 2017/18

	• Communication and engagement with EDS both internally and externally • Inclusion of revised EDS in annual equality report • Work with Local Interest Group to change focus of EDS to Trust Wide • Expand membership of Local Interest Group to be more diverse	
7	**To ensure a safe and inclusive working environment for BME Staff** • Annual review of access to training for BME Staff • Develop clear action plan to respond to the 2016 WRES using best practise from the WRES report released on 18th April • Analyse via group and take any appropriate remedial action • Support BME Staff network group to have a visible presence in organisation • Release staff to the 'Stepping Up' BME Leadership Programme - Bands 5/6 and Bands 7 • Monitor 'First Line Leadership Attendance' of BME Staff to ensure it does not drop below 30% • Direct contact with BME staff to advertise leadership programmes and management development • Direct contact with BME staff to advertise and encourage 'Middle Manager' Leadership Programme • Inclusive communications across organisation in branding, photographs , videos and other media	**Progress at August 2017** • Action plan for WRES outstanding. Support offered from national WRES which we will take up • Significant support to BME network from a number of executives and deputies, including a specific approach to BME mentoring • Inclusive panellists launched in partnership with BME network • Regular meetings with BME network with Director of OD, Deputy Director of OD, Chief Nurse and Chief Executive • All BME colleagues invited to apply for NHS Leadership Academy BAME Stepping Up Programme • Good representation on First Line Leaders Programme (43%) • Director of OD developing an approach to BME Leadership • Internal communications support with posters, messages, promotional items, attendance at AGM, all internal events.

Inclusion and Diversity. Proposed Pledges for 2017/18

		• Supporting to exhibit at Fiesta, Jamacia in the Square • Jointly planning an Educate & Celebrate Cultural Event during October 2018 Black History Month
9	**In addition we will further add to our portfolio of leadership development activities a series of structured development and mentorship programmes for people with PC** • Annual review of data and analysis, will be brought to the board • Continue LGBT Leadership Programme in partnership with Birmingham LGBT • Access and support for 'Stonewall UK' mentoring scheme • Case studies, posters, videos and marketing that is inclusive and accesses staff with PC.	**Progress at August 2017** • Bethan Downing leading the development of mentoring for people with PC - and a wider offer to the organisation
10.	**Run communications campaigns each month with emphasis on protected characteristics (PC) based on CIPD Diversity Calendar and with visible support from employee network groups** e.g • February LGBT History Month • October Black History Month • Religious Celebrations • International Women's Day • Mental Health Awareness	**All ongoing**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Risk Registers
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Allison Binns, Deputy Director of Governance
DATE OF MEETING:	3 August 2017

EXECUTIVE SUMMARY:

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

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

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
	✓	✓

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

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

Comments:

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

Aligned to BAF, quality and safety agenda and requirement for risk register process as part of external accreditation programmes.

PREVIOUS CONSIDERATION:

At the July Risk Management Committee and the Clinical Leadership Executive

Sandwell and West Birmingham Hospitals NHS Trust

Report to the Trust Board on 3 August 2017

Trust Risk Register

1. INTRODUCTION

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

2. TRUST RISK REGISTER

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

One new risk on Results Acknowledgement (2642) has been escalated for Trust Board to discuss.

3. HIGH IMPACT RISKS

Following the review of high impact, low likelihood risks all Clinical Groups/Corporate Directorate risk owners have been asked to review their risk assessments that fall into this category. The Risk Management Team is in the process of removing duplicates and cleaning the data and supporting Clinical Groups/Corporate Directorate risk owners. There is an expectation that this work will be completed by the August Risk Management Committee prior to reporting the resulting high impact risks to the CLE in August and the Board in September 2017.

4. RECOMMENDATION

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

Allison Binns
Deputy Director of Governance

27 July 2017

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
221	Live (With Actions)	Informatics	Informatics(C)	IT Software - Clinical System Failure / Issue	There is a risk of failure of a trust wide implementation of a new EPR due to insufficient skilled resources within the Trust given the fixed time and budgetary constraints. This now focuses on resources to deliver the implementation including business change, training and champions.	4x4=16	Recruitment of suitably skilled specialist resources for EPR Programme and Infrastructure Stabilisation Funding allocated to LTFM Delivery risk shared with supplier through contract Project prioritised by Board and management.	5x4=20	Embed Informatics implementation and change activities in Group PMOs and production planning Develop and publish implementation checklists and timescales for eDocs and EPR. Report progress at Digital PMO and Ctte Agree and implement super user and business change approaches.	Mark Reynolds	30/06/2017	22/03/2017	Monthly	Treat
2272	Live (With Actions)	Emergency And	Accident & Emergency (C)	Quality Of Care	The Trust has un-substantiated beds open due to: _admissions above plan _extended Length of Stay (LOS) above bed plan assumptions _too many Delayed Transfers of Care bed days (DTOC) - our plan accommodated 35 actual	5x5=25	Activate business continuity for 10 additional patients in ED: For up to 10 patients additional to ED cubicle capacity - likelihood this occurs 12 hours of the day -Receive patients and starting assessment in the circulating corridor areas of ED -Staffing of the above areas to be put in place utilising block booking	5x4=20	support from OCM and capacity to support ED cohorting patients in corridor = x1 crew 4 pts Seek social care business continuity response to eradicate all acute delayed transfer of care patients. Plans not available Raise at A&E Delivery Group.	Rachel Barlow	31/03/2017	19/07/2017	Monthly	Treat

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

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
				or pending DTOC patients; those numbers have increased to 89-109 over November/December period We are unable to consistently staff the additional beds safely. The Trust will consider the closure of the un-substantively staffed beds in the new year. The impact of this would potentially result in overcrowding in ED and a deterioration in time to assessment, diagnosis and treatment, which would result in decreased patient and staff experience, longer ambulance waiting times and will undoubtedly adversely impact on patient outcomes.		of bank / agency. -Equipping area with privacy screens , dynamap and patient trollies to be available -A computer on wheels to be allocated to this team so they can process and document assessment and care. A CAD screen should be installed in the main desk to anticipate incoming ambulances outside of RAM. -2 RAM cubicles to be kept for rotation of WMAS presenting patients through this area for detailed examination etc; 2 majors cubicles would rotate patients from the waiting room dependent on triage scores Queue ambulances on ambulance arrival point x 10 : Ambulances would be held for up to 60 minutes on the ambulance arrival area and remain under the care of the WMAS staff until the patients could be handed over on the ED environment safely.		Command and control structure with documented continuity plan to manage this scenario. Complete written guidance for both scenarios (a) and (c) Command and control structure to be put in place if plan activated to support ED and live assessment of risk Work with WMAS on risk assessment to understand their response to these scenarios					

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
						Activate business continuity for 20 additional patients in ED and or patients waiting for 60 minutes on the ambulance arrival area: For up to 20 patients additional to ED cubicle capacity - likelihood estimated to be up to 6 hours a day The approach to mitigate, the ED capacity would need to be expanded. This would be through 2 options: 1)A temporary tent on the ambulance arrival area 2)Expand ED in line with the major incident plan. This would displace adjacent out patients, which would need to be relocated. -Staffing and equipment would need to be in place -Access to patient first IT system to be in place Further to the above measures, if ambulance waits persisted and delays to patient assessment exceeded an hour, the Trust would seek to close to further arrivals of urgent care patients: Attendance avoidance would be sought by: Triage all non-majors							

Risk Ref No. / Status / Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
					activity to urgent care centres Divert WMAS to other EDs							
215 Live (With Actions) Waiting List	Waiting List Management	Performance	Due to lack of EAB bed, nursing home capacity and waits for domically care there is a deteriorating level of Delayed Transfers of Care (DTOC) bed days which results in an increased demand on acute beds.	4x5=20	ADAPT joint health and social care team in place. Progress made on new pathway. Joint health and social care ward established in October at Rowley.	4x4=16	EAB and nursing home capacity remain unmitigated risks. System Resilience partners review of demand and capacity still outstanding. Nursing home and domiciliary care provision is potentially vulnerable across the market place. The system resilience partners considering risk and mitigation as part of A&E delivery group.	Rachel Barlow	31/03/2017	26/10/2016	Quarterly	Treat

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666	Monitor	Paediatrics	Lyndon 1	Incident	Lack of Tier 4 bed facilities for Children-Young people with mental health conditions means that they are admitted to the paediatric ward. There is no specialist medical or nursing MH team to care for their needs with limited access to in/OOH CAMHS support. Whilst safety for the children can be maintained, therapeutic care is compromised and there can be an impact on other children and parents.	4x4=16	Mental health agency nursing staff utilised to provide care 1:1 All admissions monitored for internal and external monitoring purposes. Awareness training for Trust staff to support management of patients is in place Children are managed in appropriate risk free environments	4x4=16	The LA and CCG are looking to develop a Tier 3+ service. An update has been requested through the CCG and a response is awaited. Tier 4 beds are being reviewed nationally.	Rachel Barlow	31/03/2017	03/04/2017	Quarterly	Tolerate
1603	Live (With Actions)	Financial	Financial Management (S)	Costs Not Planned	As a result of significant reliance on non-recurrent measures and balance sheet flexibility to support the Trust's financial performance cash balances have been eroded and there is a risk that this may compromise future investment plans.	4x5=20	Management controls - Routine cash flow forecasting including rolling 15 month outlook - Routine five year capital programme review & forecast - Routine medium term financial plan update - Routine monitoring of supplier status avoiding any 'on stop' issues	3x5=15	- Deliver operational performance consistent with delivery of financial plan to mitigate further cash erosion - Establish and conclude task & finish programme to resolve significant outstanding debtor and creditor issues - Excellence in working capital management including appropriate creditor stretch, timely debtor recovery and pharmacy	Tony Waite	31/03/2018	22/11/2016	Quarterly	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
							Independent controls / assurance - Internal audit review of core financial controls - External audit review of trust Use of Resources including financial sustainability - Regulator scrutiny of financial plans		stock reduction - Establish and progress cash generation programme including accelerated programme of surplus asset realisation					
566	Live (With Actions)	Emergency And Accident & Emergency (S)		Staffing	STAFFING - SENIOR MEDICAL STAFF There is a risk that further reduction or failure to recruit senior medical staff in ED leads to an inability to provide a viable rota at consultant level which may impact on delays in assessment, treatment and patient safety.	4x5=20	Recruitment campaign through local networks, national adverts, head-hunters and international recruitment expertise. Leadership development and mentorship. Programme to support staff development. Robust forward look on rotas through leadership team reliance on locums (37% shifts filled with locums). Registrar vacancy rate 59%. Consultant vacancy rate 35%.	3x5=15	Recruitment ongoing with marketing of new hospital. CESR middle grade training programme to be implemented as a "grow your own" workforce strategy. Development of recruitment strategy	Rachel Barlow	31/03/2017	19/07/2017	Quarterly	Treat

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1643	Live (With Actions)	Operations		Incident	Unfunded beds staffed by temporary staff in medicine place an additional ask on substantive staff elsewhere, in both medicine and surgery. This reduces time to care, raises experience, safety and financial risks.	5x4=20	Overseas recruitment drive (pending) Use of bank staff including block bookings Close working with partners in relation to DTOCs Close monitoring and response as required. Partial control - Bed programme did initially ease the situation but different ways of working not fully implemented as planned.	3x4=12	Contingency bed plan to be agreed in October for winter 2016/17. Current unfunded beds have temporary staffing. Bed programme to ensure robust implementation of EDD planning on admission and implementation of red/green working on wards.	Rachel Barlow	31/03/2017	26/10/2016	Monthly	Treat
410	Live (With Actions)	Ophthalmology	Outpatients - EYE (S)	Environment - Clinical (IC Related)	Risk of Breach of Privacy and Dignity Standard, Information Governance Risk and Infection Control Risk at Sandwell Outpatient Department as a consequence of poor building design in SGH Ophthalmology OPD. Clean/dirty utility failings cannot be addressed without	5x4=20	Reviewing plans in line with STC retained estate Staff trained in IG and mindful of conversations being overheard by nearby patients / staff / visitors	3x4=12	To continue to work with STC design team and Ophthalmology team to ensure design and build of OPD2 is fit for purpose to ensure patient privacy, dignity and associated infection control issues are prioritised in the new build. April 2017 - informed by Jayne Dunn that OPD2 was no longer going to be for ophthalmology and	Rachel Barlow	31/03/2017	22/05/2017	Quarterly	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
					re-development of the area. Risk that either a patient's health, or privacy/dignity will be compromised as a consequence of poor building design. Clean / dirty utility failings cannot be addressed without re-development of the area.				would remain in current area. Raised at RMC May 2017.					
121	Live (With Actions)	Maternity_ Health	Maternity 1	Costs Not Planned	There is a risk that due to the unpredictable birth activity and the impact of cross charging from other providers against the AN / PN tariff ,as a result is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service.	4x4=16	Maximisation of tariff income through robust electronic data capture. Robust validation of cross charges from secondary providers.	3x4=12	Options for management of maternity pathways payment between primary and secondary provider for AN/PN care in progress by the Finance Director - with cross provider SLA planned. Risk proposed for removal from TRR when 2016-17 SLA is signed.	Rachel Barlow	29/12/2017	17/05/2017	Monthly	Treat

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325	Live (With Actions)	Informatics	Medical Director's Office	IT Software - Clinical System Failure / Issue	There is a risk of a breach of patient or staff confidentiality due to cyber attack which could result in loss of data and/or serious disruption to the operational running of the Trust. This recognises advice from NHS CareCERT and Government about an ongoing threat to UK infrastructure from cyber attack.	4x4=16	Prioritised and protected investment for security infrastructure via Infrastructure Stabilisation approved Business Case Information security assessment completed and actions underway.	3x4=12	MDM Tighten up use of MDM controls. Remove out of date accounts and update old OS versions. This has been neglected and therefore is a security risk. Complete rollout of Windows 7. Upgrade servers from version 2003. 287 servers have been moved to Windows Server 2008 and 2012. There are 104 using Windows Server 2003 that need to be migrated. These will be completed by Christmas. Review Network Firewall Rules Review network firewalls rules. Remove inessential services. Achieve Cyber Security Essentials The Trust must achieve cyber-security essentials as part of the minimum commitment to security. This will likely form part of our CQC inspections. Restricted Devices Security Controls Implement security controls (VLAN, IPSEC) to stop access to and from restricted devices. Over time this	Mark Reynolds	30/06/2017	20/01/2017	Quarterly	Treat

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
								should harden the Trust infrastructure against attack, recognising that securing the physical network is a challenge on the estate.					
114 Live (With Actions)	Human Resources	Human Resources	Cost Improvement Not Met	FINANCE - Excess pay cost Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment reduction of 1400 WTEs, leading to excess pay costs	4x5=20	The Executive led delivery plan is progressing the reduction of WTEs alongside a change management programme. Learning from previous phases, changes in legislation and broad stakeholder engagement are factored into the delivery plan.	3x4=12	Phase 2 Transformation implementation in progress. Consultation sign-off October 2016. Phased implementation of individual plans over a two year period, started Q1 2016-17.	Raffaela Goodby	31/03/2018	20/09/2016	Quarterly	Treat

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1738	Live (With Actions)	Ophthalmology	BMEC Outpatients - Eye	Quality Of Care	There is a risk that children, particularly under 3 years of age, who attend the ED at BMEC with an emergency eye condition, do not receive either timely or appropriate treatment, due to limited availability OOH of specialist paediatric ophthalmologists and/or the availability of a paediatric anaesthetist.	4x4=16	Contingency arrangement is for a general ophthalmologist to deal with OOH emergency cases. Agreement with BCH to access paediatric specialists advice and where specialist care is required patients can be transferred to BCH. There is a cohort of anaesthetists who are capable of anaesthetising children under 3 who can provide back-up services when required. Where required patients can be transferred to alternative paediatric ophthalmology services beyond the local area.	3x4=12	Actions agreed following a meeting of senior clinicians and Executive Directors, some of which are in progress or completed: Engage with ophthalmology clinical lead at BCH and agree a plan for delivering an on call service. SWBH MD to engage with BCH MD re. joint working (completed). Liaise with commissioners over the funding model for the Paediatric OOH service. Paediatric ophthalmologists from around the region to participate in OOH service (for discussion and agreement at a paediatric ophthalmology summit meeting). Clarify with Surgery Group leads what the paediatric anaesthetic resourcing capacity is. A full OOH paediatric on-call service to be set up in negotiation with commissioners, BCH and other ophthalmology units across the region.	Roger Stedman	30/11/2018	22/05/2017	Quarterly	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
									Midland Met will treat paediatric emergencies and will have access to paediatric anaesthetists within 24 hours.					
2642	Live (With Actions)			Clinical Results	*** PROPOSED ADDITIONAL RISK FOR TRR *** There is a risk that as a result of test results not being seen and acknowledged because individual test results can be viewed on multiple different IT systems some of which have no mechanism for acknowledgment or audit trail of who has viewed the result - That patients will have treatment delayed or omitted.	**3x5=15**	There is results acknowledgment available in CDA only for certain types of investigation. Results acknowledgement is routinely monitored and shows a range of compliance from very poor, in emergency areas, to good in outpatient areas. Policy: Validation Of Imaging Results That Require Skilled Interpretation Policy SWBH/Pt Care/025 Clinical staff are require to keep HCR up to date - Actions related to results are updated in HCR	**2x5=10**	To ensure results are always endorsed (mandatory) for all types of clinical investigation in whatever application it is being viewed. (Person responsible TBA)	Roger Stedman	/ /	27/07/2017	Quarterly	Treat

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
						SOP - Results from Pathology by Telephone (attached)							
228 Live (With Actions)	Informatics	Informatics(C)	IT Hardware - Clinical System Failure / Issue	There is a risk that a not fit for purpose IT infrastructure will result in a failure to achieve strategic objectives and significantly diminishes the ability to realise benefits from related capital investments. e.g. successful move to paperlite MMH, successful implementation of Trust Wide EPR.	**3x4=12**	Approved Business Case in place for Infrastructure Stabilisation programme (approved by Trust Board June 2015) Specialist technical resources engaged (both direct and via supplier model) to deliver key activities Informatics has undergone organisational review and restructure to support delivery of key transformational activities Informatics governance structures and delivery mechanisms have been initiated to support of transformational activities	**3x3=9**	Complete network and desktops refresh. Stabilisation of all aspects of the local IT infrastructure will be completed end March 2017. The replacement of PCs, printers, monitors, etc., and upgrade of the network is conducted in parallel. 80% of the work was completed by December 2016	Mark Reynolds	31/03/2017	16/01/2017	Quarterly	Treat

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
						Infrastructure work to refresh networks and desktops is underway.							
768 Live (With Actions)	Operations	Elective Access Inpatient	Performance	There is a risk that data quality errors arise due to an inadequate referral management system which could lead to delays for patients.	**5x3=15**	Historical backlog of open referrals closed in Q3 2015. SOP and training in place as part of actions at time. Audit of current open referrals open pathways completed and shows some remaining inconsistencies in referral management practice.	**3x3=9**	Closed referral validation to be completed.The programme is near completion with a delivery plan for the end of October. CSC to fix bug on PAS system. The initial technical development has not fully fixed the bug. the further development would require a full PAS upgrade and CSC / HIS have advised this is not likely to be until later than 2017-18. Data quality programme to be completed.	Rachel Barlow	31/12/2016	26/10/2016	Quarterly	Treat

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214	Live (With Actions)	Waiting List	Waiting List Management	Performance	Lack of assurance of standard process impact on 18 week data quality which results in underperformance of access target.	**4x3=12**	SOP in place Substantive Deputy COO for Planned Care appointed and new Head of Elective Access in place. Improvement plan in place for elective access with training being progressed. 52 week breaches continue to be an issue for the Trust. The RCA identified historical incorrect pathway administration and clock stops. There has been no clinical harm caused to patients. The 52 week review was completed with TDA input. The action plan is focused on prospective data quality check points in the RTT pathway, competency and training.	**3x3=9**	Implement full action plan. Planned care PMO is being established to oversee programme delivery as scheduled. Source e-learning module for RTT with a competency sign off for all staff in delivery chain. Decision to be made on the support training product in November. Data quality process to be audited	Rachel Barlow	31/03/2017	26/10/2016	Quarterly	Treat

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533	Live (With Actions)	Ambulatory	Oncology Medical	Service Level Agreement - Operational	The Trust has excess waits for oncology clinics because of non-replacement of roles by UHB and pharmacy gaps.	3x5=15	Being tackled through use of locums and waiting times monitored through cancer wait team.	3x3=9	Recruitment being managed by UHB. Good progress reported for the GI position.	Roger Stedman	31/01/2017	26/05/2017	Quarterly	Treat
534	Live (With Actions)	Ambulatory	Oncology Medical	Performance	Trust non-compliance with some peer review standards due to a variety of factors, including lack of oncologist attendance at MDTs, which gives rise to serious concern levels.	3x4=12	Oncology recruitment ongoing and longer term resolution is planned as part of the Cancer Services project.	3x3=9	Contingent on start date for GI appointments	Roger Stedman	31/03/2017	26/05/2017	Monthly	Treat

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327	Live (With Actions)	Interventional	Imaging Management (C)	Recruitment	Reduced ability to provide an Interventional Radiology service as a result of difficulties in recruiting Interventional Radiology consultants, results in delays for patients and loss of business.	4x3=12	Interventional radiology service is available Mon - Fri 9-5pm across both sites. The QE provides an out of hours service for urgent requests. Locum arrangements in place to support workforce plan. Two consultants recruited who will start in 2017.	2x3=6	BCA plans to be delivered to commence in April 2016. PPAC & staff currently being consulted and volunteers for rotas sought. Working on Rota to cover our first commitment Saturday 30th April. The BCA service started in April as planned, with 1st SWBH weekend end April. So far, all weekends have been covered but there are some concerns around potential shortages of radiographers, with no radiographer currently available for a weekend in November and at the New Year - the qualified ones are committed in CT. The CD for IR is arranging radiologist locum cover for some of the weekends, and Walsall is providing some additional cover. Pilot to cover Saturday and Sunday 9-5pm at SWBH, Wolverhampton and Dudley with BCA commenced April 16; SWBH has received it's first OOH patient. To be done on a rotational basis. Over reliance on one consultant, but 2 more are starting in the New Year. Recruitment is progressing but availability of vascular IR sessions	Rachel Barlow	31/12/2017	17/07/2017	Quarterly	Treat

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Current risk score (LxS)	Actions	Lead Owner	Expected completion	Latest review	Review	Control potential
								is proving an potential barrier, as our sessions at UHB have been taken. Some sessions have been arranged at Dudley, and talks are taking place with UHB. Medical Director of Dudley Group of Hospitals working to create vascular access at Russell's Hall. Some sessions have been arranged at Dudley, and talks are taking place with UHB.					
538 Live (With Actions)	Ambulatory	Oncology Medical	Performance	Differential and extended chemotherapy wait times between sites due to staff vacancies results in inequality of service for patients.	**2x4=8**	Review / amend pathway Staff vacancies recruited to. Latest audit (Nov 15) provides assurance that wait times have significantly improved; 9 days on each site. Monthly monitoring of performance carried out to check that staff recruitment maintains sustainable change. New 2 stop chemotherapy model introduced to equalise waits from beginning of May 2016. New model implemented and improvements being monitored by Cancer Board.	**1x4=4**	Further Executive review at performance management review in November to confirm if the solution has succeeded in full.	Rachel Barlow	31/12/2016	26/05/2017	Quarterly	Treat

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Assessment

Risk Number: 2642 **Status:** Live (With Actions)

Site:	City Hospital	**Department:**	Medical Director's Office (C)
Clin. Grp / Corp Dir:	Medical Director Office	**Owner:**	Roger Stedman
Directorate:	Medical Director Office	**Assessor:**	Roger Stedman
Specialty:	Medical Director's Core Team	**RR Level:**	Clinical Group/Corporate Direc
Risk monitored by:	Quality & Safety Committee		

Initial Risk	Curent Risk	Target Risk
Severity (5) x Likehood (3) = 15 Red	Severity (5) x Likehood (2) = 10 Amber	Severity (5) x Likehood (1) = 5 Yellow

Risk Type: Clinical Care/Treatment **Risk Sub-Type:** Clinical Results

Risk Statement	Scope	Hazard
*** PROPOSED ADDITIONAL RISK FOR TRR *** There is a risk that as a result of test results not being seen and acknowledged because individual test results can be viewed on multiple different IT systems some of which have no mechanism for acknowledgment or audit trail of who has viewed the result - That patients will have treatment delayed or omitted.	All clinical areas where test results (pathology and Imaging) are used	Test results not being seen and acknowledged because individual test results can be viewed on multiple different IT systems some of which have no mechanism for acknowledgment or audit trail of who has viewed the result. Any patient

Controls in Place:

1	There is results acknowledgment available in CDA only for certain types of investigation.	Policy/Procedure/System
2	Results acknowledgement is routinely monitored and shows a range of compliance from very poor, in emergency areas, to good in outpatient areas.	Inspection/Audit/Monitor
3	Policy: Validation Of Imaging Results That Require Skilled Interpretation Policy SWBH/Pt Care/025	Policy/Procedure/System
4	Clinical staff are require to keep HCR up to date - Actions related to results are updated in HCR	Policy/Procedure/System
5	SOP - Results from Pathology by Telephone (attached)	Policy/Procedure/System

	ATTACHMENTS AND DOCUMENTATION	Date added
1	Histo (Telephone).pdf	27/07/2017
2	Haematology (Telephone).pdf	27/07/2017
3	Chemistry (Telephone).pdf	27/07/2017
4	Immunology (Telephone).pdf	27/07/2017
5	Microbiology (Telephone).pdf	27/07/2017
6	Imaging Results Validation Policy Pt Care025 SWBH.	28/07/2017

Actions:

1	To ensure results are always endorsed (mandatory) for all types of clinical investigation in whatever application it is being viewed. (Person responsible TBA)	01/12/2017	Open

Review Dates:

Last Review Date: 27/07/2017 **Next Review Date:** 25/10/2017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Performance Report – P03 June 2017
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Finance & Performance Director
AUTHOR:	Yasmina Gainer, Head Performance Management & Costing
DATE OF MEETING:	3 August 2017

EXECUTIVE SUMMARY:

IPR – Summary June 017

- × **ED 4 hour** performance for June was 83.47% (81.57%), non-compliant with 95% national target; 3014 breaches in the month
- × **Never Event** reported in June due to 'wrong eye laser'.
- × **Falls** increased in June to 87. Falls with harm remain very low & favourable to peer comparison.
- ✓ **RTT** June delivery at 93.3% against the national standard of 92%. Waiting list at 33,028, patient backlog of patients at 2,122 [2024) increase to May. There were no 52 week incomplete breaches in the month of June.
- ✓ **Acute Diagnostic waiting times** within 6 weeks as at June 99.15% recovering to compliance of 99%, but still not at previous delivery levels;
- ✓ **62 day cancer** compliant at 85.2% at May vs. target of 85%; all other cancer targets continue to deliver. June delivery is anticipated to deliver to standards and hence Q1 delivery secured. Whilst performance is consistently good, cancer delivery requires increased 'effort'; Cancer PTL established from June.
- × **Neutropenic sepsis** considerable improvement on prior months, but remains below 100% standard [4/40 (10%) patients did not receive treatment within the required 1hr timeframe.
- × **Elective Operations Cancellations** consistently under-delivering and at 1.3% against 0.8% target in June; cancellations are the high still at 58 on day cancellations of which 20 were validated as avoidable; No 28 Day Guarantee or urgent cancellations during June. Theatre utilisation rate at 77% improving to a number of previous months.
- × **Hip fractures** best practice tariff performance in month improved from last months to 84%, but slightly remains below 85% standard and the Trust fails to keep this level of performance on a consistent basis.
- × **Sickness rates** in the month of June at 4.36%; cumulatively at 4.52% against the Trust target of 2.5%. Short-term sickness at 444, long term sickness slightly increasing to 218.
- × **Mortality reviews** 50% in April; remains significantly below 90% standard;
- ✓ **Mortality rate** indicators remain within confidence limits. MDO review of emergent divergence between weekday and weekend rates.
- ✓ **MSA Breaches** none incurred in June.
- ✓ **VTE** delivers full year to national standard at 96.3% in June with 298 patients missing the assessment.
- ✓ **MRSA** – no cases year to date
- ✓ **CDiff** – x6 cases year to date against a target of 7.5.
- ✓ **Readmissions** at 7.2% in May (7.1%). The Trust now tracks better than peer group.

Requiring attention – action for improvement :

Cancelled operations

- We continue to see high levels of cancellations which impact patient experience as well as contractual obligations
- High levels of 'on day' cancellations causing attention with regulators, coupled with late starts and low theatre utilisation warranting a refreshed cancellations process.
- Remedial action plan agreed with CCG to be overseen through Theatres Management Board
- Theatre Improvement Project established on 14th June to drive out 'theatre value chain' improvements as recently recommended also by EY review.

Neutropenic Sepsis

- Shows improvement but stubborn to further reduction to secure 100% local 'always event' compliance standard. MD to action improvement. 4 patients missed it in June (21 year to date this year).

Sepsis [CQUIN]

- To address performance in respect of patients identified for screening who are screened and for those patients who are confirmed with sepsis to receive IV antibiotic within 1 hour.

Recovery Action Plans (RAPs)

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

The Trust now has the following RAPs ongoing for action:

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

CQUINs 2017/18

- The trust has 9 National CQUINs to deliver in-year of which some are continuations from last year and will also carry on into 18/19. 3x Specialised Commissioners schemes and some Public Health screening programmes which continue from previous years (breast & bowel screening). There will be no local CQUINs for the next two year plans.
- Total funding for CQUINs in 2017/18 is £8.8m
- As at today, 1x scheme has been withdrawn from delivery in 17/18 (Alcohol and Tobacco) which carries a £1.35m funding which will be distributed across the remaining CQUINs. This implies greater financial risk if the other CQUINs do not deliver.
- Q1 reporting is in progress for end of July and as we are nearing completion, it is becoming evident that Sepsis screening and treatment is below required levels of performance and not likely to recover full funding in this period. One other scheme still to be progressed and rated red at present.

- A CQUIN Dashboard is attached within the IPR listing performance across all schemes, but confirmation is awaited from commissioners, which will follow over the next weeks.

REPORT RECOMMENDATION:

The Board is asked to consider the content of this report.
Its attention is drawn to the matters above and commentary at the 'At a glance' summary page in the IPR report

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Operational Management Committee, Performance Management Committee, CLE

Sandwell and West Birmingham Hospitals NHS Trust

SWBTB (08/17) 009a

Integrated Quality & Performance Report

Month Reported: June 2017

Reported as at: 26/07/2017

TRUST BOARD

Contents

June 2017

Infection Control

3x C. Diff cases reported during the month of June;
x6 cases year to date against a target of 7.5
An annual trajectory of 30 has been agreed with the CCG for 17/18.
On track, but close to target.

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

MRSA Screening - June month:
- Non-elective patients screening 91.3%
- Elective patients screening 88.4%
both indicators are compliant with 80% target in-month and year to date

Elective screening is compliant with standard at a whole trust level; Scheduled Care within Medicine Group is at 25% and persistently under-achieving - escalation to CNO to ensure effective remedial action within the group.

MSSA Bacteraemia (expressed per 100,000 bed days) for the month of June at 5.2 against a tolerance rate of 9.42. But at a rate of 12 on a year to date basis. 7/12 months elevated levels.
Escalated to CNO and Infection Control clinical lead for review & assurance

Harm Free Care

95.7% reported for June against NHS Safety Thermometer against the target 95%; second months running at required standard.

x87 [x70] falls reported in June with x1 [x0] fall resulting in serious injury. 226 falls reported year to date
36 falls within community and 51 in acute setting. A significant increase in the community setting to previous month.
Falls remain subject to ongoing CNO scrutiny.

x6 [x9] avoidable, hospital acquired pressure sores reported in June of which 2x at grade 2 and 4x at grade3
x5 separate cases reported within the DN caseload.

x3 [x4] serious incidents reported in May; routine collective review in place and reported to the Q&S Cttee.

- x1 never event was reported in June (wrong eye laser);
- WHO Safer Surgery performance consistently marginally below 100% standard.
This is subject to MD review and re-positioning of target with CCG upon which the IPR will reflect any relevant changes.

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

x6 (x14) DOLS have been raised in June of which 6 were 7-day urgents;

Venous Thromboembolism (VTE) Assessments in June at 96.3% compliant with 95% standard across all Groups except Medicine & EC where it has been narrowly missed.

Missing 298 [346] assessments in June . Stubborn number of assessments missed - being addressed through Safety Plan roll out.

Obstetrics

The overall Caesarean Section rate for June is 25.8% and hence slightly above the 25% standard. 24.9% year to date against the 25% target.
Elective and non-elective rates are 8.9% and 16.9% respectively.
9/12 months elevated levels.
Matter considered at Q&S & Board and to be kept in view.

Adjusted perinatal mortality rate (per 1000 births) for June is 4.12 [7.6] within the threshold levels of 8.
The indicator represents an in-month position and which, together with the small numbers involved provides for sometimes large variations.
The year to date position is within the tolerance at 5.3 and meeting the target of 8.
Nationally, this indictor is monitored using a 3 year cumulative trend, based on which the Trust is within normal confidence limits.

- Post Partum Haemorrhage (>2000ml) for the first time in 18 months reporting at a rate of 5 against threshold of 4 and therefore a matter for attention and assurance.
- Puerperal Sepsis within normalised range; ongoing review by Group Director & MD for assurance.

- Early Booking Assessment (<12 + 6 weeks) - SWBH specific definition target of 90% has consistently not been met and for June the delivery is 77.6%; however, performance is consistently delivering to nationally specified definitions (80%) in large part due to significant excess of registrations over births in the Trust, so not a fully reflective indicator as such.
- Deliveries, reducing to last month and still continue to be below registrations.

Breastfeeding initiation performance reports quarterly, and as at June quarter is at 73.1% below the target of 74.0%. Still one of the better performances regionally.

Mortality & Readmissions

The Trust overall RAMI for most recent 12-mth cumulative period is 101 (latest available data is as at March)
RAMI for weekday and weekend each at 98 and 109 respectively. MDO review of recent divergence to Q&S August.

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

- Deaths in Low Risk Diagnosis Groups (RAMI) - month of March is 88. This indicator measures in-month expected versus actual deaths so subject to larger month on month variations.
- Crude in-month mortality rate for May is 1.1 [1.2] lower than 16-mths avg of 1.4;
- The rolling crude year to date mortality rate remains consistent at 1.3 and consistent with last year same period at this stage and stable to long term average.
- There were x113 [x105] deaths in our hospitals in the month of May; significantly lower than last year same period which was at 158.

Mortality review rate in April at 50% worsening to previous monthly trends; an exception report has been requested from the MD office to identify causes
Remains subject to MDO attention for remedy.

Readmissions (in-hospital) reported at 7.2% in May (7.2% in Apr) static to last month.

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

Stroke Care & Cardiology

Stroke data for June indicates that 86% [95.0%] of patients are spending >90% of their time on a stroke ward which is not compliant with the 90% operational threshold and the first non-compliance for a number of months.
Subject to validation.

June admittance to an acute stroke unit within 4 hours is at 90.27% above the local target of 90% but also the national target of 80%.
National target of 80% is consistently met.

Pts receiving CT Scan within 1 hour of presentation is at 78% [71.4%] in June being consistently compliant with 50% standard;

Pts receiving CT Scan within 24 hrs of presentation delivery in month at 97.6% [97.1%] meeting the 95% standard in month and consistently year to date

June performance for thrombolysis is 0 in the month, with 3 eligible patients missing the target. The exception report highlights that x2 patients CT reports were delayed. 3rd Breach still required validation at the time of this report.

For June , Primary Angioplasty Door to balloon time (<90 minutes) was at 88.9% and Call to balloon time (<150 minutes) at 93.8% hence both indicators delivering consistently against 80% targets

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

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

Cancer Care

- May performance delivery across all cancer targets including 62 Days at 85.2%
- June cancer performance expected to deliver to targets.
- July being currently validated.

May validated position is that :
- x9.5 [x8] patients waited longer than the 62 days.
- x2 [x5] patients waited more than 104 days at the end of May
-The longest waiting patient as at the end of May was at 139 days [140 days]

- (4/40 patients) neutropenic sepsis June cases failed to receive treatment within prescribed period (less than 1hr). Number of missed delivery is reducing, but the aim is to achieve 100% target consistently.
- 0% of Tertiary referrals were met within 38 days by the Trust for the month of May - the consistent failure to meet this target requires attention and escalated to GDO for review & assurance.

Patient Experience - MSA & Complaints

There were no MSA breaches in June.

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

The number of complaints received for the month of June is 88 with 2.8 formal complaints per 1000 bed days.
100% have been acknowledged within target timeframes (3 days).
8.6% of responses have been reported beyond agreed target time, showing steady improvement to last months.

Patient Experience - Cancelled Operations

- 58 [65] sitrep declared late (on day) cancelations were reported in June of which avoidable were high.
- Of 58 patients who were cancelled, 20 [27] were validated as avoidable in June.
- The proportion of elective operations cancelled at the last minute for non-clinical reasons was 1.3% for June (rising since Jun16 when at 0.7%) failing the tolerance of 0.8% consistently.
13/12 months consistent failure to achieve standard

- There were no breaches of the 28 days guarantee in June
- No urgent cancellations took place during the month of June

Theatre utilisation is consistently below the target of 85% at a Trust average of 77.3% in June - the highest performance in the last 12 months but below 85% target. The indicator alone does not measure productivity and hence this is subject to the Theatre Improvement Project overseen by the Theatres Board

Emergency Care

- The Trust's performance against the 4-hour ED wait target in June was 83.47% 81.57% [81.57%] against the 90% STF & 95% national target
- 3, 014 breaches were incurred in June

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

- WMAS fineable 30 - 60 minutes delayed handovers at 242 [159] in June.
- x6 [x12] cases were > 60 minutes delayed handovers in June
- Handovers >60mins (against all conveyances) 0.14% in June exceeding the target of 0.02%.

Fractured Neck of Femur Best Practice Tariff delivery for June is at 84% showing an improvement on previous month, and just 1% below the national target of 85%.
Consistently below target.

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

Referral To Treatment

- RTT incomplete pathway for June is at 93.3% [93.79%]; continuing to perform to trajectory in aggregate.

- Specialities which continue to under-perform against 92% standard are: T&O, Oral surgery, Plastic Surgery and Dermatology

- The RTT backlog for June has 2,188 [2,024] patients waiting over 18+

- The total waiting list has remained fairly static for the last three months stabilising at 32,000-33,028 patients (Sept16 high at 37,380)

- July performance is expected to deliver the national standard of 92% and the Trust is tracking this performance

There were no 52 week breaches in June on the incomplete pathway.

- Diagnostics performance has delivered at 99.08% in June just clearing the national standard of 99% , mainly impacted by CT equipment failure in the month
- July performance is expected to deliver improved levels of breaches

Data Completeness

- The Trust's internal assessment of the completion of valid NHS Number Field within inpatient data sets remains below the 99.0% operational threshold (May 98.3%). OP and A&E datasets deliver to target.
- ED required to improve patient registration performance as this has a direct effect on emergency admissions.
- Patients who have come through Malling Health will be validated via the Data Quality Department.
- Ethnicity coding is performing for Inpatients at 91% against 90% target, but under-delivering for Outpatients. This is attributed to the capture of data in the Kiosks and revision to capture fields is being considered.

Open Referrals, non RTT pathways/ without future waiting list activity, stand at 118,000 as at June showing a steadily increasing trend again as administration/IT processes persistently do not close down referrals/pathways as appropriate. A project to re-visit this has been kicked off and new PTL meetings will focus on working these through. Low patient risk rated (green risk) amount to c15,000 which are part of the 118,000, are subject to auto-closures since Jan2016.

Staff

PDR overall compliance as at the end of June is at 88.3% against the 95% target. Medical Appraisal at 85.7% (performance indicates appraisals 'validated' not 'carried out').

In-month sickness for June is at 4.36% (4.71%) decreasing slightly to last month ; the cumulative sickness rate is 4.52%. The number of short term sickness 444 cases; long term 218 cases show a small increase to last month.

The Trust annualised turnover rate is at 11.6% in June.
Specifically, nursing turnover in June is at 12.0% now higher than the overall staff turnover e.g. more nurses are leaving than other staff. Both are still well above trust aspirations in respect of turnover rate.

Mandatory Training at the end of June is at 87.1% overall against target of 95%; Health & Safety related training is above the 95% target at 95.7% in June.
Safeguarding training recovery plans failing at 2 levels, with a further exception report extending delivery to Sept17.

CQUINs & Local Quality Requirements 2017/18

- The Trust has been funded to support 9x national CQUINs and 3x Specialised Commissioning schemes and several Public Health schemes. The funding value in 2017/18 is £8.8m.
- Quarter 1 reporting completes at the end of July. There is one risks in Q1 reporting in respect of Sepsis delivery.
- Commissioners feed back is expected over the next couple of weeks

Local Quality Requirements 2017/18 are monitored by CCG and the Trust is fineable for any breaches in accordance to guidance. The Trust has got a number of formally agreed RAPs (recovery action plans) in place at this stage which continued into 17/18:
- Safeguarding training for which the performance notice action plan has been accepted, but failing to deliver trajectory - failure to deliver 2 training levels now to be rectified by Sept17
- Community falls & dementia delivery is being assessed
- On the Day Cancellations are subject to TIP
- Gynae 4 week community clinics are delivering in line with improvement trajectory
- A&E including morning discharges and other A&E indicators are subject to an overall plan.
- A new IPR page has been added to highlight and monitor areas of non-compliance (Local Quality Requirements page).
-

STF Criteria & NHSi Single Oversight Framework

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

Q1 ED funding [£236k] not secured due to non-compliance with 90% standard.
Q2 STF £315k at risk if fail to deliver 90% standard for the quarter.

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

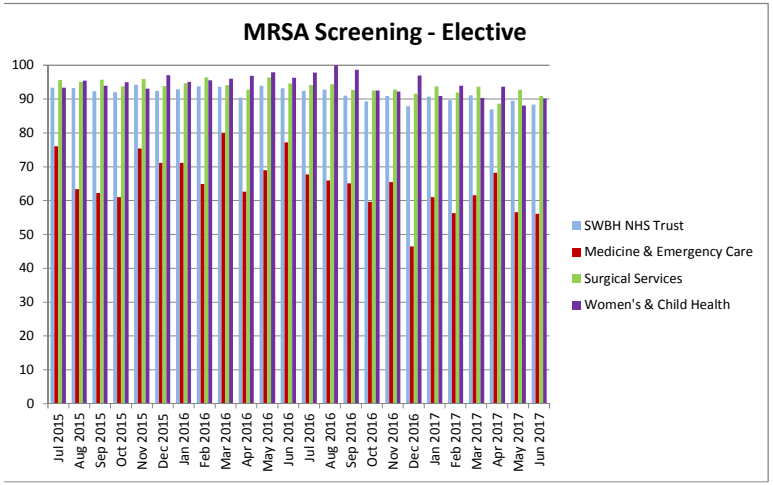
Summary Scorecard - June (In-Month)

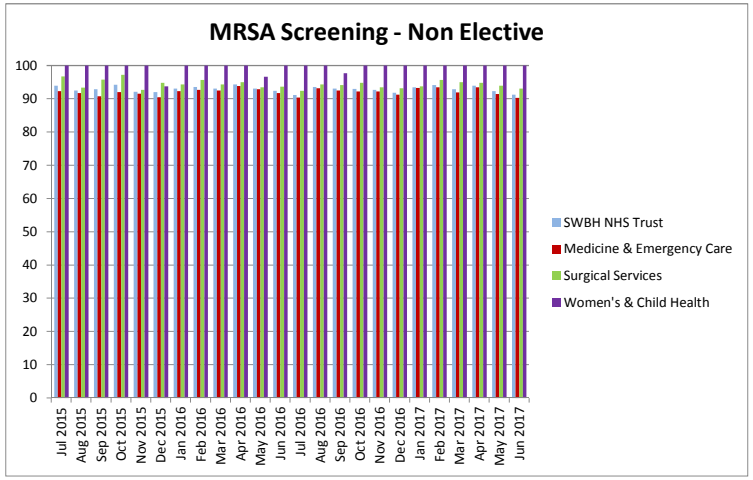
Summary Scorecard

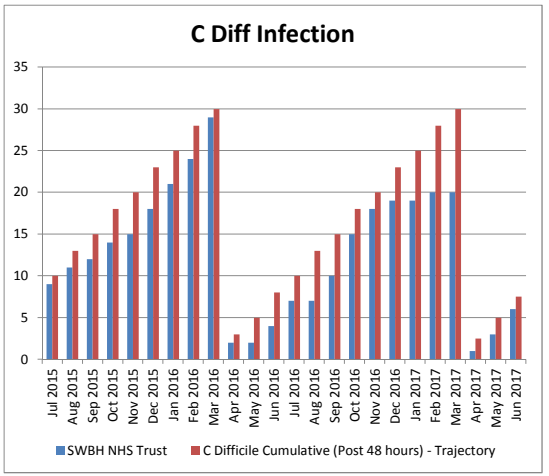
Section	Red Rated	Green Rated	None	Total
Infection Control	1	5	0	6
Harm Free Care	10	3	9	22
Obstetrics	3	4	5	12
Mortality and Readmissions	1	1	11	13
Stroke and Cardiology	1	10	0	11
Cancer	0	10	5	15
FFT, MSA, Complaints	13	2	6	21
Cancellations	5	3	0	8
Emergency Care & Patient E	10	4	4	18
RTT	5	3	6	14
Data Completeness	2	8	9	19
Workforce	5	1	13	19
Temporary Workforce	0	0	28	28
SQPR	9	0	1	10
Total	65	54	97	216

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Jan 2016) J F M A M J J A S O N D J F M A M J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
4		d	C. Difficile	<= No	30	2.5		Jun 2017	3	0	0					3	6	
4		d	MRSA Bacteraemia	<= No	0	0		Jun 2017	0	0	0					0	0	
4			MSSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9.42		Jun 2017								5.2	12.0	
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	94.9	94.9		Jun 2017								10.4	8.5	
3			MRSA Screening - Elective	=> %	80	80		Jun 2017	56	91	90					88.4	88.4	
3			MRSA Screening - Non Elective	=> %	80	80		Jun 2017	90	93	100					91.3	92.6	

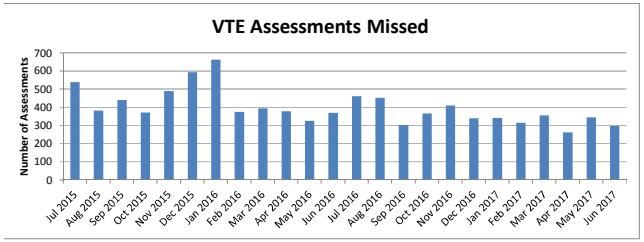


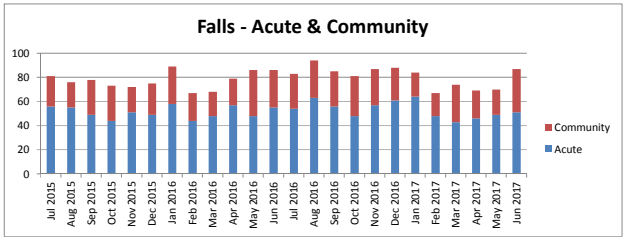


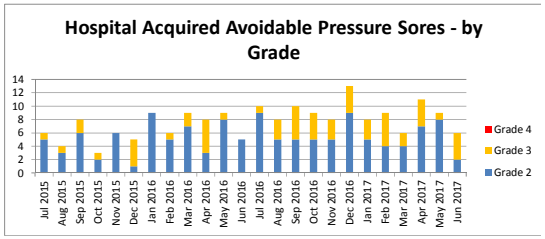


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jan 2016) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
8		d	Patient Safety Thermometer - Overall Harm Free Care	=> %	95	95																			Jun 2017								95.7	95.0	
8		d	Patient Safety Thermometer - Catheters & UTIs	%			4.00	2.00	1.00	3.00	6.00	2.00	3.00	3.00	3.00	1.00	6.00	2.00	2.00	0.00	0.00	3.00	2.00	1.00	Jun 2017								0.09	0.17	
	NEW		Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	-	25	22	15	14	23	15	14	6	Jun 2017	5	0	0	-	-	1		6	35	
	NEW		Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	-	25	22	14	14	23	15	14	6	Jun 2017	5	0	0	-	-	1		6	35	
	NEW		Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	-	6	0	0	0	0	0	0	0	Jun 2017	0	0	0	-	-	0		0	0	
	NEW		Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	-	4	15	14	8	8	15	12	9	Jun 2017	6	0	0	-	-	3		9	36	
	NEW		Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	-	6	6	2	11	6	3	11	7	Jun 2017	3	0	0	-	-	4		7	21	
	NEW		Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	-	1	0	1	1	0	1	0	2	Jun 2017	2	0	0	-	-	0		2	3	
	NEW		Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	-	-	-	-	-	5	2	1	0	0	3	1	1	Jun 2017	1	0	0	-	-	0		1	5	
8			Falls	<= No	804	67	89	67	68	79	86	86	83	94	85	81	87	88	84	67	74	69	70	87	Jun 2017	34	11	1	1	0	36		87	226	
9			Falls with a serious injury	<= No	0	0	2	2	2	1	0	4	1	3	3	1	2	3	3	1	2	1	1	1	Jun 2017	0	1	0		0	0		1	3	
8			Grade 2,3 or 4 Pressure Ulcers (Hospital Aquired Avoidable)	<= No	0	0	9	6	9	8	9	5	10	8	5	9	8	13	8	9	6	11	9	6	Jun 2017	5	0	0			1		6	26	
	NEW		Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload Acquired)	<= No	0	0	-	-	3	3	2	1	4	3	2	0	2	5	6	8	6	5	8	5	Jun 2017						5		5	18	
3		d	Venous Thromboembolism (VTE) Assessments	=> %	95	95																			Jun 2017	94.5	98.1	97.3					96.3	96.1	
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	100	100																		-	May 2017	100.0	99.9	99.7		0.0			99.9	99.9	
3			WHO Safer Surgery - brief (% lists where complete)	=> %	100	100																			Jun 2017	98	100	100		100			98.9	99.3	
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	100																			Jun 2017	96	99	97		100			97.7	98.1	
9		d	Never Events	<= No	0	0	0	1	0	0	0	1	1	0	0	0	1	0	0	1	0	0	1	1	Jun 2017	0	1	0	0	0	0		1	2	
9		d	Medication Errors causing serious harm	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	-	0	0		0	0	
9		d	Serious Incidents	<= No	0	0	12	8	5	2	1	10	5	6	4	6	5	10	5	6	5	4	4	3	Jun 2017	1	2	0	0	0	0	0	3	11	
9			Open Central Alert System (CAS) Alerts	<= No			7	6	5	1	13	3	11	12	12	14	10	8	6	5	4	8	9	27	Jun 2017								27	44	
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	No	0	0	2	1	2	0	0	0	0	1	1	2	1	2	0	1	0	0	0	1	Jun 2017								1	1	

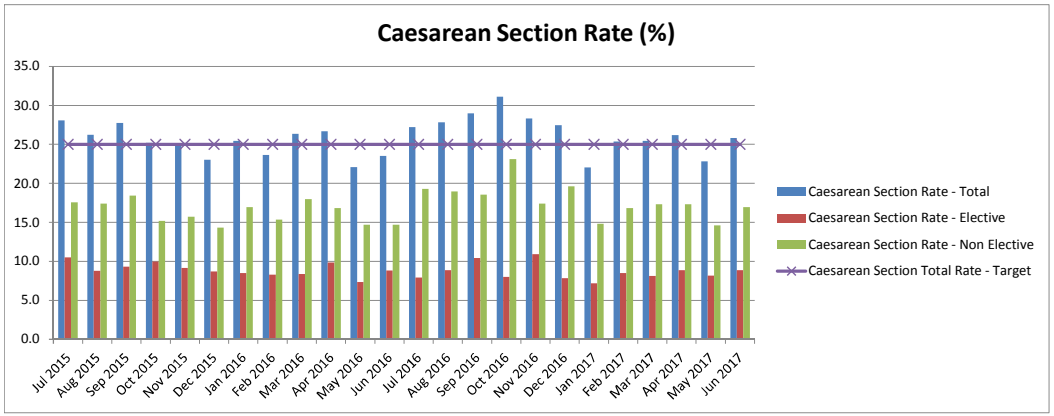


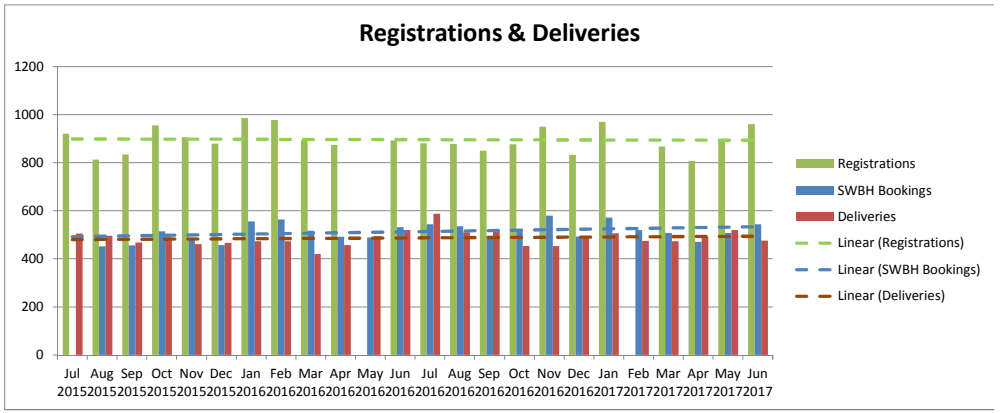




Patient Safety - Obstetrics

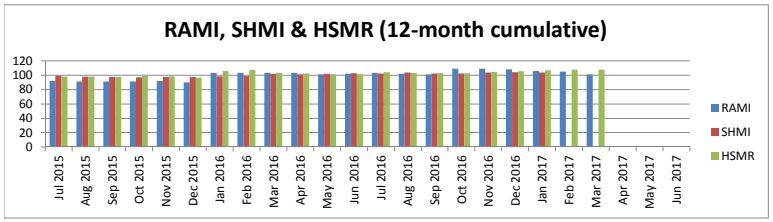
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory 2016-2017 Year	Trajectory 2016-2017 Month	Previous Months Trend (since Jan 2016) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Month	Year To Date	Trend
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			Jun 2017	25.8	24.9	
3			Caesarean Section Rate - Elective	<= %			8	8	8	10	7	9	8	9	10	8	11	8	7	9	8	9	8	9	Jun 2017	8.9	8.7	
3			Caesarean Section Rate - Non Elective	<= %			17	15	18	17	15	15	19	19	19	23	17	20	15	17	17	17	15	17	Jun 2017	16.9	16.3	
2		d	Maternal Deaths	<= No	0	0																			Jun 2017	0	0	
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Jun 2017	5	9	
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																			Jun 2017	1.26	1.61	
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Jun 2017	4.12	5.33	
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	90.0	90.0																			Jun 2017	77.6	78.5	
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																			Jun 2017	156.2	141.4	
2			Breast Feeding Initiation (Quarterly)	=> %	74.0	74.0	-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		Jun 2017	73.09	73.09	
2			Puerperal Sepsis and other puerperal infections (variation 1 - ICD10 O85 or O86) (%) -	<= %			0.7	1.6	1.8	1.8	3.7	1.9	1.4	1.8	3.2	2.9	2.8	3.5	2.9	1.9	2.6	4.4	2.5	2.5	Jun 2017	2.52	3.14	
2			Puerperal Sepsis and other puerperal infections (variation 2 - ICD10 O85 or O86 Not O864) (%)	<= %			-	0.8	1.5	1.3	3.4	1.3	1.4	1.5	3.0	1.8	1.9	1.7	2.5	1.6	2.3	3.0	1.6	1.6	Jun 2017	1.61	2.07	
2			Puerperal Sepsis and other puerperal infections (variation 3 - ICD10 O85) (%)	<= %			-	0.8	1.1	1.0	2.4	1.3	1.4	1.5	3.0	1.4	1.3	1.0	2.0	1.6	2.1	2.3	1.4	1.6	Jun 2017	1.59	1.76	

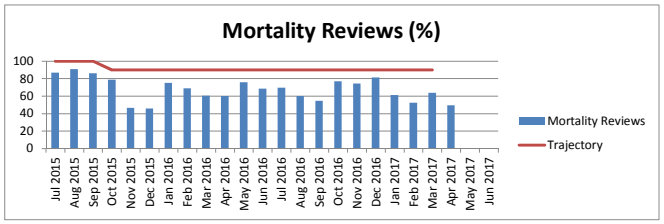


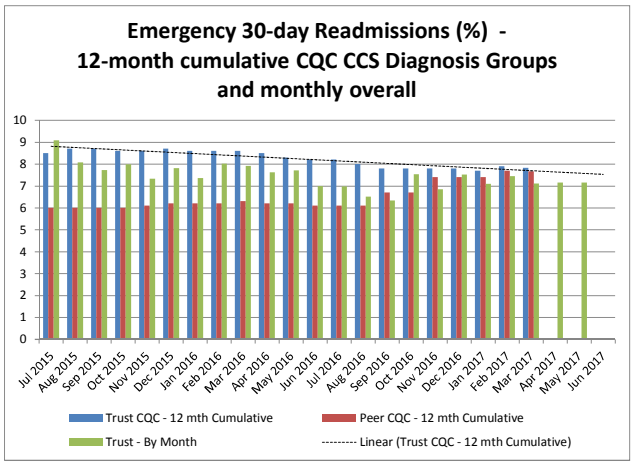


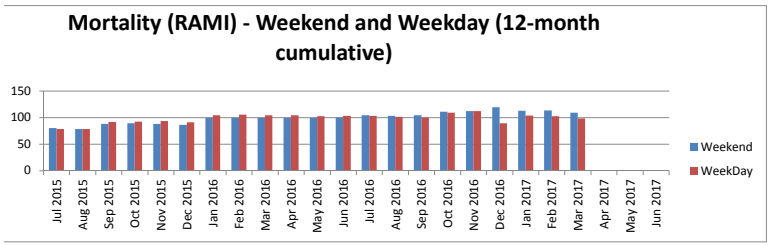
Clinical Effectiveness - Mortality & Readmissions

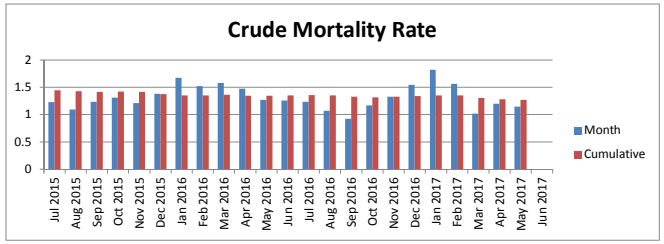
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jan 2016) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	103	103	103	103	101	102	103	102	101	109	109	108	106	105	101	-	-	-	Mar 2017									1250	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	104	105	104	104	102	103	103	101	100	109	112	89	104	102	98	-	-	-	Mar 2017									1227	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	99	99	99	99	99	100	104	103	104	111	112	119	112	113	109	-	-	-	Mar 2017									1285	
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	98	99	102	101	102	103	102	104	102	102	104	104	104	-	-	-	-	-	Jan 2017									1028	
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			106	107	103	102	101	101	104	103	103	103	105	106	107	108	108	-	-	-	Mar 2017									1249.6	
5		C	Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	68	113	82	103	50	3	103	43	56	94	139	84	105	72	88	-	-	-	Mar 2017								88		
3			Mortality Reviews within 42 working days	=> %	90	90	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	-	-	Apr 2017	50	46	0					50	50	
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.7	1.5	1.6	1.5	1.3	1.3	1.2	1.1	0.9	1.2	1.3	1.5	1.8	1.6	1.0	1.2	1.1	-	May 2017								1.15		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.4	1.4	1.4	1.3	1.3	1.4	1.4	1.4	1.3	1.3	1.3	1.3	1.3	1.4	1.3	1.3	1.3	-	May 2017									1.27	
	NEW		Deaths in the Trust	No			163	146	158	142	121	123	119	102	87	108	129	143	172	139	100	105	113	-	May 2017								113	218	
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			7.4	8.0	7.9	7.6	7.7	7.0	7.0	6.5	6.3	7.5	6.8	7.5	7.1	7.4	7.1	7.2	7.2	-	May 2017								7.16		
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			8.2	8.2	8.1	8.0	7.9	7.8	7.6	7.5	7.4	8.0	7.3	7.1	7.2	7.2	7.1	7.1	7.0	-	May 2017									7.05	
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			8.6	8.6	8.6	8.5	8.3	8.2	8.2	8.0	7.8	7.8	7.8	7.8	7.7	7.9	7.8	-	-	-	Mar 2017	-	-	-						-	





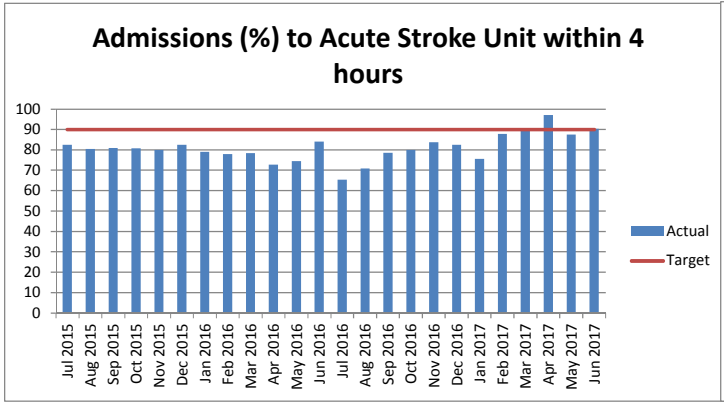


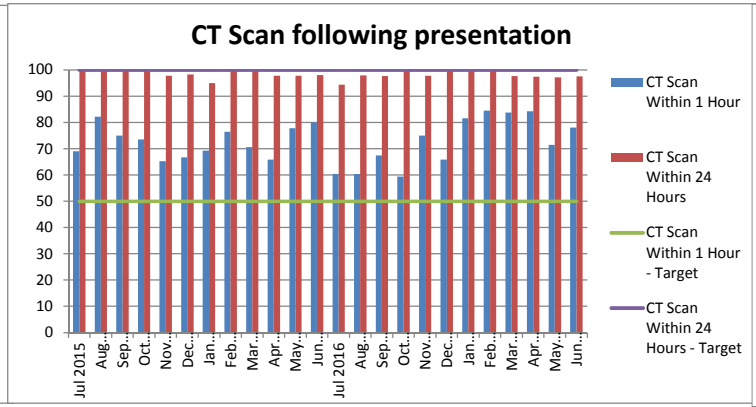


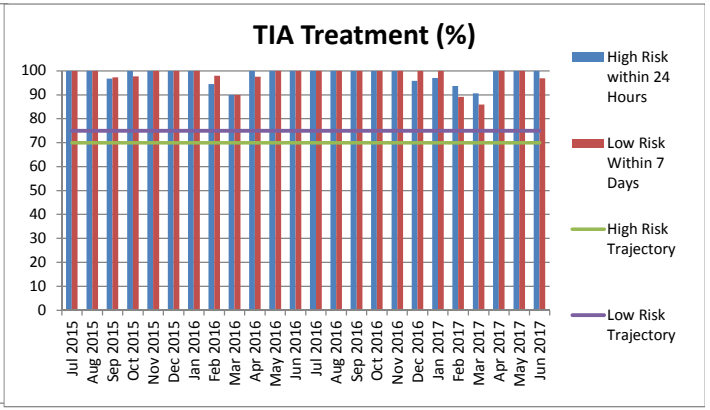


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Jan 2016) J F M A M J J A S O N D J F M A M J	Data Period	Month	Year To Date	Trend
3			Pts spending >90% stay on Acute Stroke Unit	=> %	90.0	90.0		Mar 2017	86.0	94.5	
3			Pts admitted to Acute Stroke Unit within 4 hrs	=> %	90.0	90.0		Jun 2017	90.2	91.6	
3			Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0		Jun 2017	78.0	78.1	
3			Pts receiving CT Scan within 24 hrs of presentation	=> %	95.0	95.0		Jun 2017	97.6	97.4	
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0		Jun 2017	0.0	44.4	
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0		Jun 2017	100.0	101.7	
3			TIA (High Risk) Treatment <24 Hours from receipt of referral	=> %	70.0	70.0		Jun 2017	100.0	100.0	
3			TIA (Low Risk) Treatment <7 days from receipt of referral	=> %	75.0	75.0		Jun 2017	96.9	99.0	
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0		Jun 2017	88.9	93.5	
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0		Jun 2017	93.8	95.2	
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0		Jun 2017	100.0	100.0	



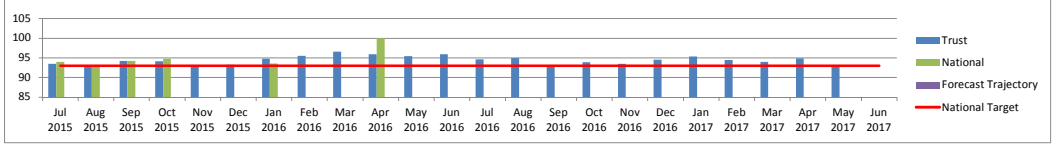




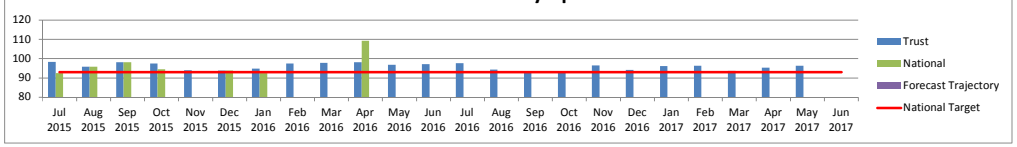
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jan 2016) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
1			2 weeks	=> %	93.0	93.0																		-	May 2017	90.1	94.3	96.6					93.2	94.0	
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		-	May 2017		-						96.2	95.7	
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	May 2017	100.0	98.8	93.1					97.9	98.5	
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0																		-	May 2017								94.1	96.3	
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																		-	May 2017								100.0	100.0	
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																		-	May 2017								-	0.0	
1			62 Day (urgent GP referral to treatment) Excluding Rare Cancer	=> %	85.0	85.0																		-	May 2017	87.5	87.5	72.7					85.2	85.4	
1	NEW		62 Day (urgent GP referral to treatment) Including Rare Cancer	=> %	85.0	85.0																		-	May 2017	87.5	87.5	72.7					85.2	85.5	
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																		-	May 2017	0.0	100.0	100.0					100.0	100.0	
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																		-	May 2017	90.5	100.0	100.0					95.0	97.1	
1			Cancer - Patients Waiting over 62 days	No			5.5	10.0	5.5	8.5	11.0	6.5	7.0	11.5	8.0	9.5	10.5	10.0	8.0	15.0	7.5	8.0	9.5	-	May 2017	2.0	4.5	3.0					9.5	17.5	
1			Cancer - Patients Waiting over 104 days	No			0	4.5	0.5	3.0	1.0	2.0	3.0	3.0	4.0	1.5	1.5	2.5	1.5	4.0	5.0	5.0	2.0	-	May 2017	0.0	1.0	1.0					2.0	7.0	
1			Cancer - Longest Waiter in days	No			98	154	98	175	95	130	113	131	140	133	77	107	120	150	162	140	139	-	May 2017	91	114	139					139		
1			Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	=> No	0.0	0.0	-	-	-	10	8	12	13	5	15	12	12	19	17	8	6	11	6	4	Jun 2017	4	0	0					4	21	
	NEW		IPT Referrals - Within 38 Days Of GP Referral for 62 day cancer pathway	%			-	-	-	-	50	33	50	43	67	50	0	0	33	0	50	0	0	-	May 2017	-	-	-					0	0	

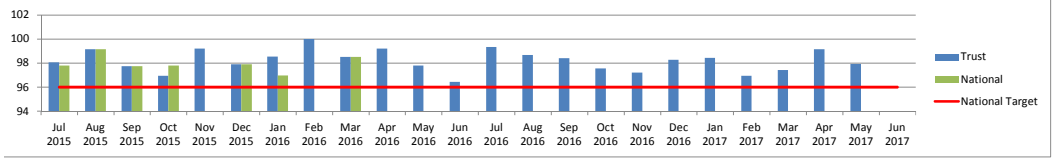
2-week wait from Referral to Date First Seen



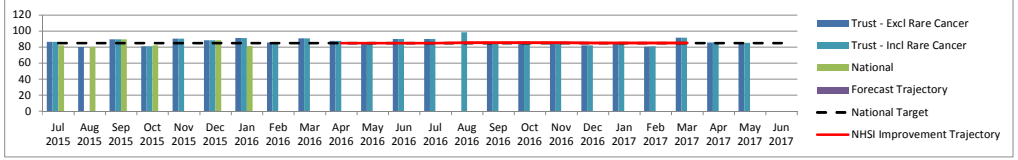
2-week wait from Breast Symptomatic Patients



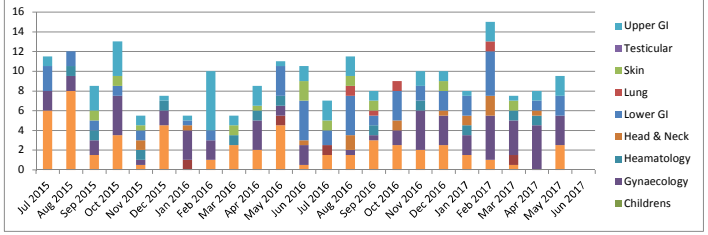
31-day Diagnosis to First Treatment



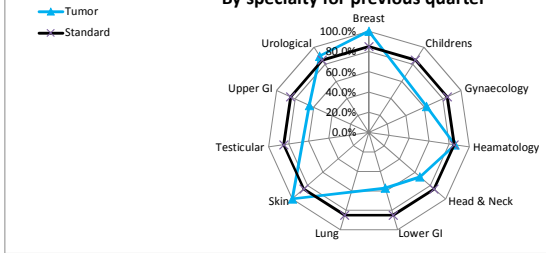
62-day Urgent GP Referral to First Treatment



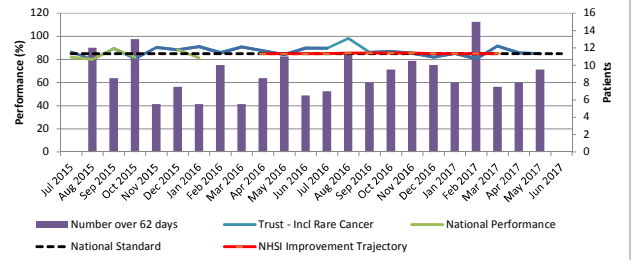
62-day Urgent GP Referral to First Treatment Breach- By Tumour Site



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

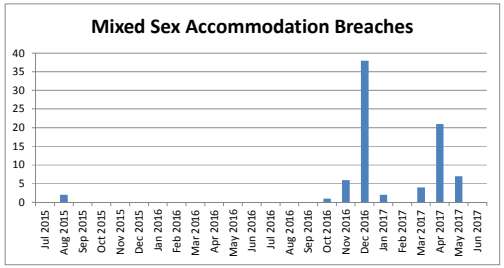


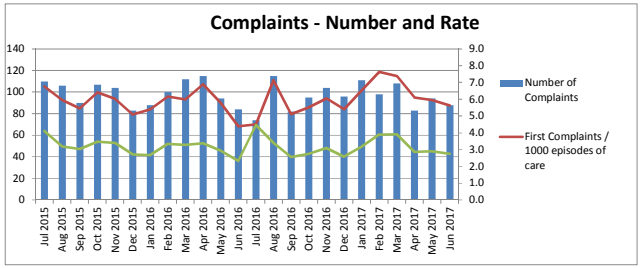
62-day Urgent GP Referral to First Treatment

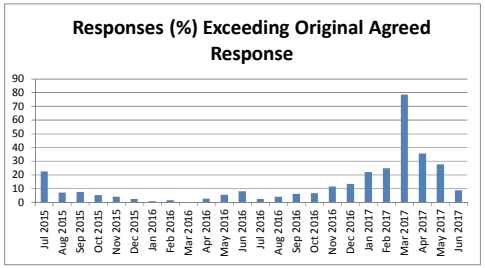


Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jan 2016) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
8		b	FFT Response Rate - Adult and Children Inpatients (including day cases and community)	=> %	50.0	50.0	15	15	14	17	16	17	17	13	20	22	17	10	15	9.7	7.9	9.3	11	11	Jun 2017								11	11	
8		a	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95.0	95.0	96	95	95	96	90	83	86	83	86	88	94	97	97	95	96	95	92	92	Jun 2017								92		
8		b	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50.0	50.0	6.3	6	5.3	5.1	8.3	10	7.8	7.5	7.1	5.6	4.8	5.9	5.4	4.3	4.2	5.5	4	2.4	Jun 2017	2.4							2.4	3.7	
8		a	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95.0	95.0	79	74	74	78	85	87	86	83	78	73	75	73	77	76	73	75	71	73	Jun 2017	73							73		
8			FFT Response Rate: Type 3 WiU Emergency Department	=> %	50.0	50.0	1.5	0.1	0	0.3	2.5	0.1	1.3	0.6	0.5	0.5	0.3	1.2	0.6	0	0	0.1	0	0	Jun 2017	-							-	0.1	
8			FFT Score - Adult and Children Emergency Department (type 3 WiU)	=> No	95.0	95.0	85	0	0	100	96	50	95	100	86	64	100	100	65	0	0	0	0	0	Jun 2017	-							0		
8			FFT Score - Outpatients	=> No	95.0	95.0	90	88	87	87	88	88	86	89	88	88	89	90	88	88	90	90	89	88	Jun 2017								88		
8	NEW		FFT Score - Maternity Antenatal	=> No	95.0	95.0	96	100	95	100	91	100	94	86	79	86	90	86	97	11	95	88	90	75	Jun 2017								75		
8	NEW		FFT Score - Maternity Postnatal Ward	=> No	95.0	95.0	95	91	91	97	100	100	100	100	74	81	93	90	91	29	83	91	86	73	Jun 2017								73		
8	NEW		FFT Score - Maternity Community	=> No	95.0	95.0	96	99	99	99	99	100	98	96	91	100	100	50	0	0	80	100	##	0	Jun 2017								0		
8			FFT Score - Maternity Birth	=> No	95.0	95.0	90	94	93	92	90	0	0	100	87	71	88	90	88	23	92	82	83	69	Jun 2017								69		
8			FFT Response Rate - Maternity Birth	=> %	50.0	50.0	23	15	10	12	9	0	0	1.4	15	5.9	17	13	8.2	5.4	21	8.9	11	7	Jun 2017								7	9	
13		a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	0	0	0	0	0	0	0	0	1	6	38	2	0	4	21	7	0	Jun 2017	0	0	0		0	0		0	28	
9			No. of Complaints Received (formal and link)	No			88	100	112	115	94	84	74	115	82	95	104	96	111	98	108	83	94	88	Jun 2017	40	20	12	1	2	8	5	88	265	
9			No. of Active Complaints in the System (formal and link)	No			113	128	147	154	144	147	127	143	144	152	148	157	176	177	194	205	##	185	Jun 2017	91	51	15	2	4	12	10	185		
9		a	No. of First Formal Complaints received / 1000 bed days	Rate1			2.7	3.3	3.3	3.4	2.9	2.3	4.5	3.4	2.6	2.8	3.1	2.6	3.2	3.9	3.9	2.9	2.9	2.8	Jun 2017	2.4	3.7	2.8					2.76	2.84	
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			5.4	6.2	6.0	6.9	5.8	4.4	4.5	7.1	5.1	5.5	6.1	5.4	6.5	7.6	7.4	6.1	6.0	5.6	Jun 2017	6.2	5.2	4.8			0		5.64	5.90	
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	=> %	100	100	100	100	100	100	100	100	96	100	100	99	100	100	99	98	94	100	##	100	Jun 2017	100	100	100	100	100	100	100	100	100	
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	<= %	0	0	0.9	1.6	0	2.6	5.6	8.2	2.4	4.2	6.3	6.6	11	13	22	25	79	36	28	8.6	Jun 2017	6.5	10	27	0	0	8.3	0	9	24	
9			No. of responses sent out	No			69	81	84	98	81	103	103	80	110	87	79	79	76	95	84	67	##	87	Jun 2017	28	30	12	1	2	5	9	87	260	
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	N	N	N	N	N	N	N	No		

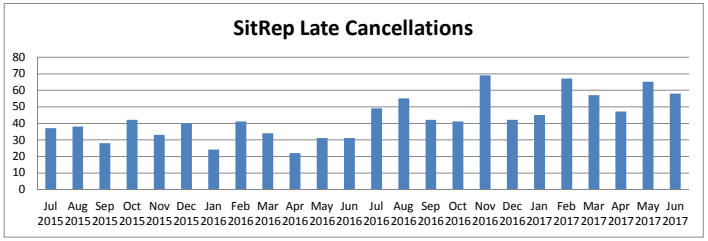


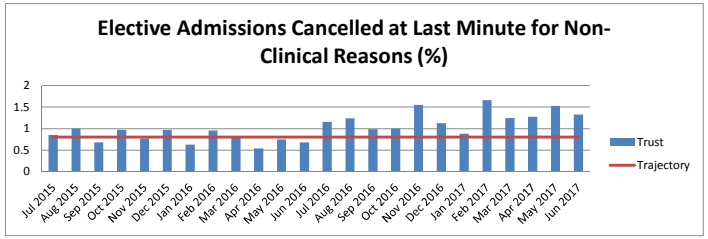


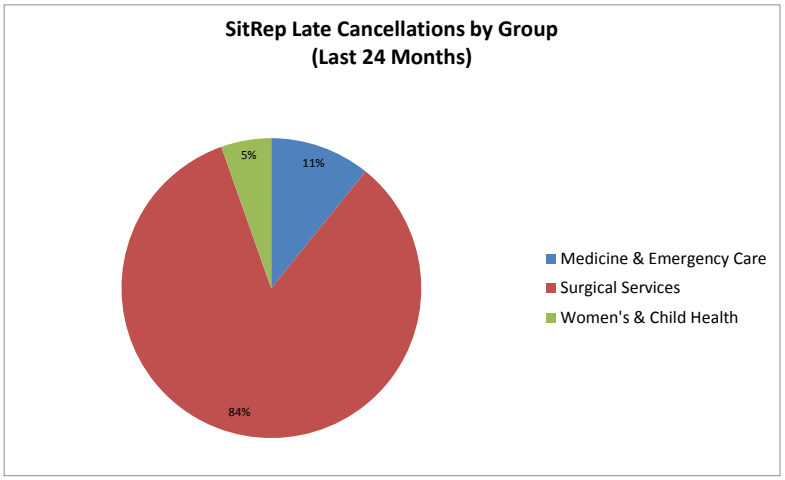


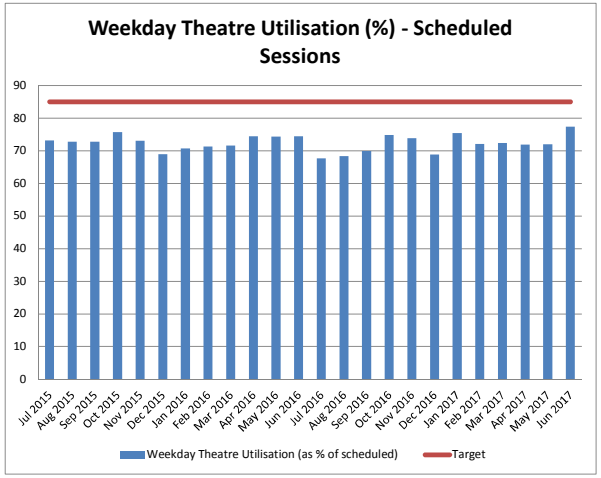
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jan 2016) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
2			No. of Sitrep Declared Late Cancellations - Total	<= No	320	27	24	41	34	22	31	31	49	55	42	41	69	43	45	67	57	47	65	58	Jun 2017	3	38	17					58	170	
2			No. of Sitrep Declared Late Cancellations - Avoidable	No			-	-	-	6	9	11	9	9	15	17	28	19	13	19	17	24	27	20	Jun 2017	3	14	3					20	71	
2			No. of Sitrep Declared Late Cancellations - Unavoidable	No			-	-	-	16	22	19	40	43	27	22	41	18	29	48	37	23	37	37	Jun 2017	0	23	14					37	97	
2		•	Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	0.8	0.8																			Jun 2017	0.16	1.71	5.57					1.3	1.4	
2		•e•	Number of 28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	1	0	3	6	0	0	1	0	0	Jun 2017	0	0	0					0	1	
2		•e	No. of second or subsequent urgent operations cancelled	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	0	0					0	0	
2			Urgent Cancellations	<= No	0.0	0.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0.0	0.0	0.0					0	0	
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	<= No	0	0	0	0	0	0	0	1	2	0	0	1	3	4	0	3	0	3	1	3	Jun 2017	1	2	0					3	7	
			Multiple Hospital Cancellations experienced by same patient (all cancellations)	<= No	0	0	63	56	57	79	63	43	56	51	60	49	50	63	61	62	67	51	45	72	Jun 2017	5	62	5					72	168	
3			All Hospital Cancellations, with 7 or less days notice	<= No	0	0	210	228	223	229	257	229	241	223	258	234	273	272	269	284	257	219	230	250	Jun 2017	34	181	35					250	699	
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0																			Jun 2017	63.3	77.9	81.7					77.4	73.8	



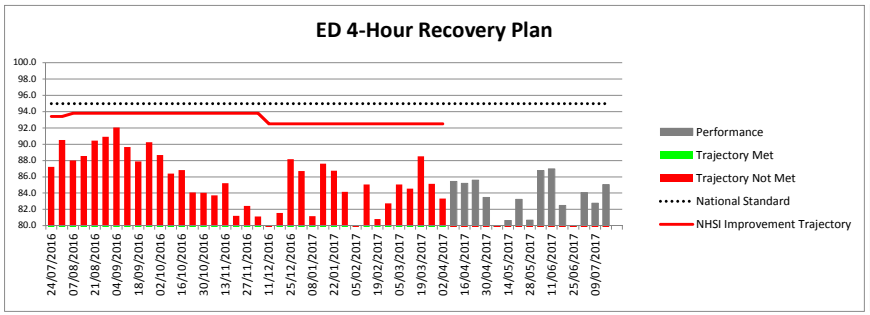


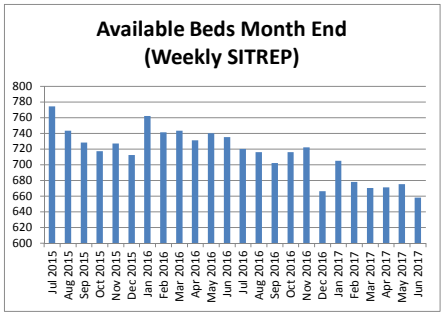


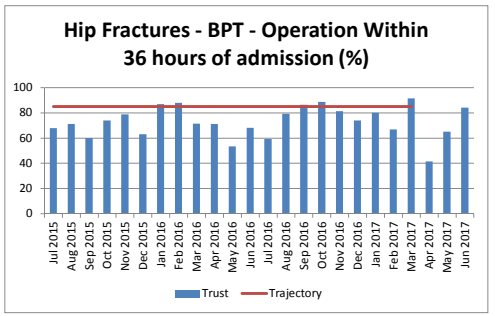


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Unit S	C	B	Month	Year To Date	Trend
2		e	Emergency Care 4-hour waits	=> %	95.00	95.00																			Jun 2017	80.7	84.3	96.7	83.47	83.31	
2			Emergency Care 4-hour breach (numbers)	No			1757	1956	2342	1608	1451	1625	2168	1884	2051	2676	3237	3324	2821	3046	2875	2814	3549	3014	Jun 2017	1577	1397	40	3014	9377	
2		e	Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			Jun 2017	0	0		0	0	
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			Jun 2017	14	13	16	14	14	
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Jun 2017	67	63	115	69	68	
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			Jun 2017	8.72	8.69	3.69	8.33	7.95	
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Jun 2017	5.92	7.43	2.69	6.40	5.86	
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	116	97	117	81	65	70	122	112	135	112	162	193	162	129	107	110	159	242	Jun 2017	141	101		242	511	
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	10	6	9	2	0	1	8	6	9	16	21	19	11	13	5	0	12	6	Jun 2017	1	5		6	18	
11			WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Jun 2017	0.05	0.23		0.14	0.14	
11			WMAS - Emergency Conveyances (total)	No			4679	3961	4513	4115	4604	4099	4363	4204	4138	4233	4261	4622	4410	4034	4206	4137	4376	4254	Jun 2017	2038	2216		4254	12767	
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																			Jun 2017	1.2	3.5		2.1	2	
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	<10 per site	<10 per site																			Jun 2017	4.25	7.75		12		
2			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	<= No	0	0	318	426	397	454	494	588	617	530	483	509	503	674	629	512	583	546	501	483	Jun 2017				483	1530	
2			Delayed Transfers of Care (Acute) - Finable Bed Days (Birmingham LA only)	<= No	0	0	185	198	232	234	228	251	245	287	215	266	272	449	435	309	375	324	258	312	Jun 2017				312	894	
2			Patient Bed Moves (10pm - 6am) (No.) -ALL	No			632	543	546	563	498	451	578	533	525	546	679	666	682	633	586	584	651	536	Jun 2017				536	1771	
2			Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units	No			320	269	232	255	222	204	268	246	248	219	273	251	249	228	221	229	234	205	Jun 2017				205	668	
			Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85.0	85.0																			Jun 2017				84.0	62.2	

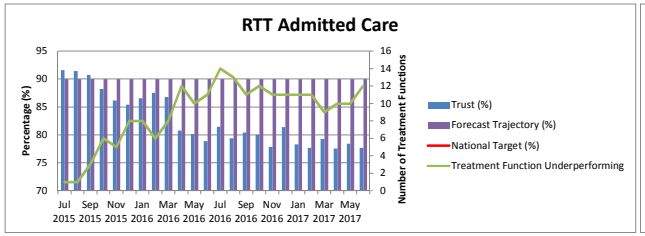


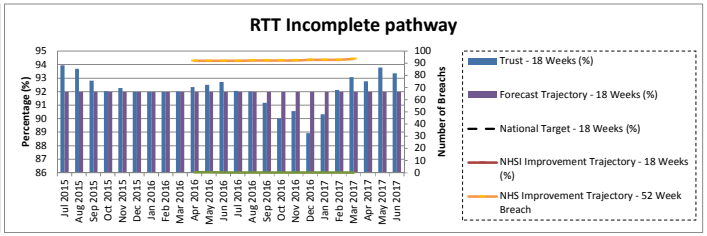


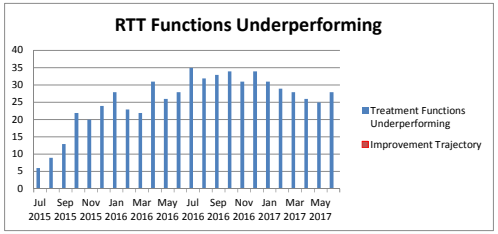


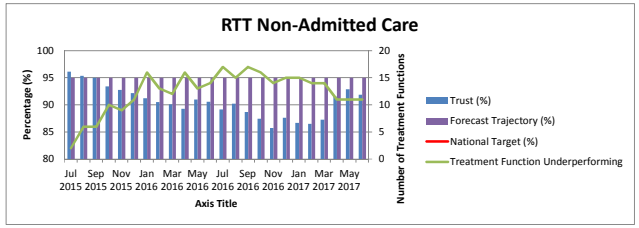
Referral To Treatment

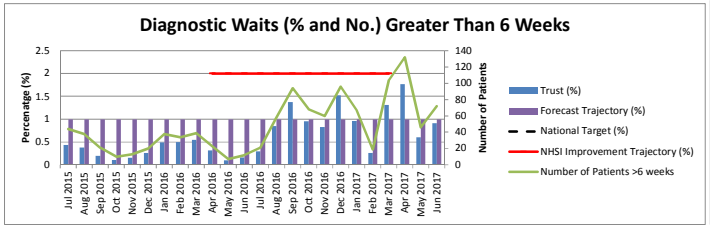
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jan 2016) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
2			RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Jun 2017	87.7	73.2	78.0					77.67		
2			RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Jun 2017	82.6	92.0	96.9					91.88		
2			RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Jun 2017	93.5	92.2	93.8					93.37		
	NEW		RTT - Backlog	No			2468	2423	2557	2566	2561	2515	2870	2968	3289	3728	3417	3908	3204	2578	2214	2327	2024	2188	Jun 2017	497	1293	97					2188		
2			Patients Waiting >52 weeks	<= No	0	0	4	5	8	3	2	4	4	0	1	4	3	2	0	3	6	5	3	2	Jun 2017	1	1	0					2	10	
2	NEW		Patients Waiting >52 weeks (Incomplete)	<= No	0	0	3	3	2	0	2	2	0	0	1	2	2	2	1	3	2	3	3	0	Jun 2017	0	0	0					0	6	
2			Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	<= No	0	0	28	23	22	31	26	28	35	32	33	34	31	34	31	29	28	26	25	28	Jun 2017	8	18	1.0					28		
			Treatment Functions Underperforming (Incomplete)	<= No	0	0	4	4	2	3	3	3	4	4	5	6	6	8	5	4	5	5	4	5	Jun 2017	1	4	0					5		
2			Acute Diagnostic Waits in Excess of 6-weeks (End of Month Census)	<= %	1.0	1.0																			Jun 2017	1.5	0.9	0.0		0.7			0.91		
	NEW		Acute Diagnostic Waits in Excess of 6-weeks (In Month Waiters)	No			1250	273	281	542	480	419	502	470	500	711	817	498	902	387	577	942	931	650	Jun 2017	197	178	-		275			650		

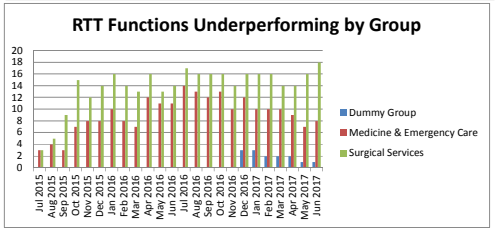


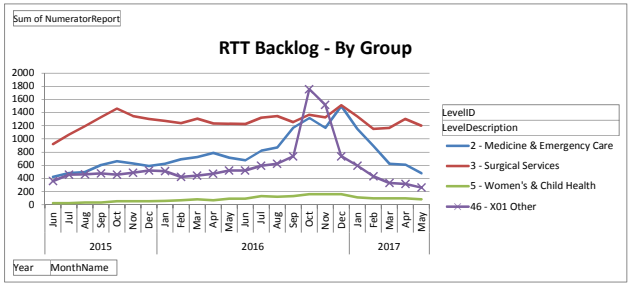


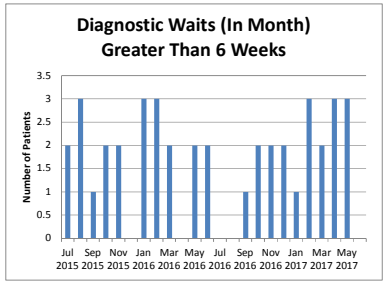


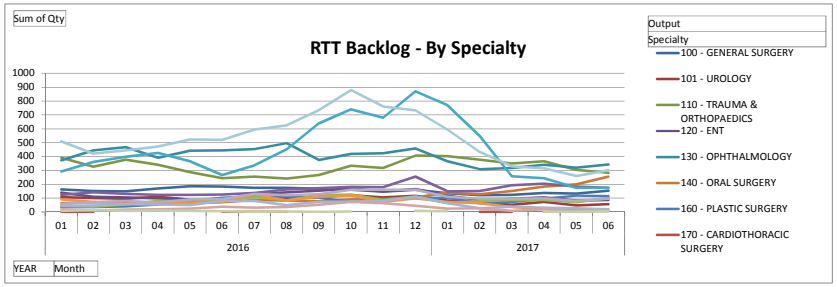






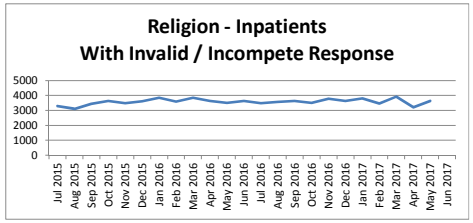


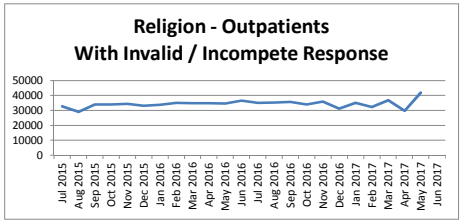


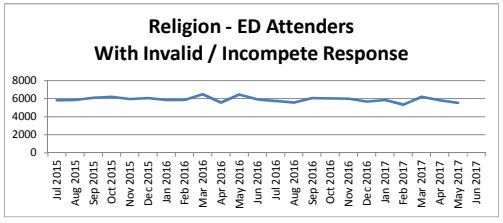


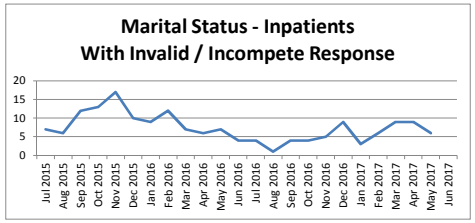
Data Completeness

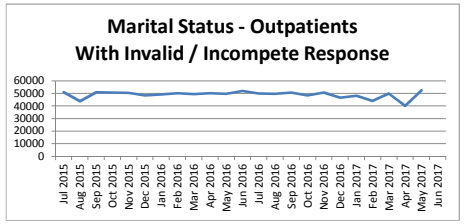
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jan 2016) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
14			Data Completeness Community Services	=> %	50.0	50.0																-	-	Apr 2017							61.2	61.2		
2			Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																-	-	Mar 2017								99.5		
2			Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																-	-	Mar 2017								99.2		
2			Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																-	-	Mar 2017								99.3		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=> %	99.0	99.0	97.5	96.5	98.1	96.7	96.7	96.9	96.3	97.9	96.5	97.3	97.5	98.3	97.7	98.3	97.7	98.2	98.3	-	May 2017								98.3	98.2	
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	=> %	99.0	99.0	99.5	99.5	99.6	99.5	99.5	99.5	99.4	99.5	99.5	99.5	99.5	99.6	99.6	99.5	99.5	99.4	99.5	-	May 2017								99.5	99.5	
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=> %	95.0	95.0	97.3	97.0	97.1	96.7	96.8	97.2	97.0	96.7	97.0	97.2	97.6	97.0	97.7	97.3	97.3	97.3	97.4	-	May 2017								97.4	97.3	
2			Ethnicity Coding - percentage of inpatients with recorded response	=> %	90.0	90.0																	-	May 2017								90.4	90.5	
	NEW		Ethnicity Coding - percentage of outpatients with recorded response	=> %	90.0	90.0																	-	May 2017								89.7	89.6	
	NEW		Protected Characteristic - Religion - INPATIENTS with recorded response	%			68.9	70.3	68.6	69.6	69.9	69.5	69.8	69.2	68.9	69.6	69.2	69.1	68.7	69.2	68.8	70.3	70.6	-	May 2017								70.6	70.5	
	NEW		Protected Characteristic - Religion - OUTPATIENTS with recorded response	%			59.3	58.4	58.1	58.1	58.2	57.8	58.0	57.8	57.9	58.1	57.5	56.9	57.0	57.2	56.9	56.7	52.9	-	May 2017								52.9	54.6	
	NEW		Protected Characteristic - Religion - ED patients with recorded response	%			63.9	62.3	62.3	64.8	63.3	64.3	66.5	65.3	64.0	64.3	64.1	64.7	64.1	64.7	64.2	64.7	67.2	-	May 2017								67.2	65.9	
	NEW		Protected Characteristic - Marital Status - INPATIENTS with recorded response	%			99.9	99.9	99.9	99.9	99.9	100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0	99.9	99.9	99.9	100.0	-	May 2017								100.0	99.9	
	NEW		Protected Characteristic - Marital Status - OUTPATIENTS with recorded response	%			40.8	40.5	40.5	39.8	39.8	39.9	40.1	40.8	40.3	40.4	39.9	35.8	40.8	41.3	41.5	41.3	41.1	-	May 2017								41.1	41.2	
	NEW		Protected Characteristic - Marital Status - ED patients with recorded response	%			41.7	42.5	41.2	40.9	41.3	41.9	40.9	39.5	40.6	40.9	41.5	40.8	40.5	41.3	41.1	39.8	42.7	-	May 2017								42.7	41.3	
2			Maternity - Percentage of invalid fields completed in SUS submission	<= %	15.0	15.0																	-	May 2017								5.9	6.0	
2			Open Referrals Total	No			192,989	187,876	190,396	194,788	199,207	204,824	206,563	210,740	215,396	219,866	222,444	225,175	226,846	230,675	235,998	239,934	245,160	250,072	Jun 2017	81,548	129,204	31,759	6,960	545	56		250,072		
	NEW		of which : Open Referrals - Not RTT and No Future Appointment / Waiting List	No			-	-	-	-	77,139	77,410	77,383	81,209	86,309	87,537	92,360	95,712	99,043	102,885	108,584	111,242	115,133	118,367	Jun 2017	37,760	57,290	16,571	3,034	492	2,578		118367		

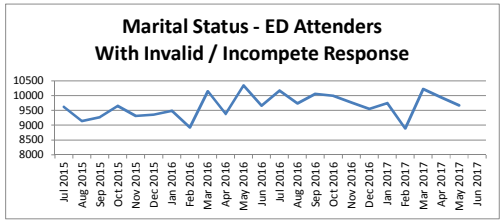


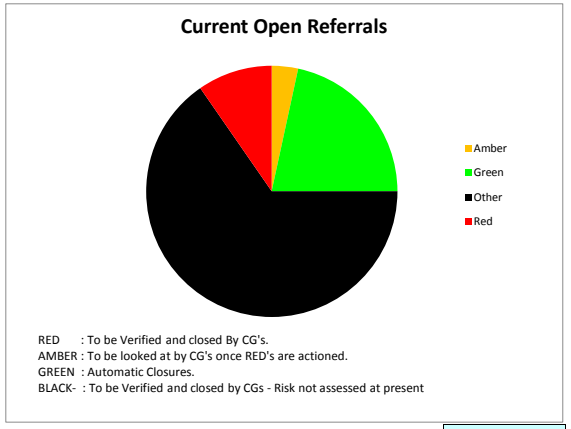






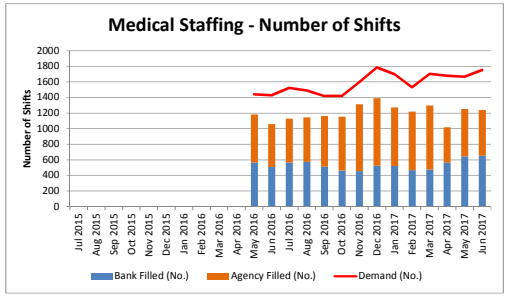


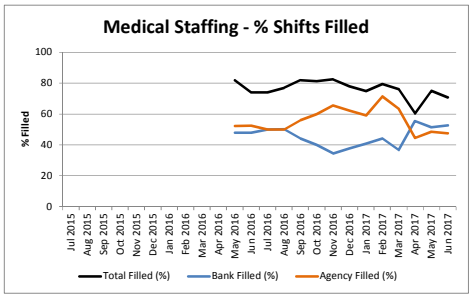


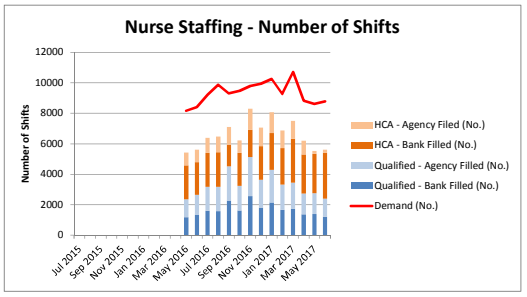


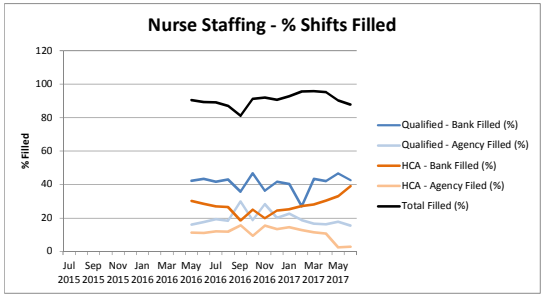
Temporary Workforce

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jan 2016) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
			Medical Staffing - Demand	No			-	-	-	-	1443	1429	1523	1491	1419	1419	1596	1786	1699	1534	1703	1682	1669	1753	Jun 2017	1144	305	291	0	13	0	0	1753	5104.0	
			Medical Staffing - Total Filled	%			-	-	-	-	81.98	74.04	74.06	76.93	81.89	81.25	82.46	77.94	74.93	79.4	76.1	60.4	75.07	70.62	Jun 2017	69.67	85.57	57.39	0	100	0	0	71	68.7	
			Medical Staffing - Bank Filled	%			-	-	-	-	47.84	47.92	50	50.13	44.06	40.07	34.42	37.79	40.93	44.12	36.65	55.51	51.48	52.58	Jun 2017	37.01	85.82	71.26	0	100	0	0	53	53.0	
			Medical Staffing - Agency Filled	%			-	-	-	-	52.16	52.36	50	49.87	55.94	59.93	65.58	62.21	59.07	71.44	63.35	44.49	48.52	47.42	Jun 2017	62.99	14.18	28.74	0	0	0	0	47	47.0	
			Medical Staffing - Filled Shifts - Snr Consultant	No			-	-	-	-	114	110	107	137	177	243	237	187	152	217	270	120	214	219	Jun 2017	162	27	17	0	13	0	0	219	553.0	
			Medical Staffing - Filled Shifts - Jnr Doctor	No			-	-	-	-	1069	951	1021	1010	998	951	1108	1196	1144	1001	1026	896	394	1019	Jun 2017	635	234	150	0	0	0	0	1019	2309.0	
			Nursing - Demand	No			-	-	-	-	8158	8413	9220	9887	9312	9476	9802	9935	10261	9268	10708	8825	8616	8784	Jun 2017	4548	1737	1100	0	16	1142	241	8784	26225	
			Nursing - Total Filled	%			-	-	-	-	90.44	89.33	89.21	86.98	81.13	91.18	92.03	90.68	92.75	95.55	95.8	95.29	90.22	87.8	Jun 2017	85.53	89.87	87.91	0	81.25	91.68	96.68	88	91.1	
			Nursing - Qualified - Bank Filled	%			-	-	-	-	42.3	43.41	41.68	43.12	35.83	46.77	36.3	41.77	40.3	27.07	43.52	42.07	46.67	42.6	Jun 2017	40.23	24.66	67.94	0	0	56.06	39.48	43	43.8	
			Nursing - Qualified - Agency Filled	%			-	-	-	-	16.01	17.56	19.34	18.41	29.95	18.76	28.38	20.17	22.55	18.71	16.76	16.32	17.77	15.5	Jun 2017	19.79	19.6	3.62	0	53.85	7.26	0	15	16.5	
			Nursing - HCA - Bank Filled	%			-	-	-	-	30.18	28.57	26.95	26.56	18.6	25.02	19.83	24.59	25.29	27.18	28.13	30.44	33.05	39.1	Jun 2017	35.55	54.9	28.34	0	46.15	33.52	60.52	39	34.1	
			Nursing - HCA - Agency Filled	%			-	-	-	-	11.39	11.07	12.01	11.92	15.62	9.444	15.49	13.48	14.48	12.91	11.59	10.74	2.509	2.8	Jun 2017	4.42	0.83	0.1	0	0	3.15	0	3	5.5	
			AHPs - Radiography - Demand (Shifts)	No			-	-	-	-	138	97	79	55	269	332	321	290	526	332	525	332	372	315	Jun 2017	0	0	0	0	315	0	0	315	1019	
			AHPs - Radiography - Filled (Shifts)	No			-	-	-	-	138	97	73	55	249	324	299	256	496	302	502	329	359	315	Jun 2017	0	0	0	0	315	0	0	315	1003	
			AHPs - Physiotherapy - Demand (Shifts)	No			-	-	-	-	191	156	192	55	63	38	190	186	276	478	356	180	242	257	Jun 2017	0	0	0	0	0	257	0	257	679	
			AHPs - Physiotherapy - Filled (Shifts)	No			-	-	-	-	191	156	192	55	63	38	190	186	274	478	346	180	242	257	Jun 2017	0	0	0	0	0	257	0	257	679	
			AHPs - Other - Demand (Shifts)	No			-	-	-	-	301	336	289	66	96	139	96	567	413	530	1009	459	527	471	Jun 2017	178	25	30	20	11	111	96	471	1457	
			AHPs - Other - Filled (Shifts)	No			-	-	-	-	301	336	288	55	95	95	200	567	412	527	885	457	527	471	Jun 2017	178	25	30	20	11	111	96	471	1455	
			Admin - Demand (Shifts)	No			-	-	-	-	1994	1954	1902	2147	2765	2839	2479	2442	2381	4128	5135	4198	4228	4423	Jun 2017	1089	662	262	319	106	110	1875	4423	12849	
			Admin - Filled (Shifts)	No			-	-	-	-	1988	1937	1855	2061	2450	2589	2452	2405	2348	4026	5079	4162	4184	4423	Jun 2017	1089	662	262	319	106	110	1875	4423	12769	
			Facilities - Demand (Shifts)	No			-	-	-	-	1903	1947	1442	1451	2160	2185	1997	2172	2066	1971	2485	1795	2031	2101	Jun 2017	24	83	0	0	12	0	1982	2101	5927	
			Facilities - Filled (Shifts)	No			-	-	-	-	1898	1933	1405	1397	1942	2135	1969	2107	1992	1926	2425	1737	1999	2101	Jun 2017	24	83	0	0	12	0	1982	2101	5837	
			Interpreters - Demand (Shifts)	No			-	-	-	-	4925	5358	5110	5034	5321	5026	5508	4803	5159	4983	5634	4511	5139	5291	Jun 2017	-	-	-	-	-	-	-	5291	14941.0	
			Interpreters - Total Filled	%			-	-	-	-	99.61	99.72	99.75	99.62	99.44	99.58	99.46	99.46	99.5	99.64	99.57	99.89	99.71	99.7	Jun 2017	-	-	-	-	-	-	-	100	99.8	
			Interpreters - Bank Filled	%			-	-	-	-	78.96	77.99	76.61	76.35	76.68	78.62	77.58	76.93	78.38	79.52	78.02	77.34	78.45	77.7	Jun 2017	-	-	-	-	-	-	-	78	77.8	
			Interpreters - Agency Filled	%			-	-	-	-	21.0	22.0	23.4	23.6	23.3	21.4	22.4	23.1	21.6	20.5	22.0	22.7	21.5	22.3	Jun 2017	-	-	-	-	-	-	-	22	22.2	
			Interpreters - Unfilled	%			-	-	-	-	0.4	0.3	0.3	0.4	0.6	0.4	0.5	0.5	0.5	0.4	0.4	0.1	0.3	0.3	Jun 2017	-	-	-	-	-	-	-	0	0.2	



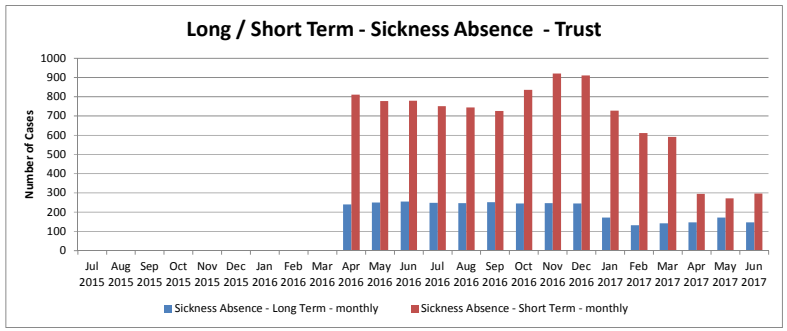


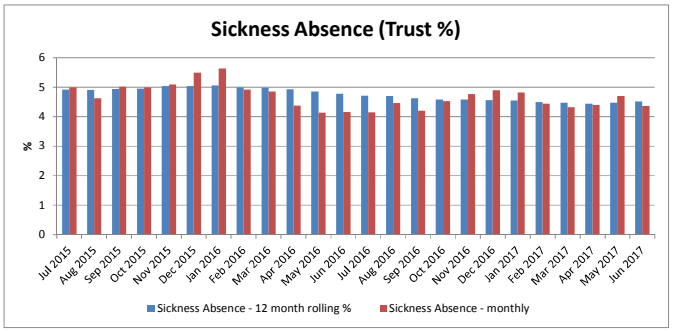




Workforce

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jan 2016) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
3		b	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	81.0	87.9	90.5	93.8	81.3	89.3	90.4		88.3	
7		b	Medical Appraisal	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	76.8	85.1	93.3	75.0	89.7	137.5	50.0	86.9	85.7	
3		b	Sickness Absence (Rolling 12 Months)	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	4.7	4.7	4.6	3.8	4.3	4.0	4.6	4.52	4.48	
3	NEW		Sickness Absence (Monthly)	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	4.6	4.9	3.9	3.4	3.9	3.7	4.6	4.36	4.36	
3	NEW		Sickness Absence - Long Term (Monthly)	No			-	-	-	240	250	256	249	247	253	245	247	246	253	205	213	214	241	218	Jun 2017	48	38	28	6	7	19	2	218	673	
3	NEW		Sickness Absence - Short Term (Monthly)	No			-	-	-	812	779	780	752	745	727	837	922	911	956	808	785	414	445	444	Jun 2017	80	55	40	39	24	57	3	444	1303	
3			Return to Work Interviews following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	71.9	82.9	84.3	85.5	71.1	79.1	80.5	79.1	79.2	
3			Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	81.6	86.7	88.6	90.9	87.5	88.9	90.5		87.1	
3			Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-		-	
3			Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	91.8	0.0	95.1	94.8	95.5	0.0	97.9		95.4	
7		b	Employee Turnover (rolling 12 months)	<= %	10.0	10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017								11.6	11.5	
	NEW		Nursing Turnover	%			14.7	14.8	13.8	13.6	12.6	11.8	11.3	11.2	11.9	12.4	11.7	11.4	11.6	11.2	11.7	11.7	11.7	12	Jun 2017								12	12	
7			New Investigations in Month	No			5	12	9	6	4	3	8	4	4	3	0	3	4	3	9	14	1	3	Jun 2017	0	0	0	0	0	1	2	3		
7			Vacancy Time to Fill	Weeks			24	26	23	26	25	23	24	24	21	25	21	21	21	22	21	20	21	23	Jun 2017								23		
7			Professional Registration Lapses	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	0	0	0	0	
7			Qualified Nursing Variance (FIMS) (FTE)	No			272	274	293	292	315	317	339	343	341	313	293	305	268	246	257	256	276	281	Jun 2017								281		
15			Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	16.0	-->	-->	-->	-->	-->	Jan 2017	8	30	13	22	20	29	18	16		
15			Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.70	-->	-->	-->	-->	-->	Jan 2017	3.68	3.79	3.66	3.82	3.58	3.83	3.64	3.7		





SQPR : Local Quality Requirements

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Trajectory RAP	RAP	Previous Months Trend (From Jan 2016) J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Group M	SS	W	P	I	C	CO	Month	Year To Date	Trend
			Safeguarding Adults Advanced Training	=> %	85	85	78	Sep-17	-	-	-	-	-	-	-	-	80	80	81	81	80	79	81	81	81	79	Jun 2017								78.669	80.21	
			Safeguarding Children Level 2 Training	=> %	85	85	78	Sep-17	-	-	-	74	73	73	72	73	71	71	73	75	76	77	77	78	79	78	Jun 2017								78.4	78.3	
			Safeguarding Children Level 3 Training	=> %	85	85		May-17	-	-	-	71	72	72	75	74	73	73	75	78	78	81	84	85	88	89	Jun 2017								88.7	87.2	
			WHO Safer Surgery - Audit - brief and debrief (% lists v	=> %	100	100	n/a	n/a	-	-	-	99	99	99	100	99	100	98	97	95	97	99	99	98	98	98	Jun 2017	95.6	99.2	96.6					97.7	98.1	
			Morning Discharges (00:00 to 12:00) - SQPR	=> %	27	27	n/a	n/a	-	-	-	16	15	17	17	13	16	16	17	17	20	17	16	16	15	17	Jun 2017	15.1	13.3	21.7					16.6	15.9	
			ED Diagnosis Coding (Mental Health CQUIN) - SQPR	=> %	90	90	n/a	n/a	-	-	-	88	88	87	87	87	87	85	86	86	86	86	87	86	86	85	Jun 2017								85.3	85.7	
			BMI recorded by 12+6 weeks of pregnancy - SQPR	=> %	90	90	90	Aug-17	-	-	-	83	81	79	79	78	87	86	82	81	84	81	77	78	80	79	Jun 2017								79.2	78.9	
			CO Monitoring by 12+6 weeks of pregnancy - SQPR	=> %	90	90	90	Aug-17	-	-	-	79	80	81	82	82	75	76	76	75	73	78	79	76	75	75	Jun 2017								74.8	75.0	
			Community - Screening For Dementia - SQPR	=> %	100	100	n/a	n/a	-	-	-	40	37	53	30	37	-	-	-	-	-	-	-	55	53	49	Jun 2017								37.2	38.4	
			Community - HV Falls Risk Assessment - SQPR	=> %	100	100	n/a	n/a	-	-	-	61	67	56	61	55	-	-	-	-	-	-	-	70	66	63	Jun 2017								54.8	60.0	
			Community Gynae Clinics - Referral to first outpatient appointment Within 4 weeks of referral	=> %	90	90	90	May-17																		93	Jun 2017								93.3		

RAP Monthly: Indicates improvement trajectory as per the 'Recovery Action Plan' agreed with Host CCG

RAP Delivery: Indicates when the indicator is expected to hit the full delivery to expected standard

Trajectory year/month: Indicates national/ local / RAP agreed performance standard

- Some of the indicators need improvement trajectories to be finalised - shown as n/a here
- The Trust needs to incorporate the ED indicators here into the wider ED plans and provide detailed improvement plans. Some of these are picked up through the 'persistent red indicators' focus.
- Community indicators are under review as there is generally a data quality issue which is being reviewed over the last few weeks, detailed plans for improvement of the actual performance are in place however

CQUINs 2017/18 Schemes (page 1 of 2)

Ref	CQUIN	Annual Plan Values (£)	Full Year Delivery	Value at Risk (£)	Indicator	Provider Setting	Description of Indicator	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4	Monthly Trend A M J J A S O N D J F M	Comments	Data Period	FULL YEAR	Trend	Next Month	3 Months
1a	National	£1,357,782			**Improving Staff Health & Wellbeing : Improvement of health & wellbeing of NHS staff**	**Acute & Community**	Annual Staff Survey results to improve by 5% in two of the three NHS annual staff survey: on health & well-being, MSK and stress	Baseline 2015/16: Q9a, 9b and 9c			2016/17 Results to 2xQs to improve by 5% for full payment	n/a Report	MSK remains the single biggest issue in respect of delivery; 15/16 survey indicated that the trust has worsened year on year in respect of MSK based questions	Jun-17				
1b	National				**Staff Health & Wellbeing : Healthy food for NHS staff, visitors and patients**	**Acute & Community**	Firstly, maintain the four outcomes that were implemented in 2016/17. Secondly, introducing three new chances to food and dring provision in year 1, 17/18 : 70% of drinks tockked must be sugar free, b) 50% of confectionary and sweets do not exceed 250 kcal c) 60% or pre-packed sandwiches and other savoura pre-packed meals avaiable contain 400kcals or less and do not exceed 5.0g saturated fat	No submissions, ensure deliverables are in place			All four outcomes delivered	n/a Report	Steve Clarke is the lead and confirms general compliance with this scheme, more to be done on the confectionary and sandwiches front.	Jun-17				
1c	National				**Staff Health & Wellbeing : Improving uptake of flu vaccination for front line staff within Providers**	**Acute & Community**	Year 1 - achieving updateof flu vaccination for frontline clinical staff of 70%	No returns		Report %age achieved	Report %age achieved	n/a Report Report	Campaig planned and the Trust is confident that this target will be delivered again this year.	Jun-17				
2a	National	£678,891			Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): **Timely identification of sepsis in emergency departments and acute inpatient settings**	**Acute**	The percentage of patients who met the criteria for sepsis screening (needed it) and were screened for sepsis (applies to all adult and child patients arriving in ED & IP wards)	Q1 Screened in ED & IP (based on sample)	Q1 Screened in ED & IP (based on sample)	Q1 Screened in ED & IP (based on sample)	Q1 Screened in ED & IP (based on sample)	Partially met Report Report Report	Ony 74% of sample patients that NEEDED sepsis screening were screened. This needs Exec support and intervention required.	Jun-17				
2b	National				Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): **Timely treatment for sepsis in emergency departments and acute inpatient settings**	**Acute**	The percentage of patients who were found to have sepsis in 2a and received IV antibiotics within 1 hour (applies to all adult and child patients arriving in ED & IP wards).	Q1 numbers found to have sepsis in ED & accute settings in sample 2a who received IV AB within 1 hr of diagnosis	Q1 numbers found to have sepsis in ED & accute settings in sample 2a who received IV AB within 1 hr of diagnosis	Q1 numbers found to have sepsis in ED & accute settings in sample 2a who received IV AB within 1 hr of diagnosis	Q1 numbers found to have sepsis in ED & accute settings in sample 2a who received IV AB within 1 hr of diagnosis	Partially met Report Report Report	Of the above screened patients, only 57% of septic patients receive their antibiotics within one hour. Outliers need to be understood and improvements to be led by the ward teams MQuAC in August to consider.	Jun-17				
2c	National				Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): **Antibiotic review**	**Acute**	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hrs	Number of AB prescriptions reviewed within 72 hrs	Number of AB prescriptions reviewed within 72 hrs	Number of AB prescriptions reviewed within 72 hrs	Number of AB prescriptions reviewed within 72 hrs	Partially met Report Report Report	Not fully reported until 31st July, but like to miss target due to missing notes preventing the review.	Jun-17				
2d	National				Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): **Reduction in antibiotic consumption per 1,000 admissions**	**Acute**	There are three parts to this indicator. 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions There are three parts to this indicator.	No returns			Reduction of 1% or 2%	n/a Report		Jun-17				
4	National	£678,891			**Improving services for people with mental health needs who present to A&E**	**Acute**		Outline Plan & Baseline data 16/17	DQ data, confirm partnerships in place	Report Progress	20% reduction in A&E attendances of those within the selected cohort	Met Report Report Report	Awaiting cofirmation, but a the Trust submitted a robust and well progressed plan.	Jun-17				
6	National	£678,891			**Offering Advice & Guidance**	**Acute**	Providers to set up and operate A&G services for non-urgent GP referrals; A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative.	Timetable & Introduction				Met Report Report Report	Awaiting confirmation, but the Trust offers A&G for all services. The GP referrals to this facility need encourging.	Jun-17				
7	National	£678,891			**NHS e-Referrals CQUIN**	**Acute**	This indicator relates to GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service. It is not looking at percentage utilisation of the system.	Supply plan to deliver Q2, Q3 and Q4 targets to include	80% of Referrals to 1st O/P Services able to be received through e-RS.	90% of Referrals to 1st O/P Services able to be received through e-RS.	100% of Referrals to 1st O/P Services able to be received through e-RS.	Met Report Report Report	A plan has supplied confirming the delivery of 80% of its 1st GP appointments via eRS by end of September. A roll out programme as per this plan is being managed with the eRS lead in patient access team.	Jun-17				
8	National	£1,357,782			**Supporting proactive and safe discharge (Acute & Community Trusts)**	**Acute & Community**	Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17).	Type 1 or 2 A&E provider has demonstrable and credible planning in place to make the required preparations so that the Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017.	Map and streamline existing discharge pathways across acute and community, and roll-out protocols in partnership across local whole-systems.	Providers returning ECDS with at least 95% of completed, valid diagnosis codes	By the end of Q4 2.5% point increase from baseline in no. patients discharged to usual place of residence.	Met Report Report Report	Awaiting cofirmation, but a the Trust submitted a robust and well progressed plan.	Jun-17				
9	National	£1,357,782			**Preventing ill health by risky behaviours - alcohol & tobacco: 9a: Tobacco Screening**	**Acute & Community**							SCHEME REMOVED: Clarification received from NHSE that this scheme will now not apply until 2018/19. The impact of this will be that the CCG will have to spread the 1.35m across the other schemes which means there is more funding at stake if other schemes do not deliver.					
					Preventing ill health by risky behaviours - alcohol & tobacco 9b: Tobacco brief advice	**Acute & Community**												
					Preventing ill health by risky behaviours - alcohol & tobacco 9c: Tobacco referral & medication offer	**Acute & Community**												
					Preventing ill health by risky behaviours - alcohol & tobacco 9d: Alcohol Screeing	**Acute & Community**												

CQUINs 2017/18 Schemes (page 1 of 2)

Ref	CQUIN	Annual Plan Values (000s)	Full Year Delivery	Value at Risk (000s)	Indicator	Provider Setting	Description of Indicator	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4	Monthly Trend A	M	J	J	A	S	O	N	D	J	F	M	Comments	Data Period	FULL YEAR	Trend	Next Month	3 Months
10	National	£678,891			Improving the assessment of wounds	Community	The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.	Establish Clinical Audit plan	Clinical Audit of wound assessments	Improvement Plan	Repeat Clinical Audit	n/a		Report		Report		Report							Jun-17					
11	National	£678,891			Personalised Care / support planning	Community	This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions. In the first year, activity will be focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be identified, the relevant workforce receive appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers.		Submission of a plan to ensure care & support planning is recorded by providers will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted (yes/no).	Provider to identify the number of patients as having multiple LTCs and who will be prioritised for personalised care and support planning (establishment of cohort) compared to the total number of patients served	Provider to confirm what proportion of relevant staff have undertaken training in personalised care and support planning.	n/a		Report		Report		Report							Jun-17					
	Specialised	£150,000			Haemoglobinopathy improving pathways		Ongoing	Baseline Report, annual O1	Evidence of governance arrangements (quarterly reports)	% of total registered patients in ODN attending for annual review at the Lead / Specialist Centre and plan to demonstrate performance to target of 85% by end of Yr 3 (quarterly reports)	Improvement in agreed patient satisfaction and outcome measure(s) (quarterly against baseline)	Met		Report		Report		Report						This is a well-established scheme which has been in place over the last couple of years.	Jun-17				
	Specialised	£130,000			Paediatric Networked Care to Reduce Recourse to Critical Care Distant from Home			Trigger 1 - Part 1: Ensure full and ongoing completion of PCCMDS as per Information Standards Notice SCCI0076 Amd 113/2015 – 'Paediatric Critical Care Minimum Data Set, Version 2.0'. The full conformance date as per the ISN is 1st December 2016.	Trigger 2 - To provide support to the lead PICU centre in conducting a review of the Provider against the Paediatric Intensive Care (PICS) standards prior to July 2017.	Trigger 3 - Ongoing participation with West Midlands Paediatric Critical Care Network meeting, including representation at meetings and implementation of clinical protocols as agreed by the Network. This may include (but is not limited to): • Condition specific treatment and referral protocols • Incident Reporting System (Padicrid)		Partially met			Report		Report		Report						The data set provision is outstanding as Cerner development is awaited (for October 2017) hence partial met	Jun-17				
	Specialised	£141,197		£12,000	Activation systems for patients with long term conditions		HIV									Report		Report		Report				Work yet to be progressed.	Jun-17				
	Public Health	£55,978			Secondary Care Dental : Audit of Day Case Activity		A prospective audit and re-audit of day-case activity carried out in the department in accordance with the Terms of Reference issued by the service commissioner.		Initial audit report by 21 July 2017, Plan to address any identified issues by 20 October 2017, report of Follow up Audit by 20 April 2018.		Follow up Audit to be carried out by 31 March 2018 and reported by 20 April 2018.	n/a		Report		Report		Report							Jun-17					
	Public Health	£31,228			Bowel Screening			Report	Report	Report	Report	Met		Report		Report		Report		Report				Scheme reports to the national screening programme and has been ongoing for the last 2 years	Jun-17				
	Public Health	£39,417			Bowel Scoping			Report	Report	Report	Report	Met		Report		Report		Report		Report				Scheme reports to the national screening programme and has been ongoing for the last 2 years	Jun-17				
	Public Health	£92,044			Breast Screening			Report	Report	Report	Report	Met		Report		Report		Report		Report				Scheme reports to the national screening programme and has been ongoing for the last 2 years	Jun-17				

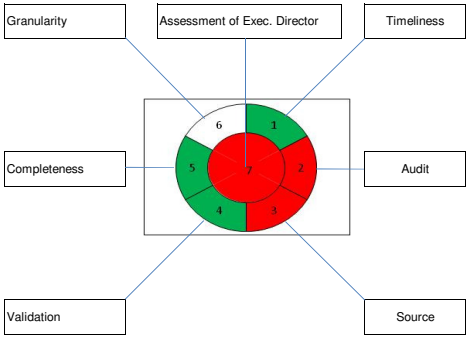
Legend

Data Sources	
1	Cancer Services
2	Information Department
3	Clinical Data Archive
4	Microbiology Informatics
5	CHKS
6	Healthcare Evaluation Data (HED) Tool
7	Workforce Directorate
8	Nursing and Facilities Directorate
9	Governance Directorate
10	Nurse Bank
11	West Midlands Ambulance Service
12	Obstetric Department
13	Operations Directorate
14	Community and Therapies Group
15	Strategy Directorate
16	Surgery B
17	Women & Child Health
18	Finance Directorate
19	Medicine & Emergency Care Group
20	Change Team (Information)

Indicators which comprise the External Performance Assessment Frameworks		
●		NHS TDA Accountability Framework
	a	Caring
	b	Well-led
	c	Effective
	d	Safe
	e	Responsive
	f	Finance
●		Monitor Risk Assessment Framework
●		CQC Intelligent Monitoring

Groups	
M	Medicine & Emergency Care
A	Surgery A
B	Surgery B
W	Women & Child Health
P	Pathology
I	Imaging
C	Community & Therapies
CO	Corporate

Data Quality - Kitemark



Each outer segment of indicator is colour coded on kitemark to signify strength of indicator relative to the dimension, with following key:

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

Red / Green	As assessed by Executive Director
White	Awaiting assessment by Executive Director

If segment 2 of the Kitemark is Blank this indicates that a formal audit of this indicator has not yet taken place

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Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate EC	AC	SC	Month	Year To Date	Trend
Patient Safety - Inf Control	C. Difficile	<= No	30	3	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	3	0	0	3	4	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective (%)	=> %	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	87	72	25	56.1		
Patient Safety - Inf Control	MRSA Screening - Non Elective (%)	=> %	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	90	91	73	90.3		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	-	19	20	14	14	16	9	7	5	Jun 2017	4	1	0	5	21	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	-	19	20	12	14	16	9	7	5	Jun 2017	4	1	0	5	21	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	-	4	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	-	3	14	12	8	8	11	6	6	Jun 2017	3	3	0	6	23	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	-	5	6	2	11	5	1	6	3	Jun 2017	1	2	0	3	10	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	-	1	0	1	1	0	0	0	2	Jun 2017	1	1	0	2	2	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	-	-	-	-	-	5	2	1	0	0	1	1	1	Jun 2017	0	1	0	1	-	
Patient Safety - Harm Free Care	Falls	<= No	0	0	40	35	32	44	37	47	39	47	44	34	41	47	50	38	34	36	39	34	Jun 2017	11	23	0	34	109	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	1	1	0	0	2	1	2	2	0	2	3	3	1	2	1	1	0	Jun 2017	0	0	0	0	2	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	4	6	4	4	3	3	5	5	4	5	7	9	5	5	4	5	5	5	Jun 2017	0	5	0	5	15	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	92.1	88.8	98.4	94.5		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	100.0	100.0	100.0	100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	100	92	0	97.6		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	99	88	0	95.6		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	1	0	0	1	5	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	-	Apr 2017	55	53	37	50		

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

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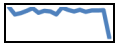
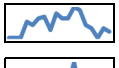
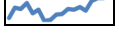
Section	Indicator		Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate EC	AC	SC	Month	Year To Date	
Clinical Effect - Stroke & Card	Pts spending >90% stay on Acute Stroke Unit (%)	=> %	90.0	90.0																-	-	-	Mar 2017		95.0		95.0	94.5	
Clinical Effect - Stroke & Card	Pts admitted to Acute Stroke Unit within 4 hrs (%)	=> %	90.0	90.0																			Jun 2017		90.2		90.2	91.6	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			Jun 2017		78.1		78.1	78.1	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.0																			Jun 2017		97.6		97.6	97.4	
Clinical Effect - Stroke & Card	Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			Jun 2017		0.0		0.0	44.4	
Clinical Effect - Stroke & Card	Stroke Admissions - Swallowing assessments (<24h) (%)	=> %	98.0	98.0																			Jun 2017		100.0		100.0	101.7	
Clinical Effect - Stroke & Card	TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=> %	70.0	70.0																			Jun 2017		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=> %	75.0	75.0																			Jun 2017		96.9		96.9	99.0	
Clinical Effect - Stroke & Card	Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=> %	80.0	80.0																			Jun 2017		88.9		88.9	93.5	
Clinical Effect - Stroke & Card	Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			Jun 2017		93.8		93.8	95.2	
Clinical Effect - Stroke & Card	Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			Jun 2017		100.0		100.0	100.0	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																-			May 2017			90.1	90.1		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																-			May 2017			100.0	100.0		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																-			May 2017			87.5	87.5		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			0.5	6	3	3.5	1.5	3.5	3	4	3.5	1	2.5	2	1.5	3	2.5	2	2	-	May 2017	-	-	2.00	2.00	4	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	4.5	0	2	0	1	2	1.5	2	0	0	1	1	1	1	1	0	-	May 2017	-	-	0.00	0.00	1	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			98	154	98	175	95	130	113	107	140	75	71	107	111	135	105	140	91	-	May 2017	-	-	91	91		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0.0	0.0	-	-	-	10	8	12	13	5	15	12	12	19	17	8	6	0	6	4	Jun 2017	-	-	4	4	10	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	0	0	0	0	0	0	0	0	0	6	30	2	0	4	21	7	0	Jun 2017	0	0	0	0	28	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			34	47	39	49	36	28	25	40	23	27	40	35	40	45	42	34	42	40	Jun 2017	27	12	1	40	116	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			50	65	63	72	57	62	46	47	55	56	63	62	66	61	75	79	79	91	Jun 2017	49	34	8	91		

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Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate EC	AC	SC	Month	Year To Date	
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Jun 2017	-	-	0.18	0.16		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	Jun 2017	0.0	0.0	0.0	0	1	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	2	1	1	0	3	0	0	6	1	0	6	2	4	6	2	3	11	3	Jun 2017	0.0	0.0	3.0	3	17	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	34	32	31	58	56	54	28	32	28	57	44	29	51	37	41	28	35	63	Jun 2017	0.0	0.0	63.3	63.3		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0.00	0.00	0.00	0.00	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95.0	95.0																			Jun 2017	80.7	84.3	Site S/C	82.5	82.1	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			'	1560	1908	1246	1046	1187	1333	1227	1280	1579	1750	1866	1776	1769	1721	1662	1742	1580	Jun 2017	1431	0	149	1580	4984	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0																			Jun 2017	0.0	0.0	Site S/C	0	0	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.0	15.0	-																		Jun 2017	14.0	13.0	Site S/C	14	14	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60.0	60.0	-																		Jun 2017	67.0	63.0	Site S/C	65	64	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			Jun 2017	8.7	8.7	Site S/C	8.7	8.4	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Jun 2017	5.9	7.4	Site S/C	6.7	6.2	
Emergency Care & Pt. Flow	WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	116	97	117	81	65	70	122	112	135	112	162	193	162	129	107	110	159	242	Jun 2017	141	101		242	511	
Emergency Care & Pt. Flow	WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	10	6	9	2	0	1	8	6	9	16	21	19	11	13	5	0	12	6	Jun 2017	1	5		6	18	
Emergency Care & Pt. Flow	WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Jun 2017	0.05	0.23		0.14	0.14	
Emergency Care & Pt. Flow	WMAS - Emergency Conveyances (total)	No			4679	3961	4513	4115	4604	4099	4363	4204	4138	4233	4261	4622	4410	4034	4206	4137	4376	4254	Jun 2017	2038	2216		4254	12767	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			Jun 2017	0.0	81.7	89.7	87.7		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			Jun 2017	0.0	61.5	93.5	82.6		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			Jun 2017	0.0	93.9	93.1	93.5		
RTT	RTT - Backlog	<= No	0	0	623	689	725	789	716	674	821	873	1172	1319	1168	1500	1154	897	622	610	479	497	Jun 2017	0	201	296	497		
RTT	Patients Waiting >52 weeks	<= No	0	0	1	3	4	0	0	0	1	0	0	1	2	1	0	0	1	1	2	1	Jun 2017	0	0	1	1		
RTT	Treatment Functions Underperforming	<= No	0	0	10	8	7	12	11	11	14	13	12	13	10	12	10	10	10	9	7	8	Jun 2017	0	5	3	8		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Jun 2017	0	1.72	0.65	1.49		

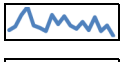
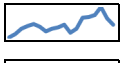
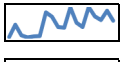
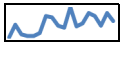
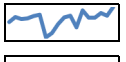
Medicine Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate EC	AC	SC	Month	Year To Date
Data Completeness	Open Referrals	No			67,608	65,055	65,979	67,205	68,646	70,876	69,993	70,424	72,581	74,142	75,046	75,926	75,925	76,880	78,278	78,984	79,971	81,548	Jun 2017	14,293	23,901	43,354	81548	
Data Completeness	Open Referrals - Awaiting Management	No			-	-	-	-	26,178	27,360	25,493	26,511	28,710	27,787	30,150	31,585	32,319	33,572	35,739	36,247	36,822	37,760	Jun 2017	10,538	12,405	14,817	37760	
Workforce	WTE - Actual versus Plan	No			204	201	219	220	207	213	220	229	231	229	231	244	202	194	208	205	199	227	Jun 2017	110.2	112	0	227	
Workforce	PDRs - 12 month rolling (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	83.46	79.24	0		82.1
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	65.22	82.61	0		83.6
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	4.54	4.80	0.00	4.68	4.67
Workforce	Sickness Absence - In month	<= No	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	4.81	4.47	0.00	4.59	5.13
Workforce	Sickness Absence - Long Term - In month	No			-	-	-	57	62	60	49	47	43	45	40	39	39	33	40	53	59	48	Jun 2017	19	20	9	48	160
Workforce	Sickness Absence - Short Term - In month	No			-	-	-	212	186	195	180	179	162	194	206	243	223	207	182	66	68	80	Jun 2017	20	33	27	80	214
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	65.4	77.1	0.0		71.84
Workforce	Mandatory Training (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	82.04	81.22	0		81.9
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-
Workforce	New Investigations in Month	No			1	6	4	1	0	0	1	1	0	0	0	0	0	1	2	3	0	0	Jun 2017	0	0	0	0	
Workforce	Nurse Bank Fill Rate %	=> %	100	100	3001	3002	4159	3992	'	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016				85	
Workforce	Nurse Bank Shifts Not Filled (number)	<= No	0	0	925	700	748	710	'	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016				710	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-
Workforce	Your Voice - Response Rate (%)	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	8	-->	-->	-->	-->	-->	Jan 2017	6.0	7.0	16.0	8.0	
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.68	-->	-->	-->	-->	-->	Jan 2017	3.51	3.90	3.58	3.68	

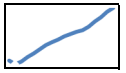
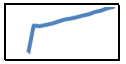
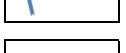
Surgical Services Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate GS	SS	TH	An	O	Month	Year To Date	Trend
Patient Safety - Inf Control	C. Difficile	<= No	7	1																			Jun 2017	0	0	0	0	0	0	2	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Jun 2017	0	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80	80																			Jun 2017	93.41	95.48	0	0	51.52	90.9		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80	80																			Jun 2017	92.36	94.93	0	100	91.43	93.1		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	-	4	0	0	0	2	1	3	0	Jun 2017	0	0	0	0	0	0	4	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	-	4	0	0	0	2	1	3	0	Jun 2017	0	0	0	0	0	0	4	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	1	4	0	Jun 2017	0	0	0	0	0	0	5	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	1	0	3	0	Jun 2017	0	0	0	0	0	0	3	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	1	0	0	Jun 2017	0	0	0	0	0	0	1	
Patient Safety - Harm Free Care	Falls	<= No	0	0	14	7	12	8	9	4	12	12	9	10	12	13	8	6	6	10	7	11	Jun 2017	7	3	0	0	1	11	28	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	0	1	Jun 2017	1	0	0	0	0	1	1	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	2	0	1	2	2	0	2	2	0	4	0	1	1	2	1	1	3	0	Jun 2017	0	0	0	0	0	0	4	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Jun 2017	97.51	98.44	0	99.21	98.59	98.1		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																		-	May 2017	99.87	99.77	0	100	100	99.9		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Jun 2017	100	100	99.52	0	100	99.7		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Jun 2017	100	100	98.57	0	100	99.2		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	0	1	0	0	0	0	1	0	0	0	1	0	0	0	0	0	1	1	Jun 2017	0	0	0	0	1	1	2	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Jun 2017	1	0	0	0	1	2	5	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98.0																	-	-	Apr 2017	43	50	0	0	0	46.2		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			6.5	6.9	7.1	6.4	6.2	5.5	6.6	5.4	5.9	6.0	5.1	5.9	6.0	6.3	5.7	6.2	6.5	-	May 2017						6.5		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.94	6.97	7.05	6.98	6.88	6.76	6.73	6.61	6.5	6.99	6.3	6.11	6	5.95	5.84	5.83	5.86	-	May 2017							5.8	

Surgical Services Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate GS	SS	TH	An	O	Month	Year To Date	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	94.3	-	0.0	-	-	94.28		
Clinical Effect - Cancer	2 weeks (Breast Symptomatic)	=> %	93.0	93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	96.2	-	-	-	-	96.17		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	98.8	-	0.0	-	-	98.77		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	87.5	-	0.0	-	-	87.5		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			2	2	3	2	9	1	4	7	4	7	4	5	5	8	2	2	5	-	May 2017	-	-	-	-	-	4.5	6	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	0	1	0	1	0	1	2	2	2	2	2	0	2	1	1	1	-	May 2017	1	-	0	-	-	1	2	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			159	74	176	73	114	170	201	292	245	351	191	158	103	193	105	119	114	'	May 2017	114	-	0	-	-	114		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0	0	-	-	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	-	0	-	-	0	0	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	1	0	8	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			25	28	38	45	29	27	24	38	30	37	29	26	32	25	36	24	29	20	Jun 2017	0	5	6	2	7	20	73	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			32	37	45	49	52	48	41	45	47	51	39	45	62	63	66	78	61	51	Jun 2017	7	21	0	8	15	51		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	2.17	2.88	0	0.85	0.93	1.71		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	1	0	3	4	0	0	0	0	0	Jun 2017	0	0	0	0	0	0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	16	33	20	18	18	22	45	43	32	29	57	31	35	49	45	32	49	38	Jun 2017	20	9	0	2	7	38	119	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	74.2	75.4	74.9	75.1	75.7	76	70.5	71.6	73.7	75.3	75.7	73	77.1	75.3	75.3	76.4	75.8	77.9	Jun 2017	74.8	81.8	0.0	83.9	78.2	77.85		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (%)	%	95.0	95.0	98.8	99.6	98.9	98.3	97.9	98.2	98.0	98.6	98.6	99.4	99.4	99.7	99.3	99.3	98.1	97.6	96.8	96.7	Jun 2017	-	-	-	-	96.67	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	<= No	0	0	-	62	98	109	82	80	119	121	63	92	76	109	70	68	112	137	109	93	Jun 2017	42	10	0	1	40	93	339	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	-	-	-	-	0	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0	4.8	3.2	2.3	3.8	4.1	2.8	2.4	3.3	2.2	2.9	3.5	2.6	4.1	3.0	3.3	3.3	3.0	3.7	Jun 2017	-	-	-	-	3.69	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0	1.1	1.0	1.7	1.8	2.0	1.1	2.0	1.7	2.5	2.1	1.4	1.1	1.0	1.1	1.7	2.0	2.4	2.7	Jun 2017	-	-	-	-	2.69	-	-	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15	-	15	19	14	25	19	14	41	15	26	14	14	0	0	0	0	0	0	Jun 2017	-	-	-	-	16	0	0	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60	-	94	108	115	106	106	121	110	103	107	100	99	-	-	-	-	-	-	Jun 2017	-	-	-	-	115	-	-	
Emergency Care & Pt. Flow	Hip Fractures BPT (Operation < 36 hours of admissions	=> %	85.0	85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017						84.0	62.2	

Surgical Services Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate GS	SS	TH	An	O	Month	Year To Date	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	76.5	56.0	0.0	0.0	77.1	73.2		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	89.4	92.3	0.0	0.0	94.2	92.0		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	92.5	86.1	0.0	0.0	94.5	92.2		
RTT	RTT - Backlog	<= No	0	0	1276	1243	1308	1236	1231	1227	1324	1350	1254	1369	1328	1514	1344	1153	1167	1304	1204	1293	Jun 2017	553	397	0	0	343	1293		
RTT	Patients Waiting >52 weeks	<= No	0	0	3	2	3	3	1	2	3	0	1	2	0	1	0	2	2	4	1	1	Jun 2017	0	1	0	0	0	1		
RTT	Treatment Functions Underperforming	<= No	0	0	16	14	13	16	13	14	17	16	16	16	14	16	16	16	14	14	16	18	Jun 2017	10	6	0	0	2	18		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	1.1	0.0	0.0	0.0	0.0	0.87		
Data Completeness	Open Referrals	No			98,377	96,175	97,723	100,371	102,540	104,891	107,435	109,035	110,630	112,597	113,840	115,090	116,146	118,262	121,184	123,687	126,992	129,204	Jun 2017	45,293	15,023	0	4,665	64,223	129204		
Data Completeness	Open Referrals - Awaiting Management	No			-	-	-	-	36,039	35,257	36,835	38,367	40,451	42,937	44,084	45,279	47,179	48,985	51,471	53,057	55,792	57,290	Jun 2017	22,215	6,963	0	2,895	25,217	57290		
Workforce	WTE - Actual versus Plan	No			178	153	149	144	143	151	158	155	152	146	140	151	185	157	166	168	172	176	Jun 2017	53.38	35.41	25.96	20	36.89	175.93		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	86.3	85.2	95.4	84.7	89.6		85.7	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	79.31	94.12	0	88.37	80		81.1	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	4.6	5.6	7.3	4.3	2.2	4.7	4.7	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	4.5	5.4	8.9	4.6	1.7	4.9	4.7	
Workforce	Sickness Absence - Long Term - In Month	No			-	-	-	46	52	62	56	46	53	52	50	53	52	33	32	30	41	38	Jun 2017	10.0	5.0	13.0	10.0	0.0	38.0	109.0	
Workforce	Sickness Absence - Short Term - In Month	No			-	-	-	164	169	161	162	168	169	181	173	181	166	149	138	61	50	55	Jun 2017	16.0	10.0	15.0	11.0	0.0	55.0	166.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	86.9	77.3	88.6	70.1	85.3	82.9	83.6	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	85.7	84.9	91.3	86.7	84.9		86.4	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-		-	
Workforce	New Investigations in Month	No			1	1	2	0	0	0	2	0	1	3	0	0	2	1	2	2	0	0	Jun 2017	0	0	0	0	0	0		
Workforce	Nurse Bank Fill Rate	=> %	100.0	100.0	83	64.9	86.3	88	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016						88.03	88	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	280	216	232	238	'	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016						238	238	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00						-	-	

Surgical Services Group

Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	30	-->	-->	-->	-->	-->	Jan 2017	12	7	7	11	13	**30**	
Workforce	Your Voice - Response Score	%			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.79	-->	-->	-->	-->	-->	Jan 2017	3.53	3.29	3.85	3.6	3.69	**3.79**	

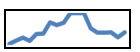
Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J		G	M	P			
Patient Safety - Inf Control	C. Difficile	<= No	0	0																		Jun 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																		Jun 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.00	80.00																		Jun 2017	90.8			90.2		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80.00	80.00																		Jun 2017	0	100		100.0		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	1	0	0	Jun 2017	0	0	0	0	1	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	1	0	0	Jun 2017	0	0	0	0	1	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	Jan-00	0	0	0	0	0	
Patient Safety - Harm Free Care	Falls	<= No	0	0	2	0	1	0	1	2	1	1	2	3	1	1	2	1	1	0	3	1	Jun 2017	1	0	0	1	4	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																		Jun 2017	99.2	96.1		97.3		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																	-	May 2017	100	99.3		99.7		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																		Jun 2017	100	100		100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																		Jun 2017	96.4	100		96.6		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																		Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																		Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																		Jun 2017	0	0	0	0	1	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate G	M	P	Month	Year To Date	
Patient Safety - Obstetrics	Caesarean Section Rate - Total	<= %	25.0	25.0																			Jun 2017		25.9		25.9	24.9	
Patient Safety - Obstetrics	Caesarean Section Rate - Elective	%			8	8	8	10	7	9	8	9	10	8	11	8	7	9	8	9	8	9	Jun 2017		8.9		8.9	8.7	
Patient Safety - Obstetrics	Caesarean Section Rate - Non Elective	%			17	15	18	17	15	15	19	19	19	23	17	20	15	17	17	17	15	17	Jun 2017		17		17.0	16.3	
Patient Safety - Obstetrics	Maternal Deaths	<= No	0	0																			Jun 2017		0		0	0	
Patient Safety - Obstetrics	Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Jun 2017		5		5	9	
Patient Safety - Obstetrics	Admissions to Neonatal Intensive Care	<= %	10.0	10.0																			Jun 2017		1.26		1.3	1.6	
Patient Safety - Obstetrics	Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Jun 2017		4.12		4.1		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	90.0	90.0																			Jun 2017		77.6		77.6		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0																			Jun 2017		156		156.2		
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100.0	97.0		N/A					N/A		N/A						N/A	N/A	-	-	Apr 2017	0	0	0	0.0		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			4.7	6.7	5.5	4.9	5.0	4.7	4.4	4.2	3.9	5.4	5.9	5.0	4.0	5.4	4.7	4.6	4.5	-	May 2017				4.5		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.1	6.1	5.9	5.8	5.6	5.4	5.2	5.2	5.1	5.4	5.0	5.0	5.0	4.9	4.8	4.8	4.7	-	May 2017					4.7	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0											#DIV/0!							-	May 2017	96.6		0	96.6		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	May 2017	93.1			93.1		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	May 2017	72.7			72.7		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			3	2	0	3	1	2	0	0.5	0.5	1.5	4	3	2	4.5	3.5	4.5	3	-	May 2017	3	-	0	3	7.5	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	0	0	1	0	1	0	0	0	0	0	0	0.5	1.5	3.5	3	1	-	May 2017	1	-	0	1	4	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			104	97	62	149	86	176	62	70	97	76	98	98	120	150	162	126	139	-	May 2017	139	-	0	139		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0	0	-	-	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	-	0	0	0	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate G	M	P	Month	Year To Date	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0			0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			17	4	13	5	10	9	15	15	15	12	9	12	14	14	12	13	8	12	Jun 2017	4	5	3	12	33	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			20	6	17	9	13	10	19	21	23	23	16	21	24	24	22	19	12	15	Jun 2017	0	0	0	15		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	7.94		-	5.6		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	Jun 2017	0			0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	6	7	13	4	10	9	4	6	9	12	6	10	6	12	10	12	5	17	Jun 2017	17			17	34	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	74	71	78	76	73	74	76	76	76	79	79	71	80	83	81	83	82	82	Jun 2017	81.7	-		81.7		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	-	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			-	15	6	16	5	5	10	7	43	18	38	38	20	23	15	9	10	7	Jun 2017	3	0	4	7	26	
RTT	RTT - Admittted Care (18-weeks)	=> %	90.0	90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	78			78.0		
RTT	RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	96.9			96.9		
RTT	RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	93.8			93.8		
RTT	RTT - Backlog	<= No	0	0	60	70	80	69	92	93	130	121	129	161	161	160	111	96	96	98	81	97	Jun 2017	97			97		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	Jun 2017	0			0		
RTT	Treatment Functions Underperforming	<= No	0	0	1	0	1	1	0	1	2	2	2	2	3	3	2	1	2	1	1	1	Jun 2017	1			1		
RTT	Acute Diagnostic Waits in Excess of 6-weeks	<= %	0.1	0.1	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0			0.0		

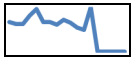
Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate G	M	P	Month	Year To Date	
Data Completeness	Open Referrals	No			23,372	23,021	22,929	23,294	24,026	24,973	24,866	25,230	25,985	26,671	27,018	27,523	27,970	28,605	29,483	30,091	30,838	31,759	Jun 2017	8,430	15,559	7,770	31759		
Data Completeness	Open Referrals - Awaiting Management	No			-	-	-	-	10,041	10,069	10,168	10,770	11,488	11,421	12,342	12,816	13,222	13,822	14,698	15,253	15,849	16,571	Jun 2017	4,672	9,595	2,304	16571		
Workforce	WTE - Actual versus Plan	No			96.9	94.7	91.8	87.3	101	99.2	97.1	118	116	107	109	126	119	111	116	119	124	116	Jun 2017	2.75	77.3	33.8	115.8		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	90.9	88.8	94.4		90.5	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	81.3	100	100		87.9	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	4.45	5.28	2.9	4.6	4.6	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	2.58	5.06	1.79	3.9	4.5	
Workforce	Sickness Absence - Long Term - in month	No			-	-	-	40	36	34	39	43	44	43	43	30	30	23	29	27	36	28	Jun 2017	2	23	3	28.0	91.0	
Workforce	Sickness Absence - Short Term - in month	No			-	-	-	99	105	94	111	96	106	113	125	114	142	83	105	50	41	40	Jun 2017	3	21	16	40.0	131.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	90.1	84.3	81.8	84.34	84.3	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	84.5	89.5	88.7		88.5	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			0	1	0	1	0	0	1	1	0	0	0	0	0	0	1	3	1	0	Jun 2017	0	0	0	0		
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0	●	●	●	●	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016				98	98	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0	●	●	●	●	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016				40	40	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	0	0																										
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	13	-->	-->	-->	-->	-->	Jan 2017	17	10	20	13		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.66	-->	-->	-->	-->	-->	Jan 2017	3.54	3.72	3.6	3.7		

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J		G	M	P			
WCH Group Only	HV (C1) - No. of mothers who receive a face to face AN contact with a HV at =>28 weeks of pregancy	No			207	193	159	207	198	244	253	219	255	119	131	109	126	-	-	-	-	-	Jan 2017		126		126	1861	
WCH Group Only	HV (C2) - % of births that receive a face to face new birth visit by a HV =<14 days	=> %	95.0	95.0	87.6	91.9	89	86.9	88.6	86.7	92.4	86.1	87.6	85.3	84.6	95.7	90.5	88.3	-	-	-	-	Feb 2017		88.3		88.25	88.5	
WCH Group Only	HV (C3) - % of births that receive a face to face new birth visit by a HV >days	%			7.69	6.68	9.33	12.8	11.4	11.8	8.76	12.3	10.5	7.71	1117	3.23	7.22	9.56	4.81	-	-	-	Mar 2017		4.81		4.81	18.29	
WCH Group Only	HV (C4) - % of children who received a 12 months review by 12 months	=> %	95.0	95.0	97.5	90.3	94.4	98.2	97.7	94.8	98.6	96.6	95.8	90.1	93.9	94.6	95.6	97.2	96.2	-	-	-	Mar 2017		96.2		96.23	95.74	
WCH Group Only	HV (C5) - % of children who received a 12 months review by the time they were 15 months	%			99.8	97.9	96.2	99.7	99.5	97.1	100	100	99.5	98.8	98.4	98.5	99.3	1.29	95.8	-	-	-	Mar 2017		95.8		95.82	90.93	
WCH Group Only	HV (C6i) - % of children who received a 2 - 2.5 year review	=> %	95.0	95.0	95.8	88.9	95.6	99	97.5	96.6	96	96	94.3	91.5	95.4	94.1	93	92.1	90.1	-	-	-	Mar 2017		90.1		90.07	94.55	
WCH Group Only	HV (C6ii) - % of children who receive a 2 - 2.5 year review using ASQ 3	%			90.2	84.2	81.6	89.2	81.9	86	88.7	88.3	91.5	92.8	89.4	89.2	89.7	82.5	84.2	-	-	-	Mar 2017		84.2		84.16	87.69	
WCH Group Only	HV (C7) - No. of Sure Start Advisory Boards / Children's Centre Boards witha HV presence	=> No	100	100	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	-	-	-	Mar 2017		1		1	12	
WCH Group Only	HV (C8) - % of children who receive a 6 - 8 week review	=> %	95.0	95.0	97.9	93.6	96	97.9	92.8	94.9	97.8	99.2	97	95	95.9	93.9	96.9	-	95.5	-	-	-	Mar 2017		95.6		95.55	96.16	
WCH Group Only	HV - % of infants for whom breast feeding status is recorded at 6 - 8 week check	=> %	100	100	98.6	99.3	99.4	99.8	99.4	99.7	99.8	99.5	99.3	94	93.6	87.9	98.6	-	86.1	-	-	-	Mar 2017		86.1		86.13	96.22	
WCH Group Only	HV - % of infants being breastfed at 6 - 8 weeks	%			37.9	35.6	43.9	42.8	39.4	41.7	49.3	40.6	39.6	40.7	37.6	43.5	43.5	-	42.2	-	-	-	Mar 2017		42.3		42.25	41.99	
WCH Group Only	HV - % HV staff who have completed mandatory training at L1,2 or 3 in child protection in last 3 years	=> %	95.0	95.0	-	-	-	100	100	100	100	100	100	100	100	100	100	100	-	-	-	-	Feb 2017		100		100	100	
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 10 - 14 day developmental check	No			335	391	341	382	400	391	391	365	413	313	132	306	377	-	357	-	-	-	Mar 2017		357		357	3827	
WCH Group Only	HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 10 - 14 day developmental check	=> %	100	100	96.3	100	100	100	98.8	98.7	101	97.3	96.3	92.4	91.3	93.5	97.2	-	91.3	-	-	-	Mar 2017		91.3		91.3	96.27	
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check	No			366	322	358	411	322	369	393	376	409	347	330	310	342	-	322	-	-	-	Mar 2017		322		322	3931	
WCH Group Only	HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check	=> %	100	100	99.7	98.8	100	99.8	99.4	99.7	95.4	96.7	94.9	89.4	86.6	86.5	88.6	-	97.9	-	-	-	Mar 2017		97.9		97.87	94.05	
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check	No			352	294	339	290	341	355	393	375	346	347	339	323	343	-	-	-	-	-	Jan 2017		343		343	3452	
WCH Group Only	HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check	=> %	100	100	89.6	92.2	91.6	91.2	90.9	92	91.4	85.6	86.3	83.6	86.7	82.4	89.8	-	-	-	-	-	Jan 2017		89.8		89.79	87.88	

Women & Child Health Group

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

Pathology Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate HA	HI	B	M	I	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	0	0	0	0	0	0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2017	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2017	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2017	-	-	-	-	-	-		
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			2	4	2	3	4	2	1	2	1	2	3	2	4	1	2	1	1	1	Jun 2017	0	1	0	0	0	1	3	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			1	4	3	3	5	4	2	2	2	3	3	1	3	4	4	3	2	2	Jun 2017	2	0	0	0	0	2		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2017	-	-	-	-	-	-	-	
Data Completeness	Open Referrals	No			3,312	3,294	3,420	3,572	3,639	3,701	3,868	5,631	5,764	5,995	6,051	6,140	6,284	6,387	6,495	6,601	6,770	6,960	Jun 2017	1,984	0	2,327	0	2,649	6,960		
Data Completeness	Open Referrals - Awaiting Management	No			-	-	-	-	1,502	1,437	1,510	2,208	2,275	2,407	2,444	2,478	2,613	2,685	2,791	2,845	2,956	3,034	Jun 2017	959	0	1,097	0	978	3,034		
Workforce	WTE - Actual versus Plan	No			32.5	22.9	30.3	25.7	31.6	35.2	39	39.8	38.4	40	37	31	34.7	30.3	23.7	18.7	28.1	27.9	Jun 2017	9.65	4.79	8.75	3.58	-1.2	28		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	98.2	91.4	93.4	89.8	92.3		94.93	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	75	100	75	66.7		79.17	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	3.44	3.56	4.55	3.15	2.83	3.84	3.94	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	6.6	0.6	3.3	4.0	2.2	3.41	2.92	
Workforce	Sickness Absence - Long Term - In Month	No			-	-	-	10	12	14	14	15	13	12	14	6	5	6	8	6	6	6	Jun 2017	3.0	0.0	2.0	1.0	0.0	6	18	
Workforce	Sickness Absence - Short Term - In Month	No			-	-	-	47	45	38	35	36	30	43	49	41	36	35	45	30	30	39	Jun 2017	3.0	2.0	20.0	6.0	2.0	39	99	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	88.7	94.1	75	97.8	96.7	85.5	84.7	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	89.9	93.4	91.1	91.1	98.9		91.2	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-		-	
Workforce	New Investigations in Month	No			1	0	0	0	0	0	0	0	2	0	0	0	1	0	0	0	0	0	Jun 2017	0	0	0	0	0	0		
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0	●	●	●	●	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016						265	265	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0	●	●	●	●	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016						0	0	
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	22	-->	-->	-->	-->	-->	Jan 2017	24	21	17	27	55	22		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.82	-->	-->	-->	-->	-->	Jan 2017	3.54	3.32	3.89	4.01	3.93	3.82		

Imaging Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate DR	IR	NM	BS	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	0	0	0	0	0	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	<= No	0	0	1.0	2.0	-	2.0	1.0	2.0	1.0	3.0	1.0	-	2.0	2.0	1.0	-	1.0	1.0	2.0	-	May 2017					6.3		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	=> %	0	0	11.0	12.0	12.0	14.0	13.0	13.0	12.0	14.0	14.0	13.0	15.0	17.0	17.0	15.0	16.0	15.0	16.0	-	May 2017						4.34	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017			78.05		78.05	78.07	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.00	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017			97.56		97.56	97.37	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2017	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2017	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	May 2017	-	-	-	-	-		
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			3	6	5	2	0	1	1	2	1	1	4	5	4	1	1	4	2	2	Jun 2017	2	0	0	0	2	8	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			3	6	5	2	1	2	2	2	0	1	4	9	3	2	2	1	3	4	Jun 2017	4	0	0	0	4		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2017	-	-	-	-	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			-	49	62	36	67	69	86	66	54	55	60	55	66	54	100	102	128	94	Jun 2017	94	0	0	0	94	324	
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0.66				0.66		
Data Completeness	Open Referrals	No			259	271	286	288	298	325	342	361	376	399	428	438	461	481	498	512	532	545	Jun 2017	545	0	0	0	545		
Data Completeness	Open Referrals - Awaiting Management	No			-	-	-	-	287	267	299	315	331	346	373	386	403	421	438	454	474	492	Jun 2017	492	0	0	0	492		
Workforce	WTE - Actual versus Plan	No			43.9	44.2	46.3	48.5	51	44.2	44.5	47	45.4	40.8	40.2	38.5	32.4	31.4	32	35	38.9	35.7	Jun 2017	22.7	2.95	2.01	4	35.7		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	79.4	80	88.9	87.5		88.1	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	95.7	0	50	75		89.8	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	3.3	9.5	2.7	4.2	4.34	4.25	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	2.1	13.0	0.0	2.5	3.86	4.09	
Workforce	Sickness Absence - Long Term - in month	No			-	-	-	10	10	8	8	7	6	7	13	10	15	13	9	6	10	7	Jun 2017	2.0	1.0	0.0	0.0	7.00	23.00	
Workforce	Sickness Absence - Short Term - in month	No			-	-	-	33	39	38	31	23	26	29	41	40	53	36	32	29	22	24	Jun 2017	11.0	0.0	0.0	4.0	24.00	75.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	·	May 2017	69	42.9	86.1	65.2	71.1	70.9	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	83	92.4	91	94.8		87.7	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017					0		
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	20	-->	-->	-->	-->	-->	Jan 2017	18	10	46	16	20		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.58	-->	-->	-->	-->	-->	Jan 2017	3.43	0	4.07	4.17	3.58		
Imaging Group Only	Unreported Tests / Scans	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								
Imaging Group Only	Outsourced Reporting	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								
Imaging Group Only	IRMA Instances	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J		AT	IB	IC			
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.0	80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	0	0	0		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	-	-	-	-	-	2	2	1	0	5	4	4	1	Jun 2017	0	1	0	1	9	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	-	-	-	-	-	2	2	2	0	5	4	4	1	Jun 2017	0	1	0	1	9	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	-	-	-	-	-	2	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	-	-	-	-	-	1	1	2	0	0	3	2	3	Jun 2017	0	3	0	3	8	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	-	-	-	-	-	1	0	0	0	0	2	2	4	Jun 2017	0	4	0	4	8	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	-	-	-	-	-	0	0	0	0	0	2	0	0	Jun 2017	0	0	0	0	2	
Patient Safety - Harm Free Care	Falls	<= No	0	0	31	23	20	22	38	31	29	31	29	33	30	27	20	19	31	23	21	36	Jun 2017	3	30	3	36	80	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	2	1	1	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	3	0	4	2	4	2	3	1	1	0	1	3	2	2	1	5	1	1	Jun 2017	-	1	-	1	7	
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Jun 2017	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			3	6	7	3	5	5	4	5	4	3	8	4	6	1	1	4	3	8	Jun 2017	3	3	2	8	15	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			3	6	7	11	7	9	8	9	7	5	5	6	6	6	6	9	10	12	Jun 2017	3	6	3	12		

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J		AT	IB	IC			
Workforce	WTE - Actual versus Plan	No			94.7	100	106	102	123	128	154	152	135	104	109	122	115	112	118	128	130	131	Jun 2017	31.6	58.9	40.7	131.22		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	91.4	90.4	86.9		92.6	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	3.18	4.78	3.92	3.99	4	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	3.39	4.32	3.43	3.72	3.75	
Workforce	Sickness Absence - Long Term - in month	No			-	-	-	26	25	26	24	27	29	22	23	29	32	24	24	24	19	19	Jun 2017	3	-	-	19	62	
Workforce	Sickness Absence - Short Term - in month	No			-	-	-	65	59	81	80	83	53	74	104	101	102	93	82	57	60	57	Jun 2017	9	21	26	57	174	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	70.1	81.5	82.3	79.13	78.89	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	88.9	0		90.2	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			0	2	0	0	0	2	0	1	0	0	0	1	0	0	0	0	0	1	Jun 2017				1		
Workforce	Nurse Bank Fill Rate	=> %	100	100	88.4	78.3	89.3	87.9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	87.87	87.87	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	90	78	86	87	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	87	87	
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	29	-->	-->	-->	-->	-->	Jan 2017	29	31	28	29		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.83	-->	-->	-->	-->	-->	Jan 2017	3.72	3.72	3.96	3.83		

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J		AT	IB	IC			
Community & Therapies Group Only	DVT numbers	=> No	730	61	47	65	51	53	55	74	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2016				74	182	
Community & Therapies Group Only	Adults Therapy DNA rate OP services	<= %	9	9	11.3	9	8.06	9.9	8.82	9.6	8.85	9.01	9.22	7.88	7.37	12.2	12.2	8.97	8.04	8.47	8.18	1177	Jun 2017				1177.1	56.2	
Community & Therapies Group Only	Therapy DNA rate Paediatric Therapy services	<= %	9	9	-	-	-	-	1.58	1.58	1.58	1.58	1.29	0	1.42	0.87	3.94	1.15	-	-	-	-	Feb 2017				1.2	1.4	
Community & Therapies Group Only	Therapy DNA rate S1 based OP Therapy services	<= %	9	9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-	
Community & Therapies Group Only	STEIS	<= No	0	0	2	1	1	0	0	2	0	0	2	1	1	0	0	0	0	0	0	-	May 2017				0	0	
Community & Therapies Group Only	Green Stream Community Rehab response time for treatment (days)	<= No	11.0	11.0	16	24	24	23	17	17	-	-	-	-	-	-	-	-	-	-	-	-	Jun 2016				17	57	
Community & Therapies Group Only	DNA/No Access Visits	%			1	1	0	1	1	2	3	2	2	2	2	2	1	2	-	-	-	-	Feb 2017				2.1		
Community & Therapies Group Only	Baseline Observations for DN	=> %	100	100	-	-	-	-	-	38.5	42.4	41.5	60.1	36.8	53	57.3	55.8	59.2	56.3	66.8	-	-	Apr 2017				66.8	66.8	
Community & Therapies Group Only	Falls Assessments - DN Intial Assessments only	%			52	55	54	61	161	70	61	55	65	42	77	69	60	62	58	69	-	-	Apr 2017				68.84		
Community & Therapies Group Only	Pressure Ulcer Assessment - DN Intial Assessments only	%			54	56	58	64	67	75	65	63	71	47	80	71	63	65	63	77	-	-	Apr 2017				76.73		
Community & Therapies Group Only	MUST Assessments - DN Intial Assessments only	%			28	32	32	37	35	40	36	32	37	26	52	46	48	36	46	58	-	-	Apr 2017				57.69		
Community & Therapies Group Only	Dementia Assessments - DN Intial Assessments only	%			28	31	21	40	37	11	30	37	45	14	53	53	52	62	44	55	-	-	Apr 2017				55		
Community & Therapies Group Only	48 hour inputting rate - DN Service Only	%			93	94	94	93	91	90	90	92	86	94	93	93	69	93	94	92	-	-	Apr 2017				91.84		
Community & Therapies Group Only	Making Every Contact (MECC) - DN Intial Assessments only	%			-	-	7	-	-	200	222	222	270	177	251	369	308	382	460	488	-	-	Apr 2017				66.39	66.39	
Community & Therapies Group Only	Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload acquired)	No			-	-	3	3	2	1	4	3	2	0	2	5	6	8	6	5	8	5	Jun 2017				5	18	
Community & Therapies Group Only	Avoidable Grade 2 Pressure Ulcers (DN caseload acquired)	No			-	-	3	3	2	1	3	1	1	0	2	2	4	6	3	5	8	3	Jun 2017				3	16	
Community & Therapies Group Only	Avoidable Grade 3 Pressure Ulcers (DN caseload acquired)	No			-	-	0	0	0	0	1	1	1	0	0	3	2	2	2	0	0	2	Jun 2017				2	2	
Community & Therapies Group Only	Avoidable Grade 4 Pressure Ulcers (DN caseload acquired)	No			-	-	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	Jun 2017				0	0	

Corporate Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	Data Period	Directorate SG	F	W	M	E	N	O	Month	Year To Date	Trend
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			4	5	8	8	10	12	4	13	8	13	11	12	11	11	14	3	9	5	Jun 2017	2	0	0	0	0	1	2	5	17	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			4	4	7	8	9	12	9	17	10	13	18	13	12	17	19	16	17	10	Jun 2017	4	0	0	0	0	3	3	10		
Workforce	WTE - Actual versus Plan	No			81.9	83.2	96.4	102	128	101	106	130	146	123	118	133	98.6	94.5	105	99.5	103	102	Jun 2017	6.68	1.29	-11.2	7.25	-6.84	34.1	70.6	101.94		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	72	76	92	89	94	94	87		90.7	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017			95					50.0	50	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	1.87	2.95	3.83	2.78	3.87	5.56	5.06	4.63	4.50	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	1.98	1.57	4.09	2.88	4.38	5.60	5.12	4.64	4.62	
Workforce	Sickness Absence - Long Term - in month	No			-	-	-	51	53	52	59	62	65	64	64	79	0	1	0	2	1	2	Jun 2017	1.00	0.00	0.00	0.00	0.00	1.00	0.00	2.00	5.00	
Workforce	Sickness Absence - Short Term - in month	No			-	-	-	192	176	173	153	160	181	203	224	191	7	8	8	3	2	3	Jun 2017	3.00	0.00	0.00	0.00	0.00	0.00	0.00	3.00	8.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	May 2017	87.3	78.8	71.3	77.2	75.3	83.4	79.5	80.5	80.8	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jun 2017	0	96	97	84	99	89	91	90.5	89	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	
Workforce	New Investigations in Month	No			2	2	2	4	4	1	4	1	1	0	0	2	1	1	4	6	0	2	Jun 2017	0	0	0	0	0	1	1	2		
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	18	-->	-->	-->	-->	-->	Jan 2017	51	45	39	30	19	6	17	18		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	3.64	-->	-->	-->	-->	-->	Jan 2017	3.83	3.61	3.98	3.55	3.52	3.62	3.37	3.64		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	IPR Persistent Reds
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Finance & Performance Director
AUTHOR:	Yasmina Gainer, Head Performance Management & Costing
DATE OF MEETING:	3 August 2017

EXECUTIVE SUMMARY:

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

Attached is a summary of such indicators and which includes a management assessment of relative priority for remediation and proposed timescale for that remediation.

The Board is asked to challenge and confirm that assessment of priority and timescale for remediation.

Next steps are the development of specific milestone plans for delivery and month on month target trajectories against which performance can be monitored & reported. Oversight and assurance shall be provided through routine consideration by the Q&S Committee.

REPORT RECOMMENDATION:

The Board is recommended to challenge and confirm:

1. Management assessment of relative priority for remediation of persistent red indicators
2. Management proposed timescale for the remediation of performance in respect of those indicators

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Operational Management Committee, Performance Management Committee, CLE

Persistent Red Recovery Plan

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

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Financial performance – P03 June 2017**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Finance Director**
AUTHOR:	**Tim Reardon – Associate Director of Finance**
DATE OF MEETING:	**3 August 2017**

EXECUTIVE SUMMARY:

Headlines

This report deals with the financial performance for P03 June 2017/18 and indications for the performance in relation to statutory duties for the full year.

The position at the end of Q1 shows performance before STF as being in line with plan. This is after £1.9m of unplanned contingencies and flexibilities.
Headline performance after STF is reported as £235k adverse to plan which reflects Q1 failure of the A&E waiting times performance element of STF.
The Trust's forecast year end position reflects this position – that is as plan pre-STF and failure of £235k after STF.

Key messages:

- P03 year to date headline performance reported as plan before STF, reliant on significant unplanned technical support, and failure of the A&E element of STF.
- Elements of technical support carry varying degrees of risk.
- Significant unidentified savings requirement requiring remediation through FIP2 process / asset sales.
- Capex programme being pursued as plan. CRL remains to be confirmed by NHSi. Dialogue on-going.
- Cash borrowing requirements subject to routine assessment. NHSI indicated at loan review meeting that the Trust should rely on land sale cash receipt and creditor stretch before submitting any loan application. Lower BPPC performance has been tolerated by NHSI at other Trusts.
- Planned care activity is marginally behind the internally phased plan (and significantly behind the plan assumed in the NHSI phased plan). Theatre efficiency remains biggest opportunity for improvement.
- Agency spending has increased from P2 to P3 due to specific one-off matters and despite a £500k reduction from March 2017 remains above plan trajectory. Requires mobilisation & delivery of plan to secure first £10m of spend reduction.

Key actions:

- Note STF partial failure in Q1 and consequent impact on forecast delivery of financial plan.
- Confirmation and execution of step reduction in costs through focus on bed reduction, pay & workforce change & procurement cost savings. Delivery of demand & capacity plan to secure income.
- Delivery of capital programme to time & revised plan consistent with enabling programme for MMH
- Monitoring and delivery of liquidity / cash improvement plan.
- Resolution of 2017.18 contract discussion with SWBCCG.
- Secure land sale to maximise cash in-flow in the first half of the financial year.

Key numbers:

- Month deficit -£1.8m being £0.2m behind plan due to STF A&E failure.
- YTD deficit -£5.2m being £0.2m behind plan due to STF A&E failure.
- Underlying YTD deficit -£9.1m being -£1.9m adverse to plan.
- STF of £1.3m assumed earned for the quarter.
- Pay bill £26.4m (vs. £26.4m each of previous two months); Agency spend £1.6m (vs. £1.4m in P2).
- Capital spend at £4.6m is £3.8m behind plan to date.
- Cash at 30th June £9.3m being above plan by £8.2m.

REPORT RECOMMENDATION:

The Committee is recommended to note the report, in particular the impact on the forecast year end position of the Q1 STF partial failure and to REQUIRE those actions necessary to secure the required plan out-turn for FY 2017/18.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x	x	x

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

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

Comments:

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

PREVIOUS CONSIDERATION:

Finance Report

Period 03 2017/18
June 2017

Trust Board
3 August 2017

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Finance Report

Summary & Recommendations

Period 03 2017/18

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

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

Outlook

- NHSI P03 return reports forecast surplus £9.7m, £235k below control total as a result of Q1 A&E STF failure.
- Reliant on significant profit on disposal to cover recognised [CIP] risk, development of production planning and roster management as core competences and CIP delivery.
- Key risks to plan known and confirmed by external review. Phase 2 of FIP2 process concluding.

P03 key issues & remedial actions

- P03 YTD headline performance reported as £235k behind plan due to STF A&E performance failure.
- Position is reliant on significant unplanned technical support and requires remediation through delivery of cornerstone P&L improvement.
- Significant unidentified savings requirement requiring remediation through follow through delivery of FIP2.
- Capex programme being pursued as plan. Formal request for CRL cover made & NHSi approval awaited.
- Near term revenue cash requirement covered by revised capex timing. Likely revenue borrowing requirement pushed back to January 2018 on presumption of asset disposal receipt in Q2.
- Planned care activity & income is slightly behind re-phased plan but aggregate patient income under-recovery against NHSI profile plan because of the re-profiling of internal plans.
- Increase in agency spend P02 to P03; mobilisation of plan to secure first £10m reduction.

Recommendation

- Challenge and confirm:
  - Forecast change to reflect Q1 A&E failure
  - reported P03 position & specifically the assumptions underpinning the deployment of technical support.
  - plausible route to pre-STF control total; requires expedited actions to reduce costs & secure profit on disposal.

Finance Report

Performance to date – I&E and cash

Period 03 2017/18

Financial Performance to Date

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

- P03 year to date reported as delivering to plan excluding STF
- Headline I&E deficit of £5,160k, a shortfall of £234k against NHSI profiled plan of £4,925k as a result of STF A&E failure.
- Underlying I&E deficit £9,146k being £1.9m adverse to plan
- Capital spend of £4,591k being £3,796k behind plan;
- Cash at 30 June is £9,292k being £8,158k more than plan.
- Use of resources rating at 4 year to date.

I&E

P03 year to date reported as delivering to plan excluding STF, with A&E waiting time performance failure for Q1 at £235k .

The underlying delivery is dependent on the benefits from £1.9m of unplanned contingencies and flexibility.

Patient related income and pay are the main drivers behind I&E underperformance. While Planned Care is marginally behind internal plan to Q1, it faces a step up in Q2 which remains to be fully secured. Key improvement opportunities remain

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

Savings

Savings required in 2017/18 are £33m. Of this total £13.2m remain unidentified and therefore high risk. Actual delivery is reported as £2.3m at Q1which is £0.3m more than the phased NHSI plan.

Capital

Capital expenditure to date stands at £4.6m against a full year plan of £46.7m. Key variance to date in is respect of timing of milestone payments re EPR. The full year programme is subject to review having regard to MMH delay.

Cash

The cash position is £8.2m above plan at 30th June. This is due to the I&E position being offset, and funded, by capital cash in the first quarter.

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

Any immediate requirement for revenue cash support is being covered by timing of capital cash outgoings. The likely revenue borrowing requirement anticipated for July in the plan has pushed back to January 2018 on presumption of asset disposal proceeds receipt in Q2.

Better Payments Practice Code

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

Finance Report

Use of Resources Rating

Period 03 2017/18

Finance and use of resources metrics	Expected Sign	03PLANYTD Plan 30/06/2017 YTD £'000	03ACTYTD Actual 30/06/2017 YTD £'000	03VARYTD Variance 30/06/2017 YTD £'000	03PLANCY Plan 31/03/2018 Year ending £'000	03FOTCY Forecast 31/03/2018 Year ending £'000	03VARCY Variance 31/03/2018 Year ending £'000
Capital service cover rating	+	4	4		1	1	
Liquidity rating	+	4	4		4	4	
I&E margin rating	+	4	4		1	1	
Distance from financial plan	+		2			2	
Agency rating	+	3	4		2	2	

Overall finance and use of resources risk rating	Expected Sign	03PLANYTD Plan 30/06/2017 YTD £'000	03ACTYTD Actual 30/06/2017 YTD £'000	03VARYTD Variance 30/06/2017 YTD £'000	03PLANCY Plan 31/03/2018 Year ending £'000	03FOTCY Forecast 31/03/2018 Year ending £'000	03VARCY Variance 31/03/2018 Year ending £'000
Overall rating unrounded	+		3.60			2.00	
If unrounded score ends in 0.5	+		0.00			0.00	
Plan risk ratings before overrides	+		4			2	
Plan risk ratings overrides:							
Any ratings in table 6 with a score of 4 override - if any 4s "trigger" will show here	Text		Trigger			Trigger	
Any ratings in table 6 with a score of 4 override - maximum score override of 3 if any rating in table 6 scored as a 4	+		4			3	

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

- Capital service cover is marginally off plan due to I&E performance;
- Liquidity at -19 days is better than the planned -28 days but remains a 4;
- I&E margin at -4.5% is marginally off -4.3% planned;
- Distance from financial plan is -0.3%;
- Agency spend is £0.8m more than plan resulting in a score of 4.

Finance Report

I&E Performance – Full Year

Period 03 2017/18

Period 3	CP Plan £'000s	CP Actual £'000s	CP Variance £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s	FY Plan £'000s	FY Forecast £'000s	FY Variance £'000s
Patient Related Income	35,336	35,389	53	105,982	101,606	(4,376)	424,405	424,405	0
Other Income	3,882	4,122	240	11,663	14,027	2,364	59,706	59,471	(235)
Income total	**39,218**	**39,511**	**293**	**117,645**	**115,633**	**(2,012)**	**484,111**	**483,876**	**(235)**
Pay	(26,072)	(26,431)	(359)	(78,212)	(79,259)	(1,047)	(300,666)	(300,666)	0
Non-Pay	(12,721)	(12,903)	(182)	(38,155)	(35,269)	2,886	(155,280)	(155,280)	0
Expenditure total	**(38,793)**	**(39,334)**	**(541)**	**(116,367)**	**(114,528)**	**1,839**	**(455,946)**	**(455,946)**	**0**
EBITDA	**425**	**176**	**(249)**	**1,278**	**1,105**	**(173)**	**28,165**	**27,930**	**(235)**
Non-Operating Expenditure	(2,083)	(2,056)	27	(6,253)	(6,255)	(2)	(9,271)	(9,271)	0
Technical Adjustments	18	19	1	50	(9)	(59)	(8,961)	(8,961)	0
DH Surplus/(Deficit)	**(1,640)**	**(1,860)**	**(220)**	**(4,925)**	**(5,160)**	**(234)**	**9,933**	**9,698**	**(235)**
Add back STF	*(524)*	*(288)*	*236*	*(1,572)*	*(1,336)*	*236*	*(10,483)*	*(10,248)*	*235*
Adjusted position	***(2,164)***	***(2,149)***	***16***	***(6,497)***	***(6,496)***	***2***	***(550)***	***(550)***	***0***
Technical Support (inc. Taper Relief)	*(250)*	*(583)*	*(333)*	*(750)*	*(2,650)*	*(1,900)*	*(3,000)*	*(3,000)*	*0*
Underlying position	***(2,414)***	***(2,732)***	***(318)***	***(7,247)***	***(9,146)***	***(1,898)***	***(3,550)***	***(3,550)***	***0***

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

The trust reported a headline deficit for P03 YTD of £5.2m being £0.2m behind plan due to STF failure related to A&E waiting times performance.

Performance before STF is reported as being in line with plan.

This was reliant on the benefit of £2.7m of contingency and flexibility of which £1.9m was unplanned.
This includes the use of taper relief for which there may be calls in future months.

The underlying deficit for P03 YTD is therefore recorded as £9.1m. This is £1.9m adverse compared with the plan underlying deficit of £7.2m.

Finance Report

Income Analysis

Period 03 2017/18

Performance Against SLA by Patient Type								
	Activity					Finance		
	Annnual Plan	Planned	Actual	Variance	Annual Plan £000	Planned £000	Actual £000	Variance £000
A&E	227,129	57,131	56,611	-519	£24,194	£6,085	£6,217	£131
Emergencies	44,108	11,072	11,198	126	£84,726	£21,269	£22,488	£1,220
Emergency Short Stay	11,645	3,227	1,799	-1,428	£9,069	£2,510	£1,367	-£1,143
Excess bed days	10,495	3,005	4,024	1,019	£2,906	£834	£1,073	£238
Urgent Care					**£120,895**	**£30,699**	**£31,145**	**£446**
OP New	169,764	39,952	45,408	5,456	£25,548	£6,011	£6,577	£566
OP Procedures	61,597	14,502	17,415	2,913	£10,487	£2,469	£2,766	£297
OP Review	387,088	91,097	83,859	-7,238	£27,008	£6,361	£5,888	-£473
OP Telephone	12,965	3,049	3,136	88	£298	£70	£71	£1
DC	39,887	9,255	8,586	-668	£32,844	£7,624	£6,947	-£677
EL	6,408	1,487	1,610	124	£16,430	£3,823	£3,928	£105
Planned Care - production plan					**£112,615**	**£26,358**	**£26,177**	**-£181**
Planned care outside production plan	24,233	7,896	8,717	821	£4,109	1,236	£1,251	£15
Maternity	20,284	5,010	4,947	-63	£19,193	£4,741	£4,677	-£64
Renal dialysis	565	133	150	17	£68	£16	£18	£2
Community	619,003	148,356	161,017	12,661	£36,658	£8,883	£8,993	£110
Cot days	12,932	3,162	3,626	464	£6,782	£1,658	£1,784	£126
Other contract lines	3,623,854	907,854	971,104	63,250	£94,419	£24,308	£23,637	-£671
Unbundled activity	68,721	17,978	17,974	-4	£7,629	£2,203	£2,192	-£11
Other					**£168,858**	**£43,045**	**£42,552**	**-£492**
Sub-Total: Main SLA income (excl fines)					**£402,368**	**£100,102**	**£99,874**	**-£228**
Year to date refresh of prior months' data					-£354	-£1	£0	£1
Group stretch SLA targets (CIP delivery)					£746	£180		-£180
Income adjustment - pass through drugs							£1,345	£1,345
Fines and penalties					-£600	-£150	-£800	-£650
Oncology: cancer drugs fund / NHSE / UHB					£7,598	£659	£176	-£483
Neurophys / maternity / interpreting / poisons / mental health					£2,753	£688	£625	-£64
Individual funding requests / private / overseas / prescriptions					£1,038	£263	£194	-£69
Injury cost recovery					£1,249	£312	£200	-£113
NHSI Plan phasing adjustment					-£2	£1,740	£0	-£1,740
Other adjustments					£1	-£83	-£6	£76
GRAND TOTAL NHS patient income					**£414,798**	**£103,710**	**£101,606**	**-£2,105**

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

Planned care within the production plan is behind by £181k to end Q1.
Notably new outpatients is £0.5m ahead of plan.

Urgent care is over-performing in A&E and in excess bed days.

The headline variance on total Patient Related Income to date is £2.1m adverse which mainly relates to the phasing adjustment to bring the PRI plan up to the level of the NHSI plan.
This is because the NHSI plan for PRI was broadly flat and the internal plan – mainly driven by Group planned care targets – ramps up activity in the latter part of the year.

Finance Report

CIP achievement

Period 03 2017/18

Year to Date up to Period 3	17/18 In Year Target £'000s	In Year Actual and Forecast Delivery: Apr Actual 1 £'000s	May Actual 2 £'000s	Jun Actual 3 £'000s	Jul F/Cast 4 £'000s	Aug F/Cast 5 £'000s	Sep F/Cast 6 £'000s	Oct F/Cast 7 £'000s	Nov F/Cast 8 £'000s	Dec F/Cast 9 £'000s	Jan F/Cast 10 £'000s	Feb F/Cast 11 £'000s	Mar F/Cast 12 £'000s	In Year 17/18 F/Cast £'000s
Medicine and Emergency Care	5,925	237	274	154	0	0	0	0	0	0	0	0	0	666
Surgical Services	8,327	130	92	128	0	0	0	0	0	0	0	0	0	350
Women and Child Health	2,519	33	50	19	0	0	0	0	0	0	0	0	0	102
Primary Care,Community and Thera	2,456	78	87	109	0	0	0	0	0	0	0	0	0	274
Pathology	640	49	78	177	0	0	0	0	0	0	0	0	0	304
Imaging	1,035	35	32	96	0	0	0	0	0	0	0	0	0	163
Sub-Total Clinical Groups	**20,902**	**562**	**613**	**683**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,858**
Strategy and Governance	344	14	14	14	0	0	0	0	0	0	0	0	0	42
Finance	392	24	24	25	0	0	0	0	0	0	0	0	0	72
Medical Director	418	34	34	34	0	0	0	0	0	0	0	0	0	101
Operations	524	0	0	0	0	0	0	0	0	0	0	0	0	0
Organisational Development	166	2	5	(3)	0	0	0	0	0	0	0	0	0	4
Estates and NHP	723	48	48	37	0	0	0	0	0	0	0	0	0	132
Corporate Nursing and Facilities	1,435	47	47	1	0	0	0	0	0	0	0	0	0	94
Sub-Total Corporate	**4,003**	**168**	**171**	**108**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**446**
Central	8,095	0	0	0	0	0	0	0	0	0	0	0	0	0
DH Surplus/(Deficit)	**33,000**	**730**	**784**	**791**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2,304**
NHSI Plan - March 2017 submission		666	667	667	1,330	1,330	1,330	2,007	2,007	2,007	2,661	2,663	15,666	33,001
TPRS Plan		795	992	1,280	1,395	1,600	1,842	2,004	1,924	1,987	1,947	1,939	2,046	19,752
Planning gap		129	325	613	65	270	512	-3	-83	-20	-714	-724	-13,620	-13,249
Delivery gap		-66	-209	-489										-763

CIP delivery to date is reported as being £0.3m ahead of NHSI plan but notably £0.8m behind the internal plan on TPRS.
Detailed forecasts are being worked up for review at P04.
The £13m unidentified CIP risk shown in P12 plan may be covered by the prospect of a profit on disposal of surplus assets.

Finance Report

Pay bill & Workforce

Period 03 2017/18

Pay and Workforce	Current Period	Previous Period	Change between periods	%	Plan YTD	Actual YTD	Variance YTD
Pay - total spend	£26,431k	£26,375k	£56k	0%	£78,042k	£79,259k	£1,216k
Pay - substantive	£21,925k	£22,267k	-£342k	-2%	£77,360k	£66,319k	-£11,041k
Pay - agency spend	£1,621k	£1,372k	£249k	18%	£376k	£4,599k	£4,223k
Pay - bank (inc. locum) spend	£2,885k	£2,736k	£149k	5%	£307k	£8,341k	£8,034k
WTE - total	6,912	6,838	74	1%	6,852	6,912	60
WTE - substantive	6,012	6,041	-29	0%	6,848	6,012	-836
WTE - agency	188	146	42	29%	0	188	188
WTE - bank (inc. locum)	712	652	60	9%	4	712	708
Memo: locum spend	£744k	£710k	£34k	5%	£139k	£2,091k	£1,952k
Memo: locum WTE	65	63	2	2%	4	65	60

NHSI locum spend target	£6,307k

Paybill & Workforce

- Total workforce at the end of June of 6,912 WTE [being 60 higher than plan], including 188 WTE of agency staff.
- Total pay costs (including agency workers) were £26.4m in June, showing little change from May and being £1.2m over internal plan.
- Significant reduction in temporary pay costs required to be consistent with FY 2017/18 plan assumptions. Focus on reduction in capacity and improved roster management.
- The Trust did not comply with national agency framework guidance for agency suppliers in June. Shifts procured outside of this are subject to COO approval and is driven by strict commitment to maintaining safe staffing.
- The Trust continues to exceed the national agency rate caps. Trust implementation and compliance is subject to granular assurance that there is no compromise to securing safe staffing levels.
- Target have been set for locum spend reduction in FY 2017/18. For SWBH the target is a spend reduction of £545k compared to FY 2016/17.

Finance Report

Group I&E Performance

Period 03 2017/18

Period 3	Current Period			Run rate change	Year to Date			Full Year
	Plan £'000s	Actual £'000s	Variance £'000s	since P2 £'000s	Plan £'000s	Actual £'000s	Variance £'000s	Plan £'000s
Medicine & Emergency Care	1,155	1,334	178	(21)	4,546	3,436	(1,110)	20,114
Surgical Services	1,677	985	(691)	(287)	2,880	1,865	(1,015)	17,845
Women's & Child Health	2,008	1,642	(365)	337	5,353	4,605	(748)	23,447
Primary Care, Community and Therapies	1,195	1,034	(162)	752	1,980	1,103	(878)	11,219
Pathology	336	551	215	471	814	841	27	3,972
Imaging	262	250	(12)	105	777	561	(216)	3,593
Clinical Groups	**6,634**	**5,796**	**(838)**	**1,357**	**16,350**	**12,410**	**(3,940)**	**80,190**
Strategy and Governance	(1,325)	(1,315)	10	(50)	(3,930)	(3,832)	97	(15,509)
Finance	(361)	(363)	(2)	7	(1,082)	(1,083)	(1)	(4,151)
Medical Director	(661)	(727)	(66)	(96)	(1,984)	(1,966)	18	(7,652)
Operations	(1,267)	(1,376)	(109)	(165)	(3,711)	(3,779)	(68)	(14,475)
Workforce & Organisation Development	(488)	(537)	(49)	(16)	(1,432)	(1,469)	(37)	(5,472)
Estates & New Hospital Project	(1,083)	(1,087)	(4)	(126)	(3,064)	(2,912)	152	(11,752)
Corporate Nursing & Facilities	(1,377)	(1,649)	(272)	(120)	(4,432)	(4,691)	(259)	(16,920)
Corporate Directorates	**(6,563)**	**(7,054)**	**(491)**	**(567)**	**(19,635)**	**(19,732)**	**(97)**	**(75,931)**
Central and Income	268	472	204	152	4,835	3,265	(1,570)	17,098
Reserves	(1,995)	(1,093)	902	(1,093)	(6,525)	(1,093)	5,432	(11,633)
Technical Adjustments	17	19	2	66	52	(9)	(61)	208
DH Surplus/(Deficit)	**(1,639)**	**(1,860)**	**(222)**	**(85)**	**(4,924)**	**(5,160)**	**(236)**	**9,932**

- While the bottom line Trust variance year to date is £236k adverse related to STF failure of A&E performance, the underlying Group variance of £3.9m adverse is highlighted as being offset by central items and release of reserves.
- Group forecasts based on Q1 performance are being prepared for consideration in P04.

Finance Report

Group I&E Variances

Period 03 2017/18

Period 3	Year to Date Variances													
	Main SLA excl P/T £'000s	Pass Thru SLA Inc £'000s	CDF and FP10s £'000s	Other PRI £'000s	STF £'000s	Other Income £'000s	Pay Substantive £'000s	Pay Bank £'000s	Pay Agency £'000s	Pay Other £'000s	Non Pay Pass Thru £'000s	Non Pay Other £'000s	Non Opex £'000s	TOTAL £'000s
Medicine & Emergency Care	756	54	0	734		(47)	2,322	(2,318)	(2,564)	528	(54)	(522)	0	(1,110)
Surgical Services	(1,238)	45	(34)	559		18	1,647	(1,130)	(745)	138	(11)	(262)	0	(1,015)
Women's & Child Health	(120)	3	0	(177)		(127)	1,196	(591)	(215)	(592)	(3)	(122)	0	(748)
Primary Care, Community and Therapie	422	(94)	(483)	150		2	1,023	(780)	(359)	(569)	577	(768)	0	(878)
Pathology	68	85	0	(104)		121	358	(100)	0	(281)	(85)	(36)	0	27
Imaging	(6)	0	0	9		(79)	176	(274)	(88)	97	0	(51)	0	(216)
Clinical Groups	**(118)**	**93**	**(517)**	**1,171**	**0**	**(112)**	**6,721**	**(5,193)**	**(3,970)**	**(679)**	**424**	**(1,760)**	**0**	**(3,940)**
Strategy and Governance	0	0	0	(36)		66	1	(18)	(16)	(9)	0	110	0	97
Finance	0	0	0	0		(7)	93	(43)	(69)	28	0	(4)	0	(1)
Medical Director	0	0	0	0		(142)	168	(130)	(1)	24	0	98	0	18
Operations	0	(18)	(27)	27		76	602	(181)	(151)	(109)	45	(332)	0	(68)
Workforce & Organisation Developmer	0	0	0	0		(115)	(70)	(26)	(1)	82	0	94	0	(37)
Estates & New Hospital Project	0	0	0	0		(30)	11	(5)	7	(80)	0	249	0	152
Corporate Nursing & Facilities	1	0	0	1		(90)	444	(471)	(21)	(42)	0	(82)	0	(259)
Corporate Directorates	**1**	**(18)**	**(27)**	**(8)**	**0**	**(243)**	**1,250**	**(873)**	**(252)**	**(105)**	**45**	**132**	**0**	**(97)**
Central	(92)	0	0	(193)	(236)	177	(28)	(16)	(0)	0	(0)	1,109	6	727
Income	(94)		0	(2,302)		84	24	0	0	0	0	0	(8)	(2,297)
Reserves	0	0	0	0		1	0	0	0	1,905	0	3,527	0	5,432
Technical Adjustments	0	0	0	0		0	0	0	0	0	0	0	(61)	(61)
DH Surplus/(Deficit)	**(303)**	**76**	**(545)**	**(1,332)**	**(236)**	**(93)**	**7,968**	**(6,082)**	**(4,223)**	**1,121**	**469**	**3,008**	**(63)**	**(236)**

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

Finance Report

Prospective View – P02+10

Period 03 2017/18

Reported Position	Apr-16 Act £'000s	May-16 Act £'000s	Jun-16 Act £'000s	Jul-16 Plan £'000s	Aug-16 Plan £'000s	Sep-16 Plan £'000s	Oct-16 Plan £'000s	Nov-16 Plan £'000s	Dec-16 Plan £'000s	Jan-17 Plan £'000s	Feb-17 Plan £'000s	Mar-17 Plan £'000s	2017/18 FY 3+9 £'000s
Patient Related Income	31,894	34,323	35,389	34,670	34,670	34,607	34,507	34,507	34,507	34,540	34,540	34,540	412,693
Other Income	4,970	4,936	4,122	4,959	4,959	4,959	5,309	5,309	5,309	5,484	5,484	14,384	70,183
Income total	**36,863**	**39,259**	**39,511**	**39,630**	**39,630**	**39,566**	**39,816**	**39,816**	**39,816**	**40,024**	**40,024**	**48,924**	**482,876**
Pay	(26,426)	(26,345)	(26,431)	(25,503)	(25,503)	(25,436)	(24,925)	(24,925)	(24,925)	(24,441)	(24,441)	(21,366)	(300,668)
Non-Pay	(10,011)	(12,411)	(12,903)	(12,758)	(12,759)	(12,763)	(12,594)	(12,594)	(12,594)	(12,382)	(12,382)	(11,355)	(147,508)
Expenditure total	**(36,437)**	**(38,756)**	**(39,334)**	**(38,261)**	**(38,262)**	**(38,199)**	**(37,519)**	**(37,519)**	**(37,519)**	**(36,823)**	**(36,823)**	**(32,722)**	**(448,176)**
EBITDA	**426**	**503**	**176**	**1,368**	**1,367**	**1,367**	**2,296**	**2,296**	**2,296**	**3,200**	**3,200**	**16,202**	**34,700**
Non-Operating Expenditure	(2,083)	(2,117)	(2,056)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(2,099)	(25,149)
Technical Adjustments	19	(47)	19	17	17	17	17	17	17	17	17	17	147
Reported DH Surplus/(Deficit)	**(1,638)**	**(1,662)**	**(1,860)**	**(714)**	**(715)**	**(715)**	**215**	**215**	**215**	**1,118**	**1,118**	**14,120**	**9,698**
Variance against NHSI plan	***7***	***(21)***	***(220)***	***(0)***	***(0)***	***(0)***	***(0)***	***(0)***	***(0)***	***(0)***	***(0)***	***0***	***(234)***

- This table shows current year to date actual performance for the first quarter and the internal Trust budgets as the forecast for the remaining months. A detailed forecast review is taking place for presentation in P4.
- The current I&E prospective view for FY 2017/18 at £9,698k forecasts plan excluding STF being met and no further failure of STF beyond the £235k Q1 failure due to A&E performance.
- The Trust identified £13.0m of risk in its NHSI plan submission, the non-recurrent in year mitigation of which is part of the Trust's savings plan (the recurrent mitigation relies on identification of full year impact of Group savings). The current anticipation is that this will be met by profit on disposal of surplus assets which remains to be confirmed.
- The plan shows a required improvement from P03 to P04 from £1.9m in month deficit to a £0.7m deficit. This relies on a ramping up of CIP delivery including curtailment of agency staff spending and use of additional beds beyond the funded bed position. Clearly there are risks associated with delivery of this financial plan position.

Finance Report

Capital

Period 03 2017/18

Programme	Year to Date Flex Plan £'000s	Year to Date Actual £'000s	Year to Date Gap £'000s	*Orders Placed £'000s*	Full Year NHSI Plan £'000s	Full Year Flex Plan £'000s	Full Year Outlook £'000s	Full Year Variance £'000s
Estates	5,202	3,679	(1,523)	*9,174*	20,624	20,624	20,624	0
Information	2,675	520	(2,155)	*2,116*	10,572	10,572	10,572	0
Medical equipment / Imaging	300	16	(284)	*57*	5,006	5,006	5,006	0
Contingency	0	0	0	*0*	0	0	0	0
Sub-Total	**8,177**	**4,215**	**(3,962)**	*11,347*	**36,202**	**36,202**	**36,202**	**0**
Technical schemes	189	376	187	*0*	10,386	10,386	10,386	0
Donated assets	21	0	(21)	*0*	84	84	84	0
Total Programme	**8,387**	**4,591**	**(3,796)**	*11,347*	**46,672**	**46,672**	**46,672**	**0**

Spending at end P03 is £3.8m behind plan year to date associated with delays to payments for the EPR (within Information) and estates schemes related to MMH, the Sandwell Treatment Centre and the Medical Education Centre.

A detailed review of the programme is taking place for consideration later in the year. This will be in the context of the Trust awaiting approval for its planned capital resource limit (CRL) from NHSI.

The £46.7m CRL includes £34.7m of anticipated adjustments NHSI have yet to confirm.

A reduced in year capital programme may be required if full NHSI approval is not forthcoming and if the outlook on I&E surpluses deteriorates or medium term cash remediation is compromised.

Finance Report

SOFP

Period 03 2017/18

Statement of Financial Position 2017/18

	Balance as at 31st March 2017	Balance as at 30th June 2017	TDA Planned Balance as at 30th June 2017	Variance to plan as at 30th June 2017	TDA Plan as at 31st March 2018	Forecast 31st March 2018
	£000	£000	£000	£000	£000	£000
Non Current Assets						
Property, Plant and Equipment	207,434	208,147	211,917	(3,770)	242,166	242,166
Intangible Assets	166	149	239	(90)	239	239
Trade and Other Receivables	43,017	50,971	56,663	(5,692)	92,045	92,045
Current Assets						
Inventories	5,268	5,511	4,179	1,332	4,177	4,177
Trade and Other Receivables	25,151	32,724	20,946	11,778	20,946	20,946
Cash and Cash Equivalents	23,902	9,292	1,134	8,158	309	309
Current Liabilities						
Trade and Other Payables	(68,516)	(63,667)	(55,263)	(8,404)	(38,646)	(38,646)
Provisions	(1,138)	(1,054)	(1,196)	142	(1,196)	(1,196)
Borrowings	(903)	(1,306)	(903)	(403)	(3,353)	(3,353)
DH Capital Loan	0	0	0	0	0	0
Non Current Liabilities						
Provisions	(3,404)	(3,369)	(2,955)	(414)	(3,012)	(3,012)
Borrowings	(33,954)	(35,337)	(27,824)	(7,513)	(50,077)	(50,077)
DH Capital Loan	0	0	0	0	0	0
	197,023	**202,061**	**206,937**	**(4,876)**	**263,598**	**263,598**
Financed By						
Taxpayers Equity						
Public Dividend Capital	205,362	215,550	219,927	(4,377)	252,540	252,540
Retained Earnings reserve	(24,972)	(30,122)	(29,691)	(431)	(5,822)	(5,822)
Revaluation Reserve	7,575	7,575	7,643	(68)	7,822	7,822
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	197,023	**202,061**	**206,937**	**(4,876)**	**263,598**	**263,598**

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

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

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

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

Finance Report

SOCF

Period 03 2017/18

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW 2017/18

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

ACTUAL/FORECAST	April Actual £000s	May Actual £000s	June Actual £000s	July Forecast £000s	August Forecast £000s	September Forecast £000s	October Forecast £000s	November Forecast £000s	December Forecast £000s	January Forecast £000s	February Forecast £000s	March Forecast £000s
Receipts												
SLAs: SWBCCG	22.627	22.930	22.303	22.603	22 603	22.603	22.603	22.603	22.603	22.603	22.603	22.603
Associates	6.278	6.675	6.356	6.466	6 466	6.466	6.466	6.466	6.466	6.466	6.466	6.466
Other NHS	1.980	750	646	1.319	602	1.912	1.131	666	795	1.161	1.428	1.606
Special sec Services	3.583	3.374	3.838	4.281	4 548	4.490	4.058	7.279	4.094	3.858	4.520	5.420
STF Funding and Taper Relief	0	0	0	1.716	0	1.749	2.097	0	1.749	0	0	1.749
Over Performance	0	0	0	0	0	0	0	0	0	0	0	0
Education & Training - HEE	353	0	4.353	0	0	4.405	0	0	4.405	0	0	4.405
Public Dividend Capital	5.050	5.138	0	2.000	3 528	3.656	3.618	8.411	3.951	3.696	3.297	3.039
Loans	0	0	0	0	0	0	0	0	0	0	0	0
Other Receipts	1.709	4.237	2.759	1.375	1 375	1.375	1.375	1.375	1.375	1.375	1.375	1.375
Land Sale Receipt					10 000							
Total Receipts	41.641	43.105	40.255	39.761	57 922	46.656	47.340	47.000	45.439	39.299	39.090	46.663
Payments												
Payroll	13.431	13.789	14.017	13.504	13 504	13.504	13.504	13.504	13.253	13.504	13.504	13.504
Tax, NI and Pensions	9.910	10.133	10.202	9.930	9 930	9.930	9.930	9.930	9.930	9.930	9.930	9.930
Non Pay - NHS	1.550	1.550	1.550	1.550	1 550	1.550	1.550	1.550	1.550	1.550	1.550	1.550
Non Pay - Trade	3.892	14.248	13.785	12.410	12 515	12.515	13.110	13.310	13.015	13.515	13.015	13.015
Non Pay - Capital	11.368	4.422	1.720	3.697	3 240	2.403	6.148	1.663	2.487	1.925	2.068	1.544
MMH PFI	3.397	2.055	2.552	2.360	3 528	3.656	3.618	8.411	3.951	3.696	3.297	3.039
PDC Dividend	0	2	0	0	0	3.637	0	0	0	0	0	3.637
Repayment of Loans & Interest	0	0	0	0	0	0	0	0	0	0	0	0
BTC Unitary Charge	440	440	440	440	440	440	440	440	440	440	440	440
NHS Litigation Authority	1.092	1.092	1.092	1.092	1 092	1.092	1.092	1.092	1.092	1.092	0	0
Other Payments	514	710	166	140	140	140	140	140	105	140	140	140
Total Payments	45.595	48.442	45.544	45.123	45 939	46.857	48.532	50.240	45.823	45.932	43.944	46.799
Cash Brought Forward	23.873	19.919	14.582	9.292	3 930	15.913	13.702	6.518	3.278	2.893	(3.740)	(7.994)
Net Receipts/(Payments)	(3.954)	(5.337)	(5.290)	(5.362)	11 983	(2.211)	(7 184)	(3.240)	(384)	(6.633)	(4.254)	64
Cash Carried Forward	19.919	14.582	9.292	3.930	15 913	13.702	6.518	3.278	2.893	(3.740)	(7.994)	(7.929)

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

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

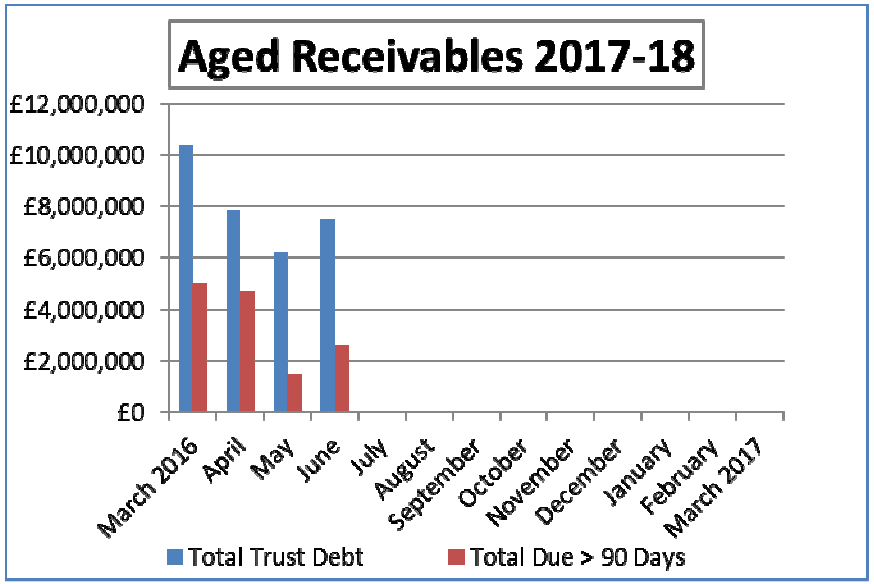
Consequently this cash flow statement reflects the latest collective view of cash flows, crucially the land sale. It can be seen that the Trust is expecting a cash shortage by January 2018. In the absence of the land sale the cash shortage would crystallise in August.

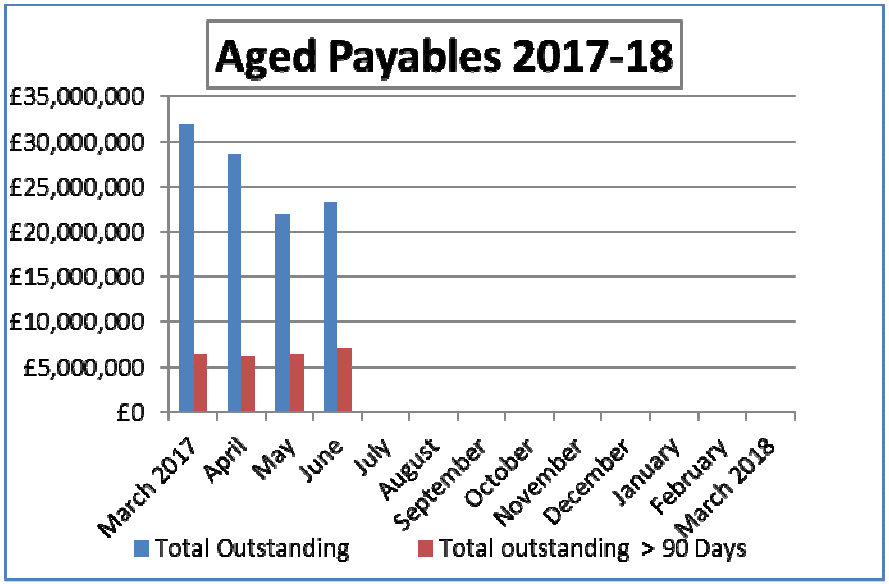
NHSI requested a split of capital and revenue cash. This identified a revenue cash shortfall from June. However, they have advised that they expect land sale cash is utilised before a loan application is made.

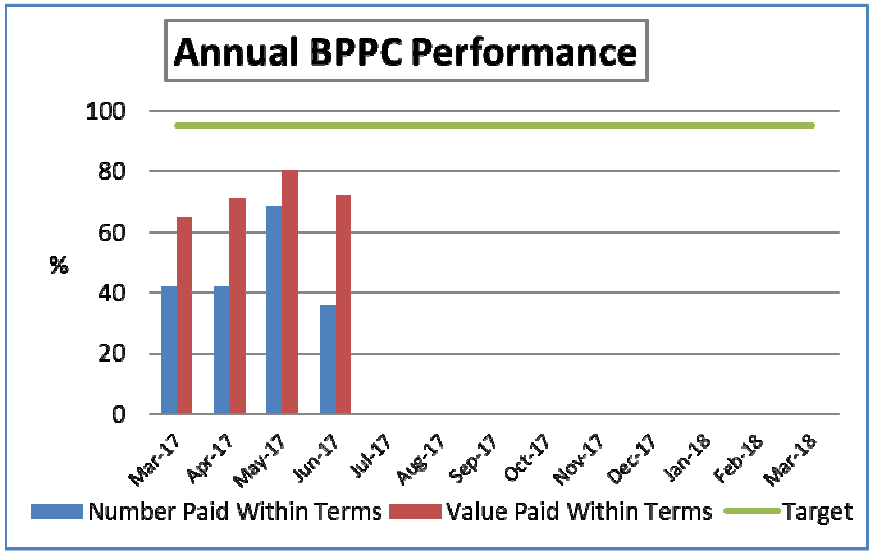
Finance Report

Aged Receivables, Aged Payables, BPPC and Cash Forecast

Period 03 2017/18







Note

- The June debt position increased as Q1 invoices were raised for the Education levy. Non NHS debt and the over 90 Day element, increased as local government debt and Overseas Patient income aged further.
- The overall Payables position has increased and the overall levels remain high as the Trust continues to manage cash pressures. The overall level of over 90 days liability increased marginally.
- BPPC is below target of 95% by volume and value as the Trust looks to effectively manage cash. Underlying performance remains the subject of improvement work with finance and procurement teams.

Appendix 1 - Technical support

Period 03 2017/18

Contingency & flexibility utilised in delivering actual performance to date

	P04 Month £k	P04 YTD £k
Unplanned contingency & flexibility		
GRNI accrual released from balance sheet	-	900
Taper relief - timing - income excess over costs accrued	-	1,000
Other contingency & flexibilities utilised	-	-
	-	1,900
Planned contingency & flexibility		
Taper relief - income used to fund planned capex	250	750
Other contingency & flexibilities utilised	-	-
	250	750
Total contingency & flexibility utlised	250	2,650

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

It is management's contention that the treatment does not miss-inform decisions and triggers in relation to STF monies.

This details the £2.65m of non-operational support that has been utilised to achieved the reported I&E position and maintain alignment with pre-STF plan and is subject to the following risks:

- Taper relief income is being fully accrued but, to date, no costs have been incurred and none are included in the I&E position. Plan anticipates £1m of costs would have incurred by the end of Q1. Costs will be incurred but this treatment is consistent with prior year practice which was subject to the year end audit. Consequently this risk relates to the funding of expenditure in future periods as opposed to the treatment of income.
- GRNI of £900k has been assumed. The Trust is working through £1.2m of GRNI realisation of which requires the Trust to clear down GRNI prior to September 2016. This is considered a balanced and prudent approach.
- Fines and penalties in relation to main commissioner contract performance have now been anticipated in the position. At P02 fines had not been included which represented a benefit to the position with associated risk.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**CIP – Q1 Delivery**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow Chief Operating Officer**
AUTHOR:	**Katie Gray Deputy Chief Operating Officer for Improvement**
DATE OF MEETING:	**3rd August 2017**

EXECUTIVE SUMMARY:

CIP Delivery in Q1

In Q1, against a planned delivery of £3,067,551, CIP totalling £2,304,372 was delivered. This is £763,179 (or 25%) behind plan.

The main areas of under delivery were related to bed closures, procurement and pay savings.

A formal update to the forecast financial position and consequent assessment of plausible route to control total compliance is on-going and shall be reported in due course. That will include relevant forecast of CIP delivery for the remainder of the year.

The focus of effort is appropriately on optimising the delivery of extant CIP schemes and adding to those on the back of the opportunity identified through FIP. That is being progressed in line with the capability solution challenged and confirmed by the Board at its July meeting.

Implementing Renewed Grip and Control of the Delivery of CIP

A standard approach to how CIP delivery is tracked through a series of Gateways brings new rigour to the CIP delivery process. Schemes pass through Gateways from “new idea” to “in development”, to “in delivery” to “delivered”.

A revised RAG rating has been implemented to better assess how each CIP scheme is progressing towards completion and forecasts delivery risk.

REPORT RECOMMENDATION:

Note Q1 delivery and exceptions.
To discuss the suitability of new arrangements for Grip and Control over CIP delivery.

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Delivery of financial plan, good use of resources
PREVIOUS CONSIDERATION:

CIP Delivery in Q1

1. **Q1 under-delivered**

In Q1, against a planned delivery of £3,067,551, CIP totalling £2,304,372 was delivered. This is £763,179 (or 25%) behind plan.

A focus on under-delivery in Q1

	Pay	Non Pay	Income	**Under Delivery £**	**Under Delivery %**
Medicine and Emergency Care	-437,062.2	-42,204.0	0.0	**-479,266.2**	**-43.0%**
Women and Child Health	-15,294.0	-20,000.0	-79,209.0	**-114,503.0**	**-53%**
Primary Care, Community and Therapies	-15,233.8	-57,244.9	-6.0	**-72,484.7**	**-21%**
Imaging	49,922.0	-94,526.2	0.0	**-44,604.2**	**-22%**
Organisational Development			-36,503.0	**-36,503.0**	**-90%**
Corporate Nursing and Facilities	-7,390.0	0.0	-4,167.0	**-11,557.0**	**-11%**
Estates and NHP	2,495.0	-7,497.5	-2,497.5	**-7,500.0**	**-5%**
Pathology	0.0	-2,000.0	1,000.0	**-1,000.0**	**-0.30%**
Finance		0.0	0.0	**0.0**	**0%**
Medical Director	0.0	0.0	0.0	**0.0**	**0%**
Operations	0.0			**0.0**	**0%**
Strategy and Governance	0.0	0.0	0.0	**0.0**	**0%**
Surgical Services	4,239.1	0.2	0.0	**4,239.2**	**+1.2%**
	-418,324.0	**-223,472.4**	**-121,382.5**	**-763,178.8**	

The table shows a ranked overview of under-delivery by Group, ordered by Amount. See the final column for a % view of the same data. Medicines & Emergency Care Group and Women & Child Health Group have the largest under-delivery by amount.

Themes of under-delivery

Three themes emerge from the data and the supporting project documentation

1. <u>Bed reduction schemes</u>
   Of the three Bed Reduction schemes, the overall under-delivery in Medicine is £307,161 for the period. Oversight and scrutiny of the Bed Base Workstream will come under the Urgent Care Board and be manged through the Medicine and Surgery GPOs. 75% of the planned bed closures are now complete. The remaining 16 beds scheduled for closure in Medicine are due to be closed in August. Surgery bed closures are on track for September.

2. <u>Procurement</u>
   £73,387 of under-delivery lies in six separate procurement schemes, one for each clinical group. Oversight and Scrutiny of the Procurement Workstream will take place at Operational Leaders Meeting (OLM) and full in year recovery is expected.

3. <u>Owed Hours</u>
   The rostering of shifts to pay back Owed Hours is covered in two schemes which are showing an under-delivery totalling £60,000. This is mainly due to an over-estimation of the size of the opportunity identified and is further complicated by less than ideal quality being input in ESR so that “owed hours” is not being coded correctly. Work is underway to resolve both issues and new schemes will have to be identified to cover the anticipated shortfall.

2. CIP Performance and Forecast

The CIP governance process provides for a routine risk assessment of the status and prospective outlook on each and all schemes. That assessment recognises significant risk if no further action is taken to mitigate that risk.
This can be seen by reference to the table below.

	Qtr 1	Qtr2	Qtr3	Qtr 4	Total
Plan	3,067,551	4,875,223	5,915,279	5,931,968	19,790,021
Delviered Q1	2,304,372				
Under-delivered Q1	-763179				
Forecast CIP Delivery Green & Amber/Green		3,351,955	4,463,666	4,522,530	12,338,151
Forecast CIP Risk Red & Amber/Red		1,523,268	1,451,613	1,409,438	4,384,319
					19,790,021

The revised RAG rating has been implemented to better assess how each CIP scheme is progressing towards completion. This is achieved by splitting the traditional “amber” status into “amber/green” (there are minor concerns, there is a credible recovery plan and there are no concerns for overall delivery) and “amber/red” (There are significant concerns, a recovery plan exists, but there is little confidence of recovery to the original schedule). A further control is in place in that a CIP scheme can be rated amber/green on a maximum of two consecutive periods. A third amber/green must be assigned amber/red.

RAG rating of schemes is summarised above against a quarterly profile, which shows there is a good degree of confidence on the delivery of £12,338,151 currently. Conversely, there is a risk associated with a further £4,384,319 of planned delivery.

RAG Rating is a new discipline and will be strengthened in the coming weeks to improve its use as in input to the forecasting process.

A formal update to the forecast financial position and consequent assessment of plausible route to control total compliance is on-going and shall be reported in due course. That will include relevant forecast of CIP delivery for the remainder of the year.

The focus of effort is appropriately on optimising the delivery of extant CIP schemes and adding to those on the back of the opportunity identified through FIP. That is being progressed in line with the capability solution challenged and confirmed by the Board at its July meeting.

Work is in train to mitigate the amber/red and red-rated risks (see Reason & Mitigation worksheet of accompanying spreadsheet, appendix 1). The associated schemes are being supported at Directorate and Group level with a focus on “recovery”. Finance and PMO Teams are working closely to remove barriers to success.

The greatest risk to delivery is in the Procurement-related schemes. Visibility to the Procurement Work Plan is limited in the Groups and it is therefore challenging for them to deploy resources appropriately. The Procurement Team will work closely with Operational Leadership Management team chaired by the Chief Operating Officer and regular procurement focused sessions have been planned. Once underway, Procurement Schemes will be tracked and monitored in GPO.

3. Implementing Grip and Control of the Delivery of CIP

New arrangements have been implemented in Clinical Groups to bring a renewed focus to the delivery of CIP.

A standard approach to how CIP delivery is tracked through a series of Gateways brings new rigour to the CIP delivery process. Schemes pass through Gateways from "new idea" to "in development", to "in delivery" to "delivered". (Appendix 2)

A revised RAG rating has been implemented to better assess how each CIP scheme is progressing towards completion.

Reporting on CIP has been enhanced to incorporate the controls described above and is reported weekly to the executive team.

A standard agenda for Finance Meetings has been implemented and meetings are run weekly at Directorate Level, supported by a member of the PMO Team. The output of these meetings flows up to Group Level where the Chief Operating Officer reviews delivery against control totals and the CIP programme.

As well as the CIP being delivered in clinical groups, corporate directorates also have a responsibility to deliver CIP and similar arrangements are beginning to be incorporated there, most notably in the Facilities where a scaled down Programme Management Office (PMO) is being established to track progress towards delivery.

A fortnightly Exec-level CIP Board has been implemented chaired by the Chief Executive Officer.

Workstreams are being developed to ensure CIP is delivered at pace. These do not disrupt the mechanisms described above, but rather aggregate them to ensure that the collective capability to deliver is maximised.

Procurement

Work is already underway scoping out the detailed requirements for this work. Scrutiny over delivery will be via Operational Leaders' Meeting (OLM).

Non-pay

This relates to non-pay items other than procurement. A non-pay workstream is already in existence and activities and delivery will be monitored and managed under the existing Corporate Non-pay Group.

Minimising diagnostic delay
An imaging programme board is being chartered with the purpose of improving outcomes for patients and reducing wasted appointments. This reports to the Planned Care Board.

Theatres
Changes will deliver our 2018-19 volumes through our Midland Met scaled theatre model. This programme reports to the Theatre Programme Board.

Bed Base
Work is underway to enable changes in our bed base. 75% of the planned closures have been achieved. This reports to the Urgent Care Board.

Community Properties
Ensuring provision of services is delivered at the optimal location in terms of safety, quality and value for money is being supported by subject matter expert.

Staffing volumes and skill mix
Consistent with our affordable pay bill and maximising spend on permanent employees. This will include a focus on the future of how facilities are delivered. This work reports to the CLE Workforce Committee.

4. Conclusion

Tiered meetings, RAG rating and Gateway Progression are new tools and have been in use for a short time. This is already providing improved focus on progression of schemes and a transparency in confidence of delivery. The maturity of forecasting will be more developed in the next reporting period as Groups and their Corporate Support colleagues increase in their confidence in using them. Richness of information on CIP Delivery will also improve as we bring elements of Gateway Progression into reporting.

Appendix 1 schemes under-delivered in Q1

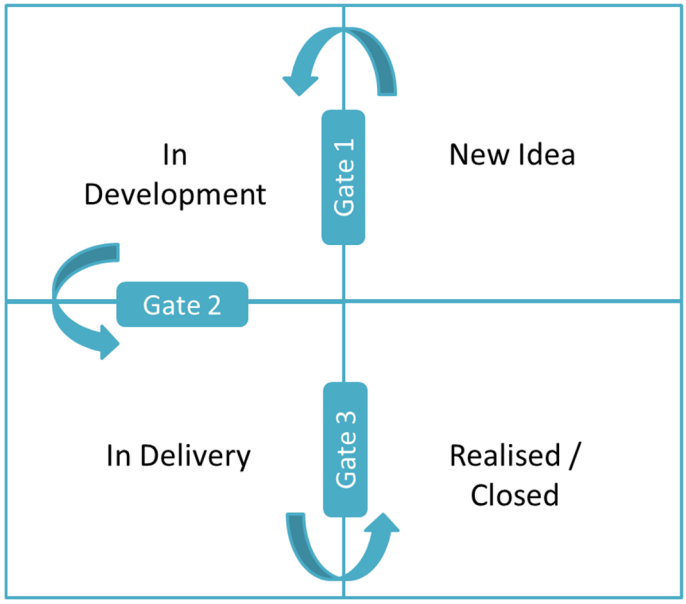
Clinical Group | Corporat	Project Cod	Project Description	Status	Plan .vs. Actuals YTD	Delivery %	Reason	Mitigation
Medicine and Emergency Care	ME750bW	Bed Reduction Programme –Jun-Nov (Lyndon 5)	IN DELIVERY	-131648.96	-88%	Delay in implementation	Credible recovery plan in place
Medicine and Emergency Care	ME750cW	Bed Reduction Programme – Beds - Focussed Care reduction	IN DELIVERY	-131000	-100%	Lack of corporate guidance. Delay in implementation	Policy to be signed off in July
Women and Child Health	WC671	Enhanced Care Babies Recording	IN DELIVERY	-75000	-100%	NHS England scheme	Contract meeting 28th July
Imaging	IM584w	Planned Activity Delivered	IN DELIVERY	-66528	-100%	Lack of definition in delivery plan	SME supportng. Delivery plan TBC start August
Medicine and Emergency Care	ME750dW	Bed Reduction Programme – 8th May (D5/D7(CCU)	IN DELIVERY	-44512.09	-100%	Delay in implementation	Plan to deliver in August
Primary Care,Community and Therapies	CT552	Reduce non-pay expenditure by 10% across majority of cost centres	IN DELIVERY	-41666.72	-100%	Mis-identification of budget lines	Will be fixed month 4. Some slipppage expected
Medicine and Emergency Care	ME857	Nursing Owed Hours - Admitted Care	IN DELIVERY	-40000	-100%	Over-estimation	Cleansing of data. Replacement scheme
Medicine and Emergency Care	ME860	Admitted Care Procurement Workplan 17-18	IN DEVELOPMENT	-36144	-87%	Unclear strategy and support	Oversight moved to OLM
Imaging	IM611	Non-Pay Authorisation/Control, Further Proc Opps	IN DEVELOPMENT	-20181.82	-100%	iProc protocol incorrect	Pursuing resolution with IT. Procurement oversight via OLM
Medicine and Emergency Care	ME862	Nursing Owed Hours - Emergency Care	IN DELIVERY	-20000	-100%	Over-estimation	Cleansing of data. Replacement scheme
Women and Child Health	WC677	Procurement Opportunities	IN	-20000	-100%	Unclear strategy and	Oversight moved to OLM
Women and Child Health	WC624W	Implementation of Speech Recognition (Medical Secretaries)	IN DELIVERY	-13488	-100%	Staff diverted to deal with letter backlog	Monitored and managed

Imaging	IM606	Senior Physicist Secondment	NEW IDEA	-12120	-100%	Cross charging protocol not agreed	Uncertain when issue will be resolved
Medicine and Emergency Care	ME866	Emergency Care Procurement Workplan 17-18	IN DEVELOPMENT	-6060	-100%	Unclear strategy and support	Oversight moved to OLM
Primary Care,Community and Therapies	CT562	Procurement Workplan 17-18	IN DEVELOPMENT	-5546.76	-100%	Unclear strategy and support	Oversight moved to OLM
Primary Care,Community and Therapies	CT567	Review Telecoms Devices and Infrastructure	IN DEVELOPMENT	-5233.28	-90%	Delay in data	Resolved. Savings will be on stream from month 4
Primary Care,Community and Therapies	CT558	iCares Cease AHP agency locum - band 6	IN DELIVERY	-4200	-100%	Postholder left after books closed	Resolved. 100% recovery in month 4
Imaging	IM570	PACS Maintenance	IN DELIVERY	-4180	-100%	Delayed	Will recover
Imaging	IM610	Procurement Opportunities	IN DEVELOPMENT	-3636.36	-100%	Unclear strategy and support	Oversight moved to OLM
Surgical Services	SA768	Reduction in Temporary pay spend associated with sickness absence back fill costs.	IN DELIVERY	-3411.61	-100%	Will not deliver	Find replacement scheme
Pathology	PA1073	Procurement Opportunities & BCA	IN DEVELOPMENT	-2000	-100%	Unclear strategy and support	Oversight moved to OLM
Surgical Services	SA771	CD Payments	REALISED/COM	-700	-100%	PA reduction not	Will deliver in full

Appendix 2

CIP Lifecycle

In order to bring rigour, focus and control to the progress towards CIP delivery, all ideas for CIP will transition through a series of three gateways. Gateway progression will be tracked on the Project Schedule and recorded in TPRS for reporting purposes. These gateways are illustrated and described below:



1. New Idea – A new idea can be identified by any individual in the Trust – this may be identified by as part of a service review, budget or spend review, as a result of previous projects, external factors such as regulatory changes or wider collaborations e.g. BCA. A clear description and route to cash will be developed. A New Idea may or may not be approved to move to the next stage. New Ideas will be considered at the Directorate CIP Delivery Group and a simple form will support the discussion of the idea and progression through the first Gateway.

Gateway 1:

Requirements to pass through Gateway 1 to "In Development"	Gateway approval process
• New Idea Form will be completed • Clear description of the project – Objective, current state and proposed future state • Financial savings (range & target) and basis of releasing cash or budget identified and agreed between Directorate and Finance • New Idea Form received at Directorate CIP Delivery Group	• Project description and Finance info presented to Directorate CIP Delivery Group and approved to proceed • Project Lead nominated by Directorate CIP Delivery Group and PMO Support assigned • Project "red line" frequency assigned, the value and importance of specific projects • Location of project documentation specified • Gateway 2 progression date assigned

Gateway 2

Requirements to pass through Gateway 2 to "In Delivery"	Gateway approval process
• All project documents (see item 3.4) developed • QIA and EIA (if required) signed off • Financial saving and phasing verified • Project resources identified to deliver the plan • TPRS completed to the agreed standard (See TPRS SOP)	• Project documentation, evidence of QIA sign off, EIA signoff (if required) and finance data presented to the Directorate CIP Delivery Group • Approval to proceed from Directorate CIP Delivery Group

2. Realised / Closed – The project can transition into "Realised / Closed" when the final actions have been completed, the change delivered, the budget(s) have been reduced and a Project Closure Document has been approved at the appropriate governance level. On-going benefit realisation will be monitored in DPOs / GPOs

Gateway 3:

Requirements to pass through Gateway 3 to "Realised" or "Closed"	Gateway approval process
• Final action on project schedule completed • Outcomes delivered and accepted by Directorate CIP Delivery Group • Confirmation that financial benefit has been realised and that TPRS is updated accordingly • Confirmation that the budget(s) have been reduced / removed by finance	• Project Closure Document accepted and approved at Directorate CIP Delivery Group

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Production Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Liam Kennedy – Deputy Chief Operating Officer – Planned Care**
DATE OF MEETING:	**3rd August 2017**

EXECUTIVE SUMMARY:

As of the 26th July, the Trust forecast a deficit of c£283K by the end of July from a total production plan of £37.8 million. This is made up from an over-performance to plan in April and May, offset by an under-delivery to plan in June and July.

The actual position at the end of Q1 is a deficit of £88K

The main area contributor to deficit in June, Ophthalmology, is forecast to rectify its position from a deficit of £130k to a breakeven point in July.

The paper summarises the forecast for Q2 and indicative forecasting for each quarter for the remainder of the year. The paper also summarise some of the key focus points in the Production plan focusing in on Surgical services:

- Variance from July position
- Using the June and July position as a gauge for the year
- Case mix change in T&O – activity and finances rephrased in year
- Ophthalmology turnaround

Governance and oversight is in place to ensure ongoing delivery of the production plan after a good start to the year. The scale of delivery in June and forecast delivery in July, those 2 months being the highest monthly plans this year, should give the Trust Board some assurance in terms of scale of delivery going forward. The August position is currently forecast to provide surplus to current plan.

REPORT RECOMMENDATION:

The Trust Board are asked to discuss the Q1 actual position and the Q2 forecast position.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Safe and sustainable services, financial plan

PREVIOUS CONSIDERATION:

Production Plan Assurance

Quarter 1 Actual outturn

In Q1 the Trust delivered a deficit of c£88k from a total production plan of £26.4 million. This is made up from an over-performance to plan in April and May, offset by an under-delivery to plan in June.

The main area to the deficit in June, contributing to the Q1 deficit was the un-forecast slippage in ophthalmology OP booking and DNA rates. The speciality had a 65% utilisation rate in June resulting in a deficit of £130K in month. This has been mediated by an overview of the entire booking process throughout Ophthalmology. This resulted in a re-distribution of staff providing Ophthalmology with an additional two members to their team to match their booking profile.

A review of the booking protocols for Ophthalmology's 4th theatre was also concluded in July to allow a greater case mix of patients passing through that theatre than previously.

July Forecast Outturn

As of the 26th July, the Trust forecast a deficit of c£283K by the end of July from a total production plan of £37.1 million for the first 4 months. This is made up from an over-performance to plan in April and May, offset by an under-delivery to plan in June and July.

July has a forecast deficit of £195K, which, when compared with a £640K deficit in June on the same number of working days and a £500K greater income target, goes some way in providing assurance in the rectification that has been put in place.

The main areas of concern for July delivery are Cardiology and General Surgery. General Surgery has delivered more activity in Month than was forecast in the production plan. However, this was the same within June and the income produced was lower than forecast. A detailed piece of work has commenced reviewing HRG coding. Initial calculations show that an additional 35 cases per month are now required due to a change in case mix. General Surgery is forecast to deliver this in July.

Cardiology is also reviewing coding practice as there is a mismatch between the booking system and the current activity levels recorded. We aim to have this completed by month end to improve the cardiology position and rectify to the £195K deficit.

Forecast outturn for July vs plan

The forecast for July month is a c£195K deficit against a plan of £10,690,896 with 3 key reasons:

- T&O underperformance due to annual leave. The profile change was performed for T&O for July. This changed is supported by the final June position, in that they fell short of 90 units of theatre activity, but managed to achieve a financial surplus. However, in July there was an initial 80 vacant theatre sessions due to Annual leave. Although this has been mitigated to just a handful it still means a c.£50K deficit for T&O in month.

- The Annual leave issue that arose in T&O is being addressed by both GDOP and Clinical lead review of all approved leave to ensure it matches service delivery. There were no other specialities with this issue.

- Workforce related capacity deficits – this remains an issue and is part of day to day running the business and is relatively small scale at individual speciality level. This deficit was forecast at beginning of year, has been escalated at weekly PMO as quantified issues with staff turnover or unscheduled absence. Specialities will revise plans to be recovered in year.

- Coding and HRG changes – Anti-coagulation, General Surgery and Cardiology have all seen changes in coding or HRG changes in month which has altered the activity against income plan. Re-alignment of the activity and a review of the correct coding is underway in all 3 area's to ensure these are rectified.

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

Speciality	**June Month Deficit forecast**	**Reason / mitigation**
Trauma and orthopaedics	-£45K	Unutilised Theatres due to annual leave. Additional 5 x Registrars from HEE in Aug to support OP activity and catch up YTD position
Cardiology	-£66K	Workforce deficit Re-profiled plan in line with new workforce assumptions
Respiratory	-£16K	Workforce deficit Seeking locum and anticipate to correct in August

Rheumatology	-£65K	Workforce deficit due to sickness – will recover activity in Q2
Breast surgery	-£30K	Workforce issue – will confirm plan to re-profile into Q3
Oral surgery	-£30K	New SLA due to be agreed start July and will recover in Q2.
Anticoagulant service	-£35K	Treatment change in practice resulting in decreasing FU activity – initial assessment show 9% activity decrease. Will look to replace activity

***these underperformance areas are mitigated by a few areas of over delivery**

Look ahead to remainder of year

The **Production plan for T&O** has been amended as discussed in last month's Paper with effect in July. The theory behind the re-phasing has proved accurate in the June Position where 90 fewer DC/EL procedures were performed but a breakeven position on inpatient activity was achieved. A Further capacity review of both inpatient and outpatient activity aligned with job plans and flexible sessions has demonstrated adequate capacity to achieve the production plan moving forward. This will be closely monitored.

Q2 Forecast and beyond

Appendix 1 below shows the forecast for Q2 and the remaining quarters based on July's forecast outturn and May Delivery. The forecast takes the income achievement per working day for May and July and then maps it against available working days for the remaining months. There is a reduction of 5 working days in Q3 to allow for the impact of the electronic roll out of Cerner Millennium.

It clearly demonstrates that the number of working days compared to the income target, for the later 2 quarters of the year, results in the production plan to achieve above the set standard. If we deliver the forecasted July activity, then the same activity and income value per working day should be achieved throughout the rest of the year.
If the activity volumes that we achieved in May are achieved throughout each of the remaining Quarters then we should be looking at a financial surplus on the production plan as highlighted below.

By the End of August the Slam Plan and the monitored Production Plan will be merged to provide the same monthly plan. The final year figure for both equates to 112million. The SLAM plan was phased slightly higher in Q2 – Q4 whereas the production plan was phased with higher delivery in the first 4 months of the year.

Governance and oversight of the Production Plan

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

Appendix 1 – Detailed Forecast for Q2 and forecast for full year based on July forecast and May Delivery

Trajectories based on July Forecast delivery

	July	August	September	Q2 position	Q3 Position	Q4 Position
Planned income	£10,690,896	£9,834,402	£9,378,166	£29,903,464	£26,508,779	£28,018,926
Delivered / forecast Income	£10,495,896	£10,495,896	£10,495,896	£31,487,687	£27,989,055	£30,488,078
Variance	-£195,000	£661,493	£1,117,729	£1,584,223	£1,480,276	£2,469,152

Trajectories based on May delivery

	July	August	September	Q2 position	Q3 Position	Q4 Position
Planned income	£10,690,896	£9,834,402	£9,378,166	£29,903,464	£26,508,779	£28,018,926
Delivered Income	£10,072,101	£10,072,101	£10,072,101	£30,216,302	£26,858,935	£29,257,055
Variance	-£618,795	£237,699	£693,934	£312,838	£350,156	£1,238,129

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Nurse and HCA Recruitment and Retention – Progress Update
SPONSOR (EXECUTIVE DIRECTOR):	Elaine Newell- Chief Nurse
AUTHOR:	Raffaela Goodby – Director of People & OD
DATE OF MEETING:	3rd August 2017

EXECUTIVE SUMMARY:

March 17 the Trust agreed an ambitious recruitment trajectory to fill vacancies at Band 5, HCA and Midwifery posts. This involved a refreshed recruitment brand 'Bring your Ambition to Life', a board investment in a recruitment microsite www.swbhjobs.co.uk and a compact recruitment process for nurses.

This report provides an update on the recruitment offers made, projected start dates, and activity taking place during the rest of the year. The report demonstrates the Trust are ahead of the HCA recruitment trajectory, the band 5 nurse recruitment trajectory, and on target for midwives and other posts. HCA vacancies have been 'over recruited' will be largely filled if all offers convert to start dates

From March 16-March 17 the Trust reduced nursing turnover by its target 3%. The target for the coming year is to maintain this reduction (at 11.7%) and further reduce by 1% to 10.7%. This reduction in turnover is included in the Trust Board's recruitment trajectory.

REPORT RECOMMENDATION:

The Trust Board note the recruitment trajectory and progress made so far
The Trust Board note the recruitment events planned for the coming 8 months

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Good use of resources

PREVIOUS CONSIDERATION:

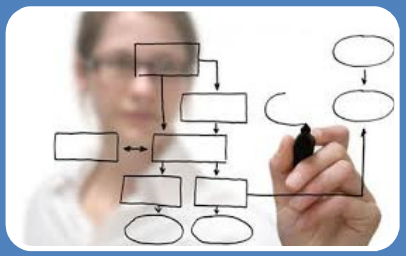
RETENTION – *REDUCE TURNOVER TO 10.7% BY MARCH 2018*

Band 5 Nurse Transfer Window - launched May 2017

- Advertise in daily communications and posters for nurses to move to another area with no lengthy process
- Implemented 'itchy feet' meetings for nurses with issues they wish to resolve rather than leave
- Based on best practice from UCLH who retained an additional 161 nurses in 18 months

International Day of Nurses - 12 May 2017

- Chief Nurse hosted 'educate and celebrate' event for nurses on 12 May
- Gave out awards, recognised good practice, celebrated different disciplines of nursing
- Competitions, employee benefits, staff networks, attracted student nurses and outside nurses to the event. One to one cup of tea from Chief Nurse



Group PMO - June 2017 roll out

- Clinical Groups monitor vacancies, turnover, sickness, PDR completion ward by ward
- Each Group PMO displays hot spots, actions for improvement, trajectories for starters etc
- Operations, OD, Nursing and Finance work together to deliver and monitor improvements

RECRUITMENT – *RECRUIT TO OUR 190 BAND 5 NURSING VACANCIES TO A VACANCY RATE OF NO MORE THAN 70, BY MARCH 2018*

Bringing your Ambition to Life

- Google ad word campaign, facebook campaign, twitter www.swbhjobs.co.uk approx 800 hits a week
- Outdoor advertising posters across the Black Country & Birmingham
  Revised recruitment process, weekly interview panels 'one stop shop' centrally led by OD

Recruitment Fayres

- Birmingham RCN Fayre in March - 50 offers over two days
- Nottingham, London fayres planned with ward managers booked to attend
- Freebies, social media, pens, contacts, raising profile@swbhjobs

Recruitment Event 13th July

- Radio advert, Birmingham Mail Advert, Posters in Trust, Social Media
- 6000 hits on swbhjobs, 160 attendees, 110 interviews, 80 offers made. 10 interview panels running during day
- Return to practice, nursing education & preceptorship, HCA focus, well attended from all groups

Recruitment Activity Report

Report Date: 27/07/2017

Criteria		Measure/Month		Actual			Notified as at Report Date		Forecast						
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Band 5 Nurses	SIP	FTE	Establishment	983.64	992.21	981.67	991.00	991.00	991.00	991.00	991.00	991.00	991.00	991.00	991.00
		FTE	FTE In Post	839.93	819.86	815.91	809.51	803.98	*801.25*	*854.35*	*878.10*	*875.37*	*879.64*	*919.38*	*924.65*
		FTE	New Starters	5.83	7.77	7.65	6.00	7.62	*63.45*	*34.10*	*7.62*	*14.62*	*50.10*	*15.62*	*7.62*
		FTE	Leavers	14.21	7.29	14.05	11.53	10.35	*10.35*	*10.35*	*10.35*	*10.35*	*10.35*	*10.35*	*10.35*
		FTE	Vacancies in month	143.71	172.35	165.76	181.49	187.02	*189.75*	*136.65*	*112.90*	*115.63*	*111.36*	*71.62*	*66.35*
	Offers External Applicants	FTE	Conditional offers (in month)	5.60	9.44	25.80	40.92								
		FTE	Offers Confirmed (in month)	3.00	11.54	5.33	15.55								
Band 6 Nurses	SIP	FTE	Establishment	582.16	585.28	585.28	585.28	585.28	*585.28*	*585.28*	*585.28*	*585.28*	*585.28*	*585.28*	*585.28*
		FTE	FTE In Post	531.19	538.07	536.75	539.57	539.00	*539.48*	*539.95*	*540.43*	*540.91*	*541.38*	*541.86*	*542.33*
		FTE	New Starters	2.40	2.45	5.50	2.85	3.73	*3.73*	*3.73*	*3.73*	*3.73*	*3.73*	*3.73*	*3.73*
		FTE	Leavers	2.80	1.92	2.68	3.42	3.25	*3.25*	*3.25*	*3.25*	*3.25*	*3.25*	*3.25*	*3.25*
		FTE	Vacancies in month	50.97	47.21	48.53	45.71	46.28	*45.80*	*45.33*	*44.85*	*44.37*	*43.90*	*43.42*	*42.95*
	Offers External/Internal Applicants	FTE	Conditional offers (in month)	9.80	3.52	9.51	2.00								
		FTE	Offers Confirmed (in month)	2.00	2.72	6.16	1.00								
Band 5 Midwives	SIP	FTE	Establishment	8.25	8.25	8.25	8.25	8.25	*8.25*	*8.25*	*8.25*	*8.25*	*8.25*	*8.25*	*8.25*
		FTE	FTE In Post	28.28	27.16	23.96	24.56	26.53	*25.95*	*25.36*	*26.77*	*27.39*	*24.97*	*25.39*	*25.79*
		FTE	New Starters	0.00	0.80	0.60	1.97	2.10	*2.10*	*2.10*	*2.10*	*2.10*	*2.10*	*2.10*	*2.10*
		FTE	Leavers	0.00	0.00	0.00	0.00	2.68	*2.68*	*0.69*	*1.48*	*4.52*	*1.68*	*1.69*	*1.69*
		FTE	Vacancies in month	-20.03	-18.91	-15.71	-16.31	-18.28	*-17.70*	*-17.11*	*-18.52*	*-19.14*	*-16.72*	*-17.14*	*-17.54*
	Offers External Applicants	FTE	Conditional offers (in month)	0.00	0.00	0.80	4.92								
		FTE	Offers Confirmed (in month)	0.00	1.80	0.00	0.00								
Band 6 Midwives	SIP	FTE	Establishment	208.10	208.10	184.30	183.80	183.80	*183.80*	*183.80*	*183.80*	*183.80*	*183.80*	*183.80*	*183.80*
		FTE	FTE In Post	129.87	127.67	124.49	122.77	122.68	*122.48*	*122.27*	*122.07*	*121.86*	*121.65*	*121.44*	*121.24*
		FTE	New Starters	0.00	0.00	1.00	2.85	1.05	*1.05*	*1.05*	*1.05*	*1.05*	*1.05*	*1.05*	*1.05*
		FTE	Leavers	0.81	0.00	2.72	2.93	1.26	*1.26*	*1.26*	*1.26*	*1.26*	*1.26*	*1.26*	*1.26*
		FTE	Vacancies in month	78.23	80.43	59.81	61.03	61.11	*61.32*	*61.53*	*61.73*	*61.94*	*62.15*	*62.36*	*62.56*
	Offers External/Internal Applicants	FTE	Conditional offers (in month)	1.00	1.00	0.60	4.00								
		FTE	Offers Confirmed (in month)	0.00	0.80	0.00	0.00								
Consultants	SIP	FTE	Establishment	313.96	315.53	313.73	313.73	313.73	*313.73*	*313.73*	*313.73*	*313.73*	*313.73*	*313.73*	*313.73*
		FTE	FTE In Post	284.47	285.17	281.97	277.52	277.91	*277.76*	*277.61*	*277.46*	*277.31*	*277.16*	*277.01*	*276.86*
		FTE	New Starters	2.00	6.00	1.40	2.39	2.39	*2.39*	*2.39*	*2.39*	*2.39*	*2.39*	*2.39*	*2.39*
		FTE	Leavers	3.30	3.00	5.85	2.00	2.54	*2.54*	*2.54*	*2.54*	*2.54*	*2.54*	*2.54*	*2.54*
		FTE	Vacancies in month	29.49	30.36	31.76	36.21	35.82	*35.97*	*36.12*	*36.27*	*36.42*	*36.57*	*36.72*	*36.87*
	Offers External Applicants	FTE	Conditional offers (in month)	3.00	0.00	3.00	3.00								
		FTE	Offers Confirmed (in month)	0.00	0.00	1.00	0.00								
Band 2 HCAs	SIP	FTE	Establishment	499.95	504.70	500.70	500.70	500.70	*500.70*	*500.70*	*500.70*	*500.70*	*500.70*	*500.70*	*500.70*
		FTE	FTE In Post	437.09	442.07	454.05	453.05	453.84	*454.27*	*475.09*	*510.91*	*511.34*	*511.78*	*512.21*	*512.64*
		FTE	New Starters	2.53	10.41	2.00	4.51	4.61	*25.00*	*40.00*	*4.61*	*4.61*	*4.61*	*4.61*	*4.61*
		FTE	Leavers	3.92	1.40	3.00	3.72	4.18	*4.18*	*4.18*	*4.18*	*4.18*	*4.18*	*4.18*	*4.18*
		FTE	Vacancies in month	62.86	62.63	46.65	47.65	46.86	*46.43*	*25.61*	*-10.21*	*-10.64*	*-11.08*	*-11.51*	*-11.94*
	Offers External Applicants	FTE	Conditional offers (in month)	11.61	10.16	28.41	59.00								
		FTE	Offers Confirmed (in month)	7.25	2.61	3.00	1.00								
Band 3 HCAs	SIP	FTE	Establishment	93.14	93.38	93.38	93.38	93.38	*93.38*	*93.38*	*93.38*	*93.38*	*93.38*	*93.38*	*93.38*
		FTE	FTE In Post	92.71	92.63	88.57	86.65	88.15	*87.55*	*86.96*	*86.36*	*85.76*	*85.17*	*84.57*	*83.97*
		FTE	New Starters	0.00	0.00	0.00	1.50	0.00	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*
		FTE	Leavers	1.00	1.80	1.92	0.00	0.60	*0.60*	*0.60*	*0.60*	*0.60*	*0.60*	*0.60*	*0.60*
		FTE	Vacancies in month	0.43	0.75	4.81	6.73	5.23	*5.83*	*6.42*	*7.02*	*7.62*	*8.21*	*8.81*	*9.41*
	Offers External/Internal Applicants	FTE	Conditional offers (in month)	0.00	2.26	0.00	1.00								
		FTE	Offers Confirmed (in month)	0.00	5.21	1.80	0.00								

Notes:

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

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

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

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

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

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

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

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

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

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

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

Data source: ESR and Recruitment data base

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Emergency Department Scorecard**
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Barlow Chief Operating Officer
AUTHOR:	Rachel Barlow Chief Operating Officer
DATE OF MEETING:	3rd August 2017

EXECUTIVE SUMMARY:

The Emergency Department daily scorecard tracks a set of data related to patient activity, clinical and professional standards.

The A&E Improvement plan is designed to improve the 4 hour performance to 90% by September. The design is based on 4 problems and the improvement activities are intended to achieve consistency in practice. Many of the professional standards in the daily scorecard align to quality and clinical care standards

A monthly quality dashboard is published which reviews delivery against a number of clinical standards such as pain and sepsis pathways, safe drug storage and documentation and incidents and complaints. A single integrated scorecard will be available by the end of August.

The Trust improvement approach is being established in ED and is intended to gain sustainable change in practice, which was a deficit in the June improvement approach. The original principles of the improvement focus remain as originally designed with incremental weekly improvement seen in July in the 4 hour standard. There is good engagement through the ED leadership team. The programme is on track. Those staff who find the consistency in practice difficult will be identified and receive additional support. The improvement focus in the quality dashboard will be incorporated into the local PMO.

Glossary to support paper

A&E	accident and emergency
AMAA	acute medical ambulatory assessment
DTA	decision to admit
ED	emergency department
EDD	expected discharge date
KPI	key performance indicator
LOS	length of stay
PMO	project management office
RAG	red amber green

REPORT RECOMMENDATION:

Discuss improvement focus and scorecard data

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

Accept	Approve the recommendation	Discuss
		x

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

Financial	**x**	Environmental		Communications & Media	x
Business and market share		Legal & Policy		Patient Experience	x
Clinical	**x**	Equality and Diversity		Workforce	x
Comments:					
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
Safe high quality care, accessible and responsive services					
PREVIOUS CONSIDERATION:					

SWBTB (08/17) 015a

Emergency Department Scorecard

1. Improvement focus

The Emergency Department scorecard tracks a set of data related to patient activity, clinical and professional standards.

The A&E Improvement plan is designed to improve the 4 hour performance to 90% by September. The design is based on 4 problems and the improvement activities are intended to achieve consistency in practice.

Problem	**Solution focus in July**	**Solution focus in August**	**Breach impact (50)**	**Scorecard Related KPI**
Lack of substantive staff and new starters leads to inconsistency in compliance	Achieve consistency in practice of professional standards for 70% of staff.	Clear workforce plan and increase fill rate of 10-6pm shifts to 5 days a week prioritising Sandwell first by 11.8.17. Put in place a tailored program for staff who require additional support to achieve consistency in practice of standards.	13	Staffing Time to triage Seen within an hour Arrival to DTA within two hours DTA to discharge within 30 minutes
Departmental Management after 7pm	Intelligent rostering, mimic additional leadership model of UC Challenge weeks Out of hours to oversee sustainable practice change in place for 2 weeks from 17.7.17	Intelligent rostering, agree sustained OOH on site leadership model to step up improvement in consistency (capacity team and on call structures) by 31.7.17 Implementation of new leadership model over August.	14	Staffing Time to triage Seen within an hour Arrival to DTA within two hours DTA to discharge within 30 minutes
Timeliness of clinical decision making in ED	Consistent Rapid Assessment and Triage 10am to 10pm rota in place ; focus now on individual skill development to increase effectiveness. By 23.7.17. Ambulatory pull development throughout July. Smart conveyancing. Only patients in ED that need to be there.	Consistent practice of Rapid Assessment and Triage 10am to 10pm, Ambulatory pull matures by end of August. Smart conveyancing. Only patients in ED that need to be there.	7	Initial assessment/Triage within 15 mins (AMB ONLY) Initial assessment/Triage within 30 mins (All Attends) Number of patients with a GP letter in ED Number of patients through AMAA from ED

				Total number of AMAA patients ED to AMAA within an hour
Patient flow from the wards to home	Bed Declaration protocol (evenings) in place from 12.7.17, more robust red to green activity and 7 day LOS management. Confirm new bed model by and launch pull / admit model at consistency of care LIA on 24.7.17.	Implement new admit / pull model	16	DTA to discharge within 30 minutes KPI for push pull to be agreed but will include EDD compliance

2. Daily data and exceptions

The score attached as appendix 1 shows activity and performance by site across a number of domains. The RAG ratings and interim targets are designed to engage staff to progress through incremental improvements. Exceptions for the week commencing the 17.7.17 include:

- Seen within an hour (including those seen by + senior review)
- Arrival to DTA within two hours (ADMITTED PATIENTS)
- DTA to discharge within 30 minutes
- Number of patients through AMAA – both sites with most improvement required at Sandwell
- Number of patients through Malling GP service – Sandwell

Triage and ambulance assessment times are good and there is evidence of the developing ambulatory care model at City.

3. Improvement approach

Each day the ED leadership team and the consultant and nurse in charge of the current shifts have a professional standard review. This is led by Liz Miller Directorate General Manager who facilitates a review of:

- The previous day's activity and professional standards
- Case by case review of waits over 8 hours with learning identified and logged for actions
- A review of today's professional standards and look ahead to the rest of the day based on the departments current status

This is an opportunity to coach and develop the clinical leadership team and to reinforce the professional standards. The themes that contribute to inconsistency in practice and underperformance are scoped to ensure an improvement approach is designed and specific , with a weekly Chief Operating Officer led PMO overseeing delivery. The current improvement projects are;

- Resus Supervision Improvement Plan – running resus whilst running the shop floor
- Triage Redesign Improvement Plan- streaming to avoid unnecessary attendance in ED
- ED Workforce, forward look, sickness visibility – intelligent rosters

- CT reporting Improvement Plan – joint rapid work with radiology
- AMAA access Improvement Plan – to reach goal of 20 patients a day

4. The Quality scorecard

Many of the professional standards in the daily scorecard align to quality and clinical care standards. A separate monthly quality dashboard is published which reviews delivery against a number of clinical standards such as pain and sepsis pathways, safe drug storage and documentation and incidents and complaints. The areas of improvement focus are documentation and medicines management.

The improvement focus in the quality dashboard will be incorporated into the local ED PMO and an integrated dashboard is in development and will be available next month.

5. Conclusion

The improvement approach is intended to gain sustainable change in practice, which was a deficit in the June improvement approach. The original principles of the improvement focus remain as originally designed with incremental weekly improvement seen in July in the 4 hour standard. There is good engagement through the ED leadership team. Those staff who find the consistency in practice difficult will be identified and receive additional support.

The Trust Board are asked to discuss the improvement focus and the scorecard.

Glossary

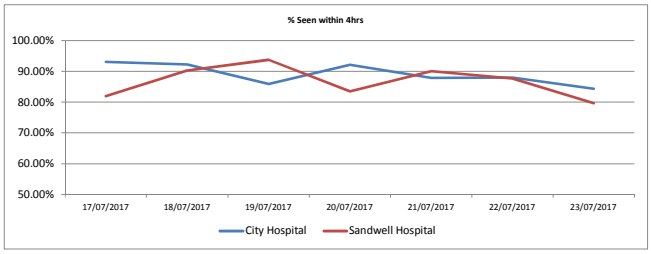
A&E	accident and emergency
AMAA	acute medical ambulatory assessment
DTA	decision to admit
ED	emergency department
EDD	expected discharge date
KPI	key performance indicator
LOS	length of stay
PMO	project management office
RAG	red amber green

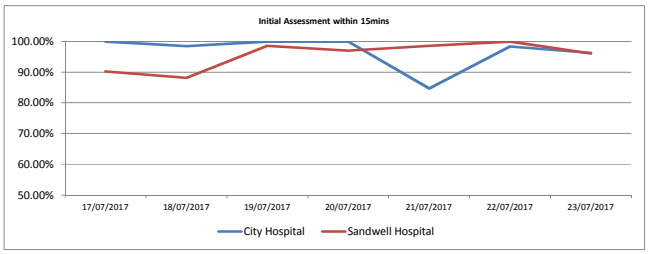
Urgent Care Daily Scorecard

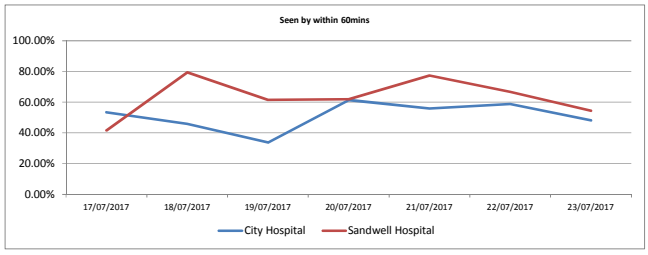
Daily Summary

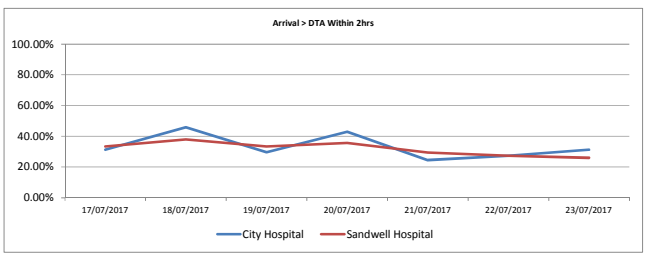
City Hospital	TARGET	CURRENT IMPROVEMENT GOAL	green	yellow	amber	red	Monday 17/07/2017	Tuesday 18/07/2017	Wednesday 19/07/2017	Thursday 20/07/2017	Friday 21/07/2017	Saturday 22/07/2017	Sunday 23/07/2017
No of Attendances							377	300	321	283	282	266	288
No of 4hr Breaches							26	23	45	22	34	34	47
No of 8hr Breaches	0	0	0	1	2	>2	4	2	1	1	0	1	2
4 hour standard	90%	90%	90%	85%	80%	<80	93.10%	92.30%	85.98%	92.23%	87.90%	88.00%	84.40%
No of Admissions							48	51	57	38	49	40	50
% of Admisisons v Attendances							12.73%	17.00%	17.76%	13.43%	17.38%	15.04%	17.36%
Initial assessment/Triage within 15 mins (AMB ONLY)	100%	100%	100%	95-99%	90-94%	<90	100.00%	98.48%	100.00%	100.00%	84.72%	98.36%	96.30%
Initial assessment/Triage within 30 mins (All Attends)	100%	100%	100%	95-99%	90-94%	<90	98.13%	96.43%	97.39%	100.00%	100.00%	96.70%	97.88%
Seen within an hour (incl those seen by + senior review)	100%	70%	>70%	65-69%	60-64%	<60	53.49%	45.96%	33.75%	61.40%	56.00%	58.82%	48.17%
Arrival to DTA within two hours (ADMITTED PATIENTS)	100%	70%	>70%	65-69%	60-64%	<60	31.25%	45.83%	29.63%	42.86%	24.49%	27.27%	31.37%
DTA to discharge within 30 minutes	90%	75%	>75%	70-74%	65-69%	<65	37.25%	23.53%	28.07%	19.57%	20.75%	44.44%	38.46%
DTA to discharge within an hour		80%	>80%	75-79%	70-74%	<70	50.98%	49.02%	57.89%	36.96%	52.86%	62.22%	57.69%
DTA to discharge more than an hour							49.02%	50.98%	42.11%	63.04%	47.17%	37.78%	42.31%
Non Admitted patients discharged wihin 4 hours	95%	90%	>90	85-89%	80-84%	<80	97.80%	97.51%	91.00%	94.76%	91.67%	91.28%	87.17%
Number of patients with a GP letter							14	11	10	17	13	1	1
Number of patients through AMAA from ED	>20	>20	>20	17-19	14-16	<14	17	12	11	13	9	2	4
Total number of AMAA patients							29	15	15	22	19	1	6
ED to AMAA within an hour	100%	100%	100%	95-99%	90-94%	<90	35.29%	41.67%	45.45%	30.77%	33.33%	0.00%	25.00%
Fast track performance (ie minors patients)	98%	95%	>95%	92-94%	90-91%	<90	100.00%	100.00%	88.89%	100.00%	100.00%	94.83%	89.61%
Malling Activity	>45	>45	>45	42-44	40-41	<40	56	48	53	54	41	54	51
Number of mental health patients							9	7	8	6	6	8	9
Number of mental health patients - 4hr breaches							1	0	1	1	1	1	3
Number of mental health patients - 8hr breaches	0						0	0	0	0	0	0	0
Number of mental health patients - 4hr breaches %	90%						88.89%	100.00%	87.50%	83.33%	83.33%	87.50%	66.67%
Ambulance Waits - Under 1hr							84	73	77	57	81	74	83
Ambulance Waits - Over 1hr	0						0	0	0	0	0	0	0
Medical staffing	full	full	full	-1	-2	-3	full	full	full	full	full	full	full
Nursing staffing	full	full	full	-1	-2	-3	-1	full	full	-1	full	full	full

Sandwell Hospital	TARGET	CURRENT IMPROVEMENT GOAL	green	yellow	amber	red	Monday 17/07/2017	Tuesday 18/07/2017	Wednesday 19/07/2017	Thursday 20/07/2017	Friday 21/07/2017	Saturday 22/07/2017	Sunday 23/07/2017
No of Attendances							322	247	291	250	253	243	251
No of 4hr Breaches							58	24	18	41	25	30	51
No of 8hr Breaches	0	0	0	1	2	>2	3	2	1	1	1	1	6
4 hour standard	90%	90%	90%	85%	80%	<80	82.00%	90.30%	93.80%	83.60%	90.16%	87.70%	79.70%
No of Admissions							72	51	51	55	65	45	52
% of Admisisons v Attendances							22.36%	20.65%	17.53%	22.00%	25.69%	18.52%	20.72%
Initial assessment/Triage within 15 mins (AMB ONLY)	100%	100%	100%	95-99%	90-94%	<90	90.24%	88.14%	98.59%	97.01%	98.61%	100.00%	96.05%
Initial assessment/Triage within 30 mins (All Attends)	100%	100%	100%	95-99%	90-94%	<90	93.54%	98.54%	97.71%	98.69%	99.54%	99.07%	100.00%
Seen within an hour (incl those seen by + senior review)	100%	70%	>70%	65-69%	60-64%	<60	41.70%	79.40%	61.45%	61.97%	77.29%	66.67%	54.55%
Arrival to DTA within two hours (ADMITTED PATIENTS)	100%	70%	>70%	65-69%	60-64%	<60	33.33%	38.00%	33.33%	35.71%	29.51%	27.27%	26.00%
DTA to discharge within 30 minutes	90%	75%	>75%	70-74%	65-69%	<65	30.99%	42.59%	38.60%	33.90%	34.85%	32.61%	48.08%
DTA to discharge within an hour		80%	>80%	75-79%	70-74%	<70	56.70%	57.41%	56.14%	50.85%	48.48%	56.52%	57.69%
DTA to discharge more than an hour							49.30%	42.59%	43.86%	49.15%	51.52%	43.48%	42.31%
Non Admitted patients discharged wihin 4 hours	95%	90%	>90	85-89%	80-84%	<80	89.91%	96.75%	94.29%	92.40%	94.70%	91.12%	87.12%
Number of patients with a GP letter							7	11	8	10	9	3	2
Number of patients through AMAA from ED	>20	>20	>20	17-19	14-16	<14	6	0	7	5	6	3	1
Total number of AMAA patients							15	11	17	9	17	5	1
ED to AMAA within an hour	100%	100%	100%	95-99%	90-94%	<90	50.00%	0.00%	28.57%	60.00%	66.67%	33.33%	0.00%
Fast track performance (ie minors patients)	98%	95%	>95%	92-94%	90-91%	<90	97.80%	100.00%	98.61%	98.36%	100.00%	98.11%	94.59%
Malling Activity	>45	>45	>45	42-44	40-41	<40	32	42	30	24	37	29	36
Number of mental health patients							10	9	11	13	4	8	2
Number of mental health patients - 4hr breaches							4	2	2	4	1	3	2
Number of mental health patients - 8hr breaches	0						0	1	1	0	0	0	1
Number of mental health patients - 4hr breaches %	90%						60.00%	77.78%	81.82%	69.23%	75.00%	62.50%	0.00%
Ambulance Waits - Under 1hr							85	58	72	65	78	73	76
Ambulance Waits - Over 1hr	0						0	0	0	0	0	0	0
Medical staffing	full	full	full	-1	-2	-3	-1	full	full	full	full	full	full
Nursing staffing	full	full	full	-1	-2	-3	-2	full	-1	-2	full	full	-3









Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Complaints report: 2017/18 Quarter 1
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Karen Wood, Head of PALS & Complaints
DATE OF MEETING:	3rd August 2017

EXECUTIVE SUMMARY:

This report sets out details of Complaints and PALS enquiries received between April and June 2017 (Quarter 1).

The report provides high level data on Formal and Informal Complaints (previously referred to as PALS and Complaints), the reasons those complaints were made and work underway to improve complaints management.

In this quarter it is reported that the complaints activity has decreased from 227 to 235, with **98% of complaints received since April 2017 being managed within their target date**. At the time of writing there are 40 complaints from 2016/17 that are overdue a response and these will be finalised by the end of September. Themes and outcomes remain consistent with previous quarters and shows a continued focus on lessons learned, and quality responses that are caring, transparent, timely and responsive to the needs of complainants.

REPORT RECOMMENDATION:

The Board is recommended to **DISCUSS** and **NOTE** the contents of the report.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		✓

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

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

Comments:

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

Safe, high quality care
Improve and heighten awareness of the need to report and learn from complaints.

PREVIOUS CONSIDERATION:

July Quality and Safety Committee

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Complaints Report

2017/18: Quarter 1

Where EVERYONE Matters

At a glance

227

Formal complaints dealt with in Q1 2017/18

531

Informal complaints dealt with in Q1 2017/18

38.45

The average number of days taken to complete a formal complaint

73% (189)

Complaints were responded to on or prior to their target date in Q1 2017/18 and year to date (regardless as to when they were received.)

98.6% (106)

Complaints received in Q1 that were responded to on or prior to their target date to date

2.8

Number of complaints received per 1000 bed days

5.4

Number of complaints received per 1000 finished consultant episodes (FCEs)

44% (100)

Of the complaints received were about the clinical care provided

64% (148)

Of resolved complaints were either partially or wholly upheld in favour of the complainant

25

Complaints reopened because of dissatisfaction with the original response

4 new / 4 closed

PHSO investigations for Q1 2017/18

In detail

The total number of compliments for this quarter was not available as the collection of this data has not been recorded consistently. This is reflective of the fact that this data is not collected in systemic way. Details of plans around improving the collection method are detailed in 'Key Areas for Focus'.

A total of 266 complaints were presented to the Trust in Q1 2017/18 compared with 302 complaints in Q4 2016/17. 39 cases were withdrawn (compared to 49 being in Q4 2016/17) leaving a total of 227 to manage. The decrease in this quarter's complaints can largely be attributed to Surgery, with an 18% (13 complaints) reduction in their total complaints against then this quarter.

A total of 531 informal complaints (previously referred to as PALS enquiries) were made in Q1 2017/18 compared to 678 Q4 2016/17, 561 in Q3 2016/17, and 718 in Q2 2016/17. Whilst there are fluctuations between the numbers of PALS concerns, the topics complained about remain relatively constant. Of note is that formal complaints about appointments have again decreased this quarter, and so have informal complaints. It was reported in Q4 2016/17 that as an average over the past 6 quarters, concerns about enquiries have made up 27% of these concerns, and Q4 2016/17 this was down to 24%, the second lowest for the past 7 quarters. In this quarter, it has decreased again to 22%.

The average number of days taken to conclude the cases closed in Q1 2017/18 is 38.44 compared to 34.44 in Q4 2016/17. This has once again exceeding the 30 day KPI, and is reflective of the cases that have already exceeded their target dates are being actively managed, to bring them to a swift conclusion. The average number of days taken to resolved complaints that have been received since 1 April 2017 is 26.17. 2 cases received since 1 April 2017 have breached their target date, against 108 sent (98%).

The number of complaints per 1000 bed days has come down slightly to 2.8 compared to 3.1 in Q4 2016/17, 2.9 in Q3 2016/17, and 3.4 in Q2 2016/17. Surgery still has the highest complaints rate, but the differential is less prevalent this quarter.

The number of complaints per 1000 FCEs was 5.4, compared to 6.0 in Q4 2016/17, 5.3 in Q3 2016/17, and 6.7 in Q2 2016/17. Surgery still has the highest complaints rate, but the differential is also less prevalent this quarter.

The most complained about theme, continues to be clinical care, at 44% (100) of complaints made. This quarter, as with last, the second most complained about issue was the attitude of staff at 15% of complaints (albeit a decrease of 5% from last quarter.) The third most complained about issue is once again our management of out appointments at 12% compared to 11% in the last quarter but was 20% in Q3 2016/17 (and the second most complained about theme in this quarter).

64% of complaints closed in Q1 2017/18 were either partially or wholly upheld in favour of the complainant compared to 57% of complaints closed in Q4 2016/17, 70% in Q3 2016/17 and 72% in Q2 2016/17. This result sees the % outcome return to closer to that of previous quarters, having been very low in Q4 2016/17.

25 complaints were reopened as a result of the complainant's dissatisfaction with their original response in Q1 2017/18. This compares to 43 in Q4 2016/17, 34 in Q3 2016/17, and 43 in Q2 2016/17. 2 of these cases were because we had not answered all issues in the complaint; the average number reopened for this reason over the last 2 years is 3 per quarter.

The decrease in new PHSO cases has continued with 4 new cases received in the last quarter compared to 4 new cases in Q4 2016/17 and 15 in Q3 2016/17 and 8 Q2 2016/17. 4 cases have been closed in Q1 2017/18 also. Consistent is the trend that the PHSO generally agree with the Trust's original investigation, although in this quarter, 2 of the 4 cases closed were upheld. This takes the % of cases upheld for the last rolling 4 quarters is 74%.

Learning from patient feedback

Concerns and complaints raised by patients and visitors must be viewed positively as an unsolicited form of feedback. These are opportunities to improve our services and the care we provide based on user experience.

It is the Trust's responsibility to ensure that this feedback is used to improve patient safety, the delivery of service, and patient experience.

Below are some examples of improvements made as a direct result of complaints received

A range of clinical concerns were raised about the complex care of a patient who was awaiting an x-ray to investigate a hip fracture. It was recognised that this delay was unacceptable. Since this patient experience, a lunch time meeting is held by ward managers where x-ray delays are identified to Imaging so that immediate remedial action can be taken, to prevent such a wait in the future.

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

A review has taken place as to positioning of the nurses call cords in bathrooms in Sandwell General Hospital. Ceiling mounted cords have been replaced by wall mounted boxes but in a recent incident, it was identified that the wall mounted boxes could not be accessed from the shower area. A health and safety review confirmed that the ceiling mounted pull cords are more appropriate and this recommendation was forwarded to the Estates Department for consideration. Appendix 1 shows the photos taken in support of this recommendation.

A number of complaints have been received from patients attending the Birmingham and Midland Eye Centre (BMEC) about being referred to the Urgent Care Clinic as opposed to A&E (having had the eye issue assessed as being non sight threatening). New posters and patients leaflets have been produced (see appendix 2) and since these have been displayed, and the process embedded, the Trust have received no further complaints of this nature.

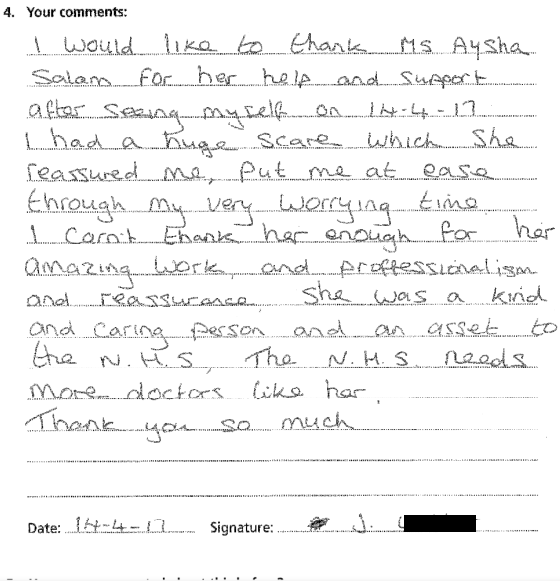
Positive Feedback
Complainant feedback

Hello Christine,

Thank you so much for all your help with mum I dont know what I would have done without everything you have done for us. You are such a kind person and even in this difficult time your there to help I will never be able to thank you enough for everything you have done for mum as you see from my email im still trying to do the best for her shes my one and only mum and thank you again.

Kindest Regards

Richard



4. Your comments:

I would like to thank Ms Aysha Salam for her help and support after seeing myself on 14-4-17 I had a huge scare which She reassured me, put me at ease through my very worrying time I Can't Thank her enough for her amazing work and proffessionalism and reassurance. She was a kind and caring person and an asset to the N.H.S, The N.H.S needs more doctors like her. Thank you so much

Date: 14-4-17 Signature: J. [redacted]

Dear Nayna & Karen

I should like to commend your Complaints Administrator Trina MASI.

She has been my 'Case-Worker' in relation to a complaint I unfortunately felt had to be made in relation to the recent discharge procedure from Sandwell Hospital of my mother; [redacted]

Trina was extremely compassionate and efficient throughout the process, including for me, most importantly, simply listening initially to the full detail of my concerns and frustrations before investigating for herself. She then comprehensively reassured me of her concerns in relation to the issues I raised, and her determination to ensure that they were appropriately addressed.

Trina was totally reliable in her communication commitments, ALWAYS responding when she indicated that she would, which was of particular importance as this was the essence of my complaint about the lack of communication by the hospital.

If the skills and commitment displayed by Trina had been matched by the various hospital administration personnel, then there would have been no complaint. A point I feel sure you may be able to cascade to hospital personnel.

I have personally thanked Trina and specifically requested that she provide me with the details of her supervisors in order that those thanks may be repeated from me by yourselves, and that she is appropriately acknowledged formally for her efforts.

Thank you

In summary

- A further drop in the number of responses sent out before or on their due date is reported, but a plan is in place to ensure the cases that have already breached their target date (all logged with the Trust prior to April 2017), are completed by the end of September 2017. All but 2 of the cases received since 1 April 2017 have been responded to on or before their due date.

- The number of informal and formal complaints has decreased, (most notably in the Clinical Group, Surgery) from a total of 235 and 678 in Q4 2016/17 to 227 and 531 in Q1 2017/18.

- The time taken to turn cases around has again averaged over the accepted 30 day quality standard, and this is largely due to the number of cases breaching their target date from 2016/17. With that said, of those cases resolved in Q1 2017/18, 73% of cases were responded to within their target date with 98% of the complaints received since April 2017 (and resolved since) have met or exceeded their target date.

- Whilst the main theme of complaints has not changed this quarter the number of complaints and concerns about appointments has again reduced. Whilst this has traditionally been the second most complained about theme, it was the third most complained about theme in Q4 2016/17 and Q1 2017/18

- PHSO cases remain steady with 4 new cases being investigated in Q1 2016/17. 4 cases were closed this quarter, with a higher percentage of not upheld outcomes. Year to date, 74% of cases reported to the PHSO are not upheld.

Key areas for focus from Quarter 1 2017/18 into Q2 2017/18

As previously reported, there are a number of quality improvement initiatives that are being undertaken by the Complaints Team, many of which are still ongoing.

1. To ensure that no complaint breaches its target date in 2017/18.
2. To implement the access point telephone network for patients and their representatives to use to call for immediate intervention at times when action is needed.
3. Better understand and implement a strategy to address the continued issue of disproportionality in the complaints rate of different ethnic groups.
4. The need to engage with complainants who have used the process, and better understand their experience.
5. To report and monitor complaints that arise as a result of the use of agency staff.

1.

The complaints team continue to work with Investigation and Governance Leads in Clinical Groups to ensure that no complaint logged since 1 April 2017 breaches its target date.

Daily and weekly reports support the follow up and escalation process that has kept all but 2 of new complaints in date in Q1 2017/18.

Further work is planned to create 'self service' complaints reports for Clinical Groups so that they can be more proactive in the management of keeping their cases in date.

2.

The telephone network project (referred to previously as the purple phone) is now underway, with locations identified, and resources agreed.

Work around how decisions will be made about how to manage differing enquiries, and how the Trust will support callers with differing language needs has started and the project is still on track to be launched in late September 2017.

3.

Over many reports, it has been recognised that there is a need to acknowledge and better understand why certain ethnic groups make disproportionate numbers of complaints, compared to their patient numbers. Appendix 3 is a summary of the issues facing the Trust in addressing this issue of equality.

By partnering with the Black and Minority Ethnic (BME) staff group *(is this the right name?)* the data shown on the in appendix 3 data will be presented at the next meeting to start the dialogue, from the BME staff's perspective about how to address what the evidence shows.

4.

It is recognised that the current survey method used for complaint service feedback is not effective, and does not provide data that identifies service improvement opportunities.

There is a need to engage with Healthwatch further to work with them on ways of involving their service users, and our complainants in providing feedback. This could include the use of focus groups, and will be discussed with them in Q2 2017/18.

5.

There is currently no identifier on the complaints data base to record whether the staff member being complained about is employed by the Trust, or is agency staff.

This has since been rectified, and will be reported in Q2 2017/18.

Appendix 1

Photos taken at the health and safety assessment following the complaint and recommendation that the ceiling pull cords are reinstated where possible.

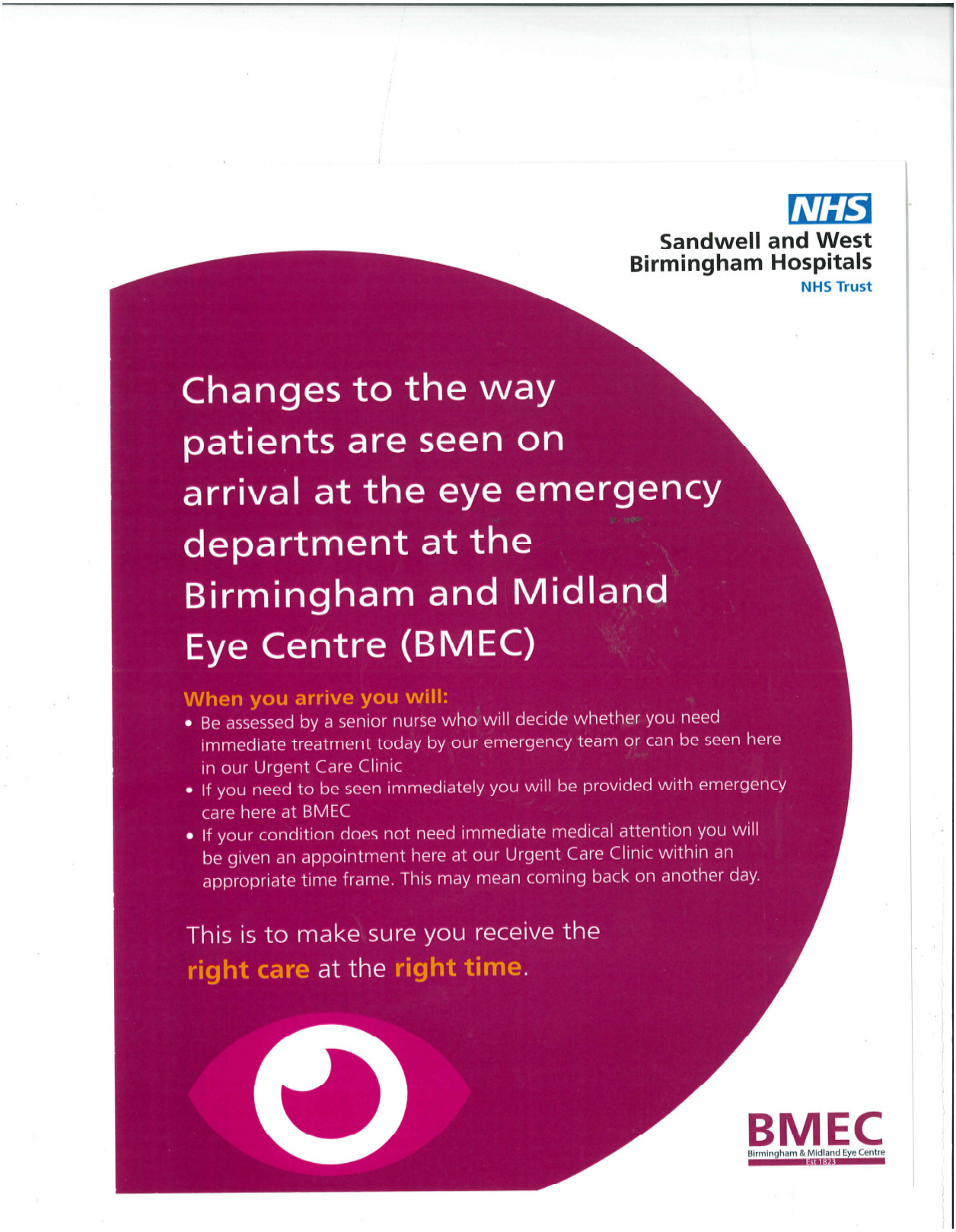
Original ceiling mounted cords

Cords were removed to make way for new wall mounted system

New wall mounted nurse all system

Appendix 2

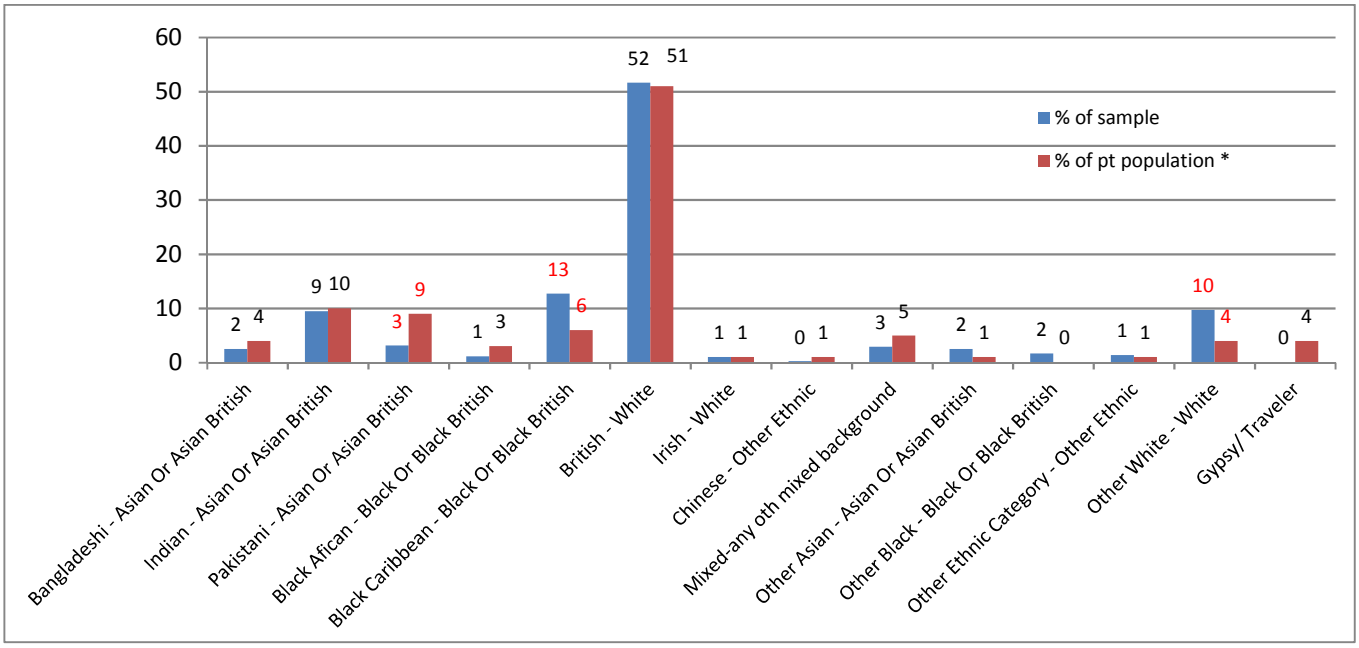
A copy of the patient poster advising of changes to the triage system at BMEC



Appendix 3

A report on the experience of patients from the BME community where this experience results in a formal complaint.

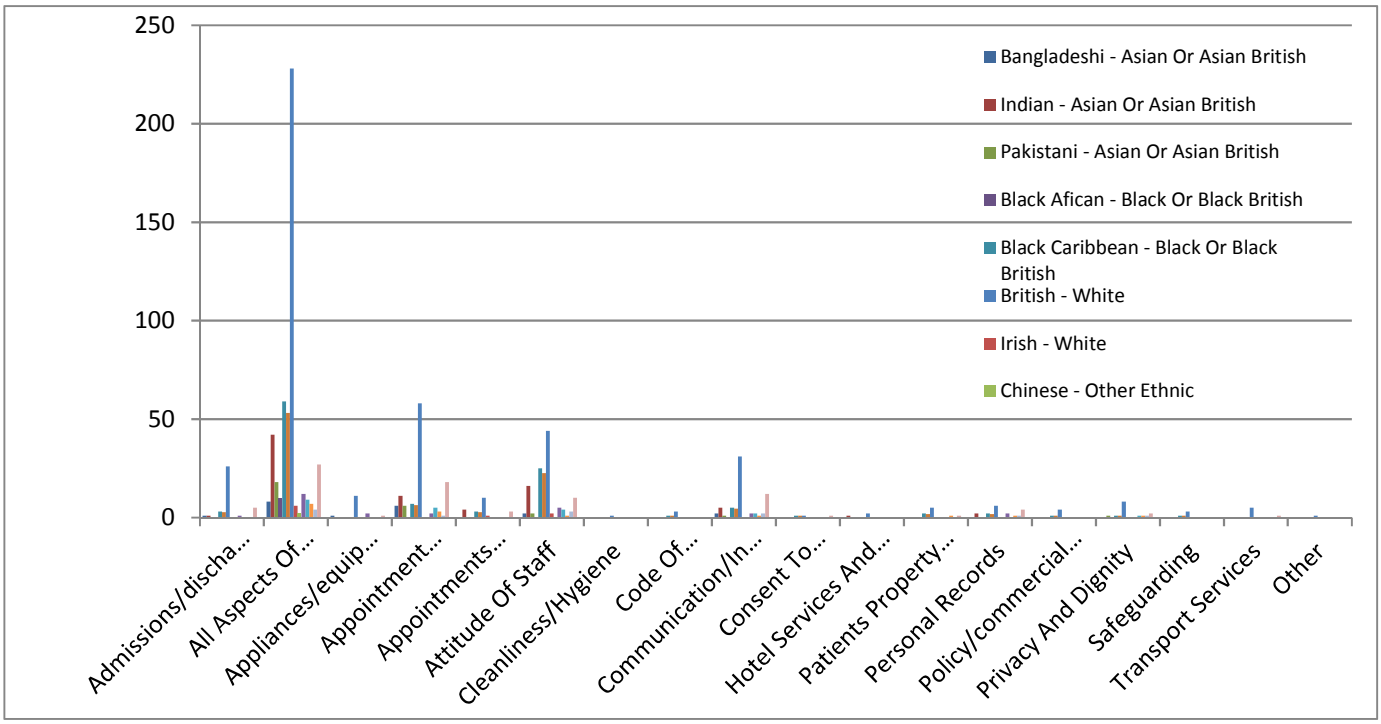
A break down by % of complaints received over the last 12 months from BME patients compared to the % of how they make up our patient population



Shown in red are the discrepancies across three main BME groups

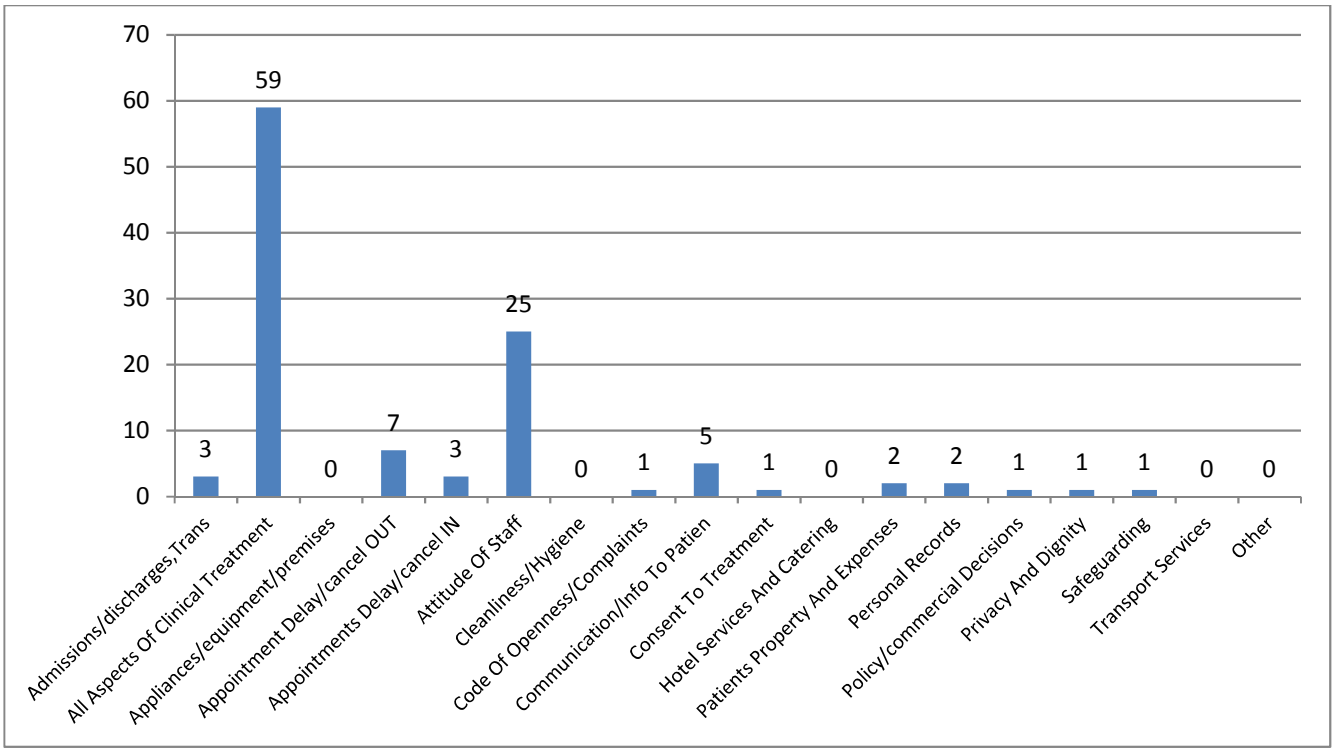
1. Pakistani- where there is a lower complaints rate to patient population. In other words, it would be expected that there would be higher numbers of complaints from this ethnic group, and it should be considered whether either as a patient group, Pakistani patients get better treatment, or when they do not have a positive experience, they do not complaint (and then consideration needs to be given as to why.)
2. Black Caribbean- where there is a higher complaints rate to patient population. In other words, it would be expected that there would be lower numbers of complaints from this ethnic group, and it should be considered whether either as a patient group, Black Caribbean patients get worst treatment, or when they do have a negative experience, they feel comfortable to complaint and do so without hesitation.
3. White other- commonly used to describe European residents of the UK eg Polish, Bulgarian etc. Here we can also see that there is a higher complaints rate to patient population. In other words, it would be expected that there would be lower numbers of complaints from this ethnic group, and it should be considered whether either as a patient group, Other White patients get worst treatment, or when they do have a negative experience, they feel comfortable to complaint and do so without hesitation.

Complaints by theme, broken up by BME

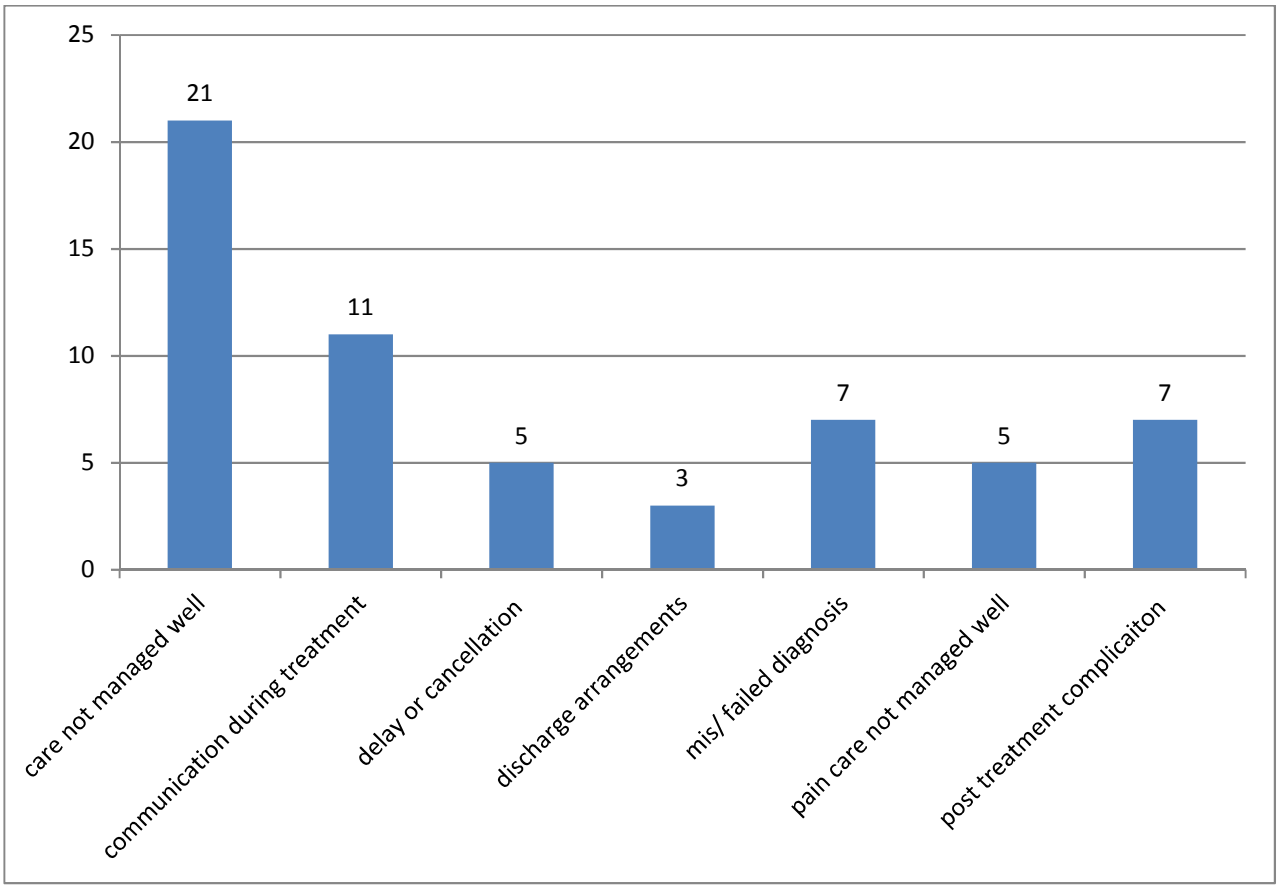


As the discrepancy around the larger number of complaints for Black Caribbean patients has been evident consistently over a long period of time, is it this issue that will firstly be tackled as this works begins.

The most complained about topic is 'All aspects of Clinical Treatment'. This is consistently the case when looking at the topics complained about for Black Caribbean patients, as shown below.



Because All aspects of Clinical Treatment is a very broad category, an analysis was undertaken as to what specifically these complaints were about, and a more specific breakdown is shown below.



This break down is not dissimilar to that of other ethnicities and in that sense does not in itself help explain the disproportionality. Understanding the issue behind the complaint however is a starting point in the discussions to be had about either reducing the complaint numbers by either improving the care, or understanding the behaviour behind the complaint, to better manage the expectations as they differ between ethnic groups.

Next Steps

This data will be presented at the next BME group so that ideas can be shared from BME staff, and a strategy developed to start to address the issue of disproportionality.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Application of the Trust Seal for Settlement Deed (Church Lane)
SPONSOR (EXECUTIVE DIRECTOR):	Elaine Newell – Chief Nurse
AUTHOR:	Steve Clarke – Deputy Director - Facilities
DATE OF MEETING:	3rd August 2017

EXECUTIVE SUMMARY:

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

Settlement Sum – Means the sum of £7,500 payable by the former landlord to Sandwell and West Birmingham Hospitals NHS Trust in accordance with clause 2.1 of the Settlement Deed.

Since the grant of the lease but prior to the disposal date, various incidences of flooding and/or water ingress occurred at the premises, causing damage to the premises and disruption to the tenants (SWBH) business therefore a claim was made against the former landlord resulting in agreed damages of £7,500.

REPORT RECOMMENDATION:

The Board are recommended to:

- Approve the application of the Trust seal to the aforementioned document.

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

Accept	Approve the recommendation	Discuss
X	X	

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

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

Comments:

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

PREVIOUS CONSIDERATION:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC MEETING MINUTES

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

Date: 6th July 2017, 0930 – 1315h

Members Present:

Mr R Samuda, Chair	(RS)
Mr M Hoare	(MH)
Mr H Kang, Non-Executive Director	(HK)
Cllr W Zaffar, Non-Executive Director	(WZ)
Ms. O. Dutton, Non-Executive Director	(OD)
Prof K Thomas, Non-Executive Director	(KT)
Mr T Lewis, Chief Executive	(TL)
Ms E Newell, Chief Nurse	(EN)
Dr R Stedman, Medical Director	(RSt)
Mr T Waite, Finance Director	(TW)
Miss K Dhami, Director of Governance	(KD)
Mrs R Goodby, Director of OD	(RG)
Ms R Barlow, Chief Operating Officer	(RB)

In Attendance:

Mrs C Rickards, Unison	(CR)
Mrs. R. Wilkins, Director of Communications	(RW)

Board Support

Miss R Fuller	(RF)

Minutes	**Reference**
1. Welcome, apologies and declaration of interests	**Verbal**
No apologies were tendered for the meeting. Mr. Samuda acknowledged and thanked the Association of Schools for agreeing to hold the Trust Board on it premises.	
3. Patient Story	**Presentation**
A video was presented and Ms Newell commented this patient was chosen to highlight the issues around interpreters following reports on interpreting on social media. It was noted that the patient spoke and understood a high level of English as a second language and it highlighted the assumption made that if you speak English you do not require an interpreter. However, patients often revert back to their mother tongue in times of stress or fear and this type of patient can be overlooked. It was also noted that the use of language line can be inappropriate when dealing with patients with mental issues, acute stress and in labour, therefore work is in train to access staff who can speak different languages and can be available when required. The team have been asked to study the model used by Birmingham Community Trusts who have a very good interpreting service. The Trust Board were informed that a trial involving clinicians and patients wearing an ear piece which would translate your speech, the use of which would be monitored especially when translating complex medical jargon would be included in the trial. Mr. Lewis assured the Trust Board the interpreter service will have renewed focus and this item would again feature at a future Trust Board for an update.	
ACTION: • Interpreting – follow up on actions and the service as noted in the Trust Board meeting 6.7.17	
4. Questions from the public	**Verbal**

Mr. Bill Hodgetts of Healthwatch made an enquiry from a family was contacted him to report they were contacted by the Trust about a deceased relative. Mr. Hodgetts asked for the hospitals records to be checked before contacting families and causing unnecessary distress. Ms. Barlow apologised for the incident and noted that before any validations commence the central indexing system which connects to the death register is checked to eliminate this type of distress, however no validation of records was currently underway but she would contact Mr. Hodgetts outside of the meeting with an update and ascertain further information about the contact.

Mr. Hodgetts asked about an Oncology Event taking place on Saturday 8th July and if Mr. Lewis would be speaking at it. Mr. Lewis confirmed he would not be speaking at the event nor attending and updated the Trust Board the oncology service is provided by UHB within the hospital campus. The issues are with the Trust regulator NHS Improvement who are trying to resolve the issues which have been unresolved for approximately 3 years and the Trust will continue to work with them to seek a resolution.

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

Mr. Samuda drew attention to the following:

AGM – Mr. Samuda reported the meeting went well and was attended by approximately 50 people. Questions were asked about the collection of patients' overseas income, STP and its governance on the people especially the residents in the West Birmingham area. it was reported the Black Country Chairs will be meeting monthly to discuss further work streams and the continued involvement of Wolverhampton. Mr. Lewis agreed to present a paper to the Trust Board next month to remind all of the extant reliance on people and to understand the risks associated with the Black Country STP and the Birmingham STP as discussions over the West Birmingham patch by parties continues.

ACTION:

- Note on the issues for SWBH residents within the Black Country and Birmingham STP documents.

6a. Major Projects Authority	**SWBTB (07/17) 002** **SWBTB (07/17) 003**

Mr. Hoare reported on the following:

Taper Relief – £3m income profiled for 2016/17 has been secured and the finance team are working on securing taper relief in 2017/18.
Distribution Strategy – The distribution strategy is the logistics of handling all goods from a central depository and servicing all sites within SWBH, a proposal has been received from DHL which is proceeding.
Charter Manager – The Charter Manager timescale has been amended to ensure all managers have achieved level 1 by Q4.
Digital Plan - The digital plan has many interdependences including the challenges of EPR, these are being addressed by Mr. Reynolds and the team.
E-Docs – Casenote scanning went live on 20th June. Feedback has been good but the launch has highlighted others areas of the infrastructure which require strengthening.
BTC Design – A presentation was given showing that no service would become homeless. There was an issue over the Fracture Clinic which Mr Kenny and the team would follow up and update the Major Projects Authority at its next meeting. It was noted that the Midland Met Hospital had an interdependence on other supports services within the BTC and the Trust in general.

Mr. Samuda thanked Mr. Hoare for standing in as Chair of this meeting.

6b. People & OD Committee	**SWBTB (07/17) 004** **SWBTB (07 /17) 005**

Mr. Kang reported on the following:

Committee Name – The Committee has been renamed People & Organisational Development Committee which reflected the work it is undertaking.
Workforce Consultation Progress – There are 18 people who are in the process of commencing or trialling new roles and 6 who are without suitable alternative employment due to their current working practices. The OD team were

congratulated on achieving a high percentage of redeploying staff throughout the process.
Aspiring to Excellence – This is the roll out of a new performance management process, a training programme has commenced and 500 of the 900 identified staff have undergone training as of July. The feedback received to date from the training sessions has been positive. The Non Executives questioned if staff understood the changes of behaviour relating to rewards and sanctions which was new to the NHS but not within industry. Mrs. Goodby acknowledged that the process focused on behaviours and change and some staff groups would find it difficult, however during the training the rewards and sanctions element has been received positively.
Junior Doctors New Contract – It was reported the Trust is following the safe working process and under the new terms the Trust would be fined if in breach. Mr. Lewis assured the committee the Trust Guardian Zoe Huish who has overview of the first year and can impose fines if doctors safe working has been compromised reported that there have been no breaches and no fines levied.

6c. Quality & Safety Committee	**TABLED SWBTB (07/17) 006**

Ms Dutton reported on the following:

Perinatal Mortality. A discussion by the Committee on how to achieve assurance following the perinatal mortality cases recorded in Q4 of 2016/17, which has been reported to the CQC. An internal and external peer review will take place with a view to strengthen the governance of the process and ensure appropriate scoring is taking place. A report will be presented to the August meeting and due to timing may be tabled at the September Trust Board.
Serious Incidents in Trauma & Orthopaedics. Mr. Lewis and Dr. Stedman will lead on a T&O safety Summit to be held in July and report back to the Quality & Safety Committee in August.

ACTION:

- An assurance report on Perinatal mortality to be provided to the September Trust Board following its presentation to the Quality & Safety Committee

6d. Finance and Investment Committee	**TABLED SWBTB (07/17) 007**

Mr. Samuda reported on the following:

Q1 13 Week Plan. Remedial actions to be taken to improve the status key actions.
Agency Spend. It was stated this position was prior to the discharge of services of Thornbury and a more improved position was expected in next month's return.
Capital Spend. Currently this is behind plan but there was no cause for concern and the position would be rectified.

7. Chief Executive's Report	**SWBTB (07/17) 008**

Mr. Lewis highlighted the following matters from his report.

Fire Assessments. The annual cycle of assurance has been completed especially around cladding. Details of which have been published in the Heartbeat magazine. Congratulations was passed Mr. Kenny and his team in providing additional assurances as required by our regulators following the recent fire disaster.

DNACPR and DOLs. This item has been escalated by the Chair of the Quality & Safety Committee and will feature on the agenda today. The expectation is to get all DNACPR patients included on eBMS to have awareness of those patients at any time and have real time facts of who have had consenting conversations.

Casenote Scanning. Ms Barlow was thanked for the hours she and the team have spent in managing the position. It was noted the technology delivered, unfortunately the supply process failed. There has been reliance on providing paper records but by 17th July the aim is to be fully electronic. These issues should be resolved by next week and the implementation issues will be picked up by the post project review team and lessons learnt will be actioned into the EPR launch in the Autumn. The post project review will be overseen by the Major Projects Authority Committee.

Ms Barlow reported the Champions were extremely useful and would be used again when EPR goes live. Notwithstanding the issues most clinical activities had notes supplied which was due to the hard work that went on behind the scenes. There was a deficit of notes unavailable each day (today that is down to 47) but there were no

cancellations as patients were risk assessed and were seen without notes due to the extensive information contained on CDA. A meeting will be held next week with the Executive and the Provider to agree and conclude the difficulties.

STP. The next Trust Board will consider a final formal proposal in respect of the Black Country Pathology by the 4 organisations. This will have an impact on patient care, employment of staff and some joint service reallocation. It was reiterated the proposal did not affect the hot lab at Midland Met Hospital.

Heart of England Trust and University Hospitals Birmingham. The Trust will be contributing to the competition and markets authority investigation into the proposed acquisition of HEFT by UHB.

European Investment. The building of Midland Met Hospital has provided opportunities for the Trust to apply for grants to improve the community. The Trust are now the lead in matching job skills from migrants or refugee doctors and they assist by helping on language skills. There are currently 14 – 20 doctors in the programme and many of these doctors will go into General Practice. Mrs. Goodby informed the Trust Board that the money granted helped assisting refugee in converting home qualifications into UK qualifications and the Trust is committed to work with 20 people each year for 3 years. Prof Thomas informed the Trust Board she sits on a local facility board, GP organisations and stated medical students are keen to work with refugee doctors to help with language skills, Prof Thomas was advised to speak to Mrs. Goodby outside of this meeting. Cllr Zaffar commended the Trust for engaging in this positive work within the West Birmingham community.

Mr. Lewis continued to inform the Trust Board the workforce and finance plans were not definitively aligned at the moment but over the next few days he wished to be in a position to issue the plans to the full Trust board. The pay bill reduction target is £18m, £13m is in pay reduction of CIP, agency target is £10m. It was stated £7m has been identified but this will reduce the pay bill by £13-£14m at year end.

8. "13 Week Plans"	**SWBTB (06/17) 009**

Mr Lewis reported on the 5 areas the Trust Board choose to focus on at its April 2017 meeting in Q1 which represents a large proportion of the Trust's 2017/18 annual plan. There are:

- The Aspiring to Excellence has made considerable progress and is almost there with the exception of developing rewards which should be complete by September.
- Midland Met progress has some supply chain issues, but work on revising the timescales with Carillion is underway to ensure the delivery gets back on track.
- The Digital Plan has a high proportion of under or un-delivered items including work on casenote scanning, EPR, Winscribe and VOIP. Mr. Lewis informed the Trust Board that he will be chairing the Digital Committee to ensure emphasis and clarity is given to this area.
- Income and Expenditure. This reflects the financial results. The Private Trust Board will discuss today the delivery infrastructure.
- Safety Plan. This has made considerable progress.

Mr. Lewis invited the Trust Board to challenge what they would like to see at its next two meetings. Mr Kang asked following the Thornbury switch off have there been many escalated requests to use the organisation. Mr. Lewis stated 3 out of 4 requests have been turned down, but there was still further to go with thinking ahead, rostering and the Emergency Department. It became evident that the Trust requires access to local mental health services and would seek to find mental health agencies rather than use Thornbury, as an incident occurred where a mental health patient was occupying an acute bed for over 30 hours with 2 members of staff. Teams still required a clear definition of what circumstances would sanction the use of Thornbury, however this would not become a guide as how to obtain the use of Thornbury as each case would be dealt with independently. The Trust would also look at noting pin numbers of staff who cancelled a shift with less than 24hrs notice and a hit team was being assembled who could be deployed at short notice, this would ease the management of late notification to fill nursing shifts. It was confirmed no request would be turned down if it impacted on staff and patient safety, all requests that have been turned down had a satisfactory resolution found.

It was explained Winscribe was a dictation tool that produces letters electronically for posting and reduces the need for secretarial input. The area is currently 9 months behind but there is a robust solution in place which includes the processing of the back log of letters but there is focus to address this and complete. VOIP telephony is using the internet

to make telephone calls rather than a telephone provider. It was noted that more work is required to the network before deployment of these services can take place.

Mrs. Perry commented the finance plan consisted of a procurement plan tied in with the regional procurement strategy and when finalised could deliver savings. It was noted that meetings were in place next week to discuss areas of pay, non pay and procurement in hitting the CIP target set.

9. Business Continuity: Board review of operational plans	**SWBTB (07/17) 010**

Ms. Barlow reported the organisations business continuity management system included clinical and non clinical areas as part of the core standards assessment which would be reviewed by the Trust Board at a future meeting. The report shows good progress and increased expertise and skill in this area to support the Trust. The organisation has experienced activation of the plan and coped well, the next step is to ensure learning is disseminated and debriefs are working well and effective.

There will be planning work for Midland Met which will include obtaining assurances from our partnership suppliers which we rely upon. The non-executive directors were invited with their knowledge of the private sector to assist in the governance and were asked to contact Ms. Barlow outside of the meeting if they could help, however there were links with Regional forums to test our plans and Ms. Barlow stated any outstanding plans will be signed off by July. Mr. Hoare queried if the plans covered incidents such as those seen in Manchester and London. It was stated the business continuity plans were departmental planning and not plans for major incidents such as Manchester and London which were covered by the Emergency Planning Committee and involved national coordination. The business continuity plans under a major incident could expend the service of critical care and use trolley spaces in the BTC to increase beds. Mr. Samuda asked if the Trust had the right people trained and how this fed into the Trust's subcontractors. Ms. Barlow confirmed the Estates team are well trained and have their own on-call senior tier and when called upon they respond very well and could cope if the IT system went down as all engineering plans are backed up. There is also contact details of partnerships that is fully documented and tested as part of the assurance process.

Mr. Lewis commented that the communication system was absent and queried if all employees know they have an active role to play and if they did not know how would they find out. This would be crucial as the next big test for the organisation was EPR and assurances would be required before implementation. Ms. Barlow stated that the Groups needed to own and test their plans but this would be tested through mock inspections and unannounced tests/visits. There would also be discussions on branding and visibility to ensure the message is communicated well.

Ms. Barlow informed the Trust Board that a complete plan of total loss of site was required as only the partial loss plan was complete. The total loss of site was a gap that is recognised and help would be required from external sources and progress would be followed up at a future meeting. It was also stated that there was no completed documentation on partnership assurance and a mechanism would be set up to scope which areas are critical. Mr. Lewis reported the Audit Committee has looked at key dependences in Q3 and were satisfied with where we are, but the emphases is on ensuring the business continuity plans were localised for areas of the organisation and staff were engaged with it.

It was agreed the completed core standard assessment would probably be reported to the next Trust Board and this item would be placed on the agenda in September and October including the audit key risks.

ACTION:

- The completed core standard assessment to be presented to the August Trust Board
- Update on business continuity at the September/October Trust Board including the audit key risks

10. Trust Risk Register	**SWBTB (07/17) 011**

Ms Dhami reported no new risks have been escalated to the Trust Board from the Risk Management Committee or the Clinical Leadership Executive. The 19 risks on the TRR will be reviewed and an update will be provided to the next meeting. A review has taken place of high impact but low likelihood risks and there are 186 risks across the organisation which were risk rated less than 15 but scored 5 catastrophic. There were a number of duplicates, some have been resolved and others that were issues not risks. A high proportion of these risks were in Estates and Mr. Kenny has agreed to recalibrate these by August 2017. A review also looked at high impact risk scoring equal to or greater than 15, again

some were duplicates. The Groups are now charged with reviewing these with a view to including on the TRR once escalated from the Clinical Leadership Executive.

Ms Dhami also informed the Trust Board that a risk assessment on results acknowledgements is being produced following this being a contributory factor in a few serious incidents. This will be presented to the Risk Management Committee by Dr. Stedman.

Prof Thomas queried if some risks included on the register were inappropriately included by staff. Ms. Dhami confirmed that all staff can report a risk but though a governance chain it is decided if it is a risk. The result of the report is shared with the member staff who raised the risk. There is also work being done in areas who highlight no risks to provide reassurance.

11. DNACPR and DoLS	**SWBTB (07/17) 012**

Dr. Stedman reported to the Trust Board that following audit findings inappropriate recordings of DNACPR discussions with patients and families existed. The current system is paper driven and full assurance could not be sought from clinical teams. The Quality and Safety Committee have discussed this situation and to improve the system the process would move from paper to electronic via the electronic bed management system (eBMS). DOLS recordings were also poor and inadequate. There is no prompt for DNACPR but this should be discussed at the ward round. It was noted the prompt for DOLS was via the safety plan.

Dr. Stedman informed the Trust Board the default position was to resuscitate and the doctor would have up to 24 hours to validate any DNACPR instruction with the patient, or the family in the absence of capacity. There has been no breaches on that standard by the Trust but a flag system would be implemented as a prompt including education plans for staff and changes will be made to the process.

Ms. Newell noted that DOLS was part of the safety plan and DOLS assessments was also paper driven but focus is on key areas where DOLS patients have been identified i.e. stroke wards, medically fit for discharge and targeted work is progressing. This work is commencing next week and will continue over 4 weeks, this will include a stop point in each day where the DOLS assessment question will be asked.

Mr. Lewis stated training was not enough as only 14 DOLS assessments was undertaken in May, but the baseline should be 5/6 times more. The coroners have reflected upon the lack of DOLS assessments in reports and a response would need to be made which set out a clear timeframe for improvement.

Dr. Stedman noted the Cambridge ruling did not impact upon the Trust, but improvements were required. Therefore, it was agreed the October Trust board would receive an updated audit data on the flag status and training for doctors.

12. 2016/17 Never Events actions: status	**SWBTB (07/17) 013**

Ms Dhami reported on the request from the June Trust Board to review the status of actions identified from the 4 never events in 2016/17. 22 actions have been identified, 18 have been implemented and 4 have not been implemented. Each learning point action is signed off to prevent reoccurrence.

The never events reported on were as follows:

1 – Maternity Department, Retained item. All actions have been completed including the use of a fluorescent wristband as a visual alert to ensure all packs are removed when relevant.

2 – Trauma & Orthopaedic Theatres, Retained item. The surgical pause has been implemented and audit evidenced to show compliance. The action of recording the drill guide on the whiteboard was agreed by the Theatre Management Group and Group Director has not a feasible action. Mr. Lewis challenged the removal of an action without consultation by him has all actions are signed off by Mr Lewis in his capacity as Chief Executive and therefore any changes would need to be authorised by him, which has not been done.

3 – Ophthalmology – Wrong site surgery. 3 actions from this Never Event have been implemented. The action whereby patients undergoing an invasive procedure in outpatients are issued with a patient identification wristband at clinic registration was decided that this extra step could lead to confusion and increased risk therefore positive patient identification would be used by the same clinician, therefore this action would be removed. Video-reflexivity would commence in Q3 and the action of the electronic self-check in system recognising two patients with the same surname attending outpatients for the same session and create an alert was assessed and it is not possible. Mr. Lewis commented the actions listed where not definite plans and there are some governance failures which would need to be addressed. Staff should be able to positively identify a patient and if they were unable they would need to be trained or moved from that area.

4 – Gynaecology, Retained item. All actions have been implemented. Prof Thomas noted the length of time to monitor the new procedure was almost 6 months before it would commence following the incident in January. Ms. Dhami would request the monitoring to commence sooner.

The Non executives queried were there learning opportunities from other Trusts in sharing who have no Never Events, as staff need an environment to speak out without the fear of disciplinary action unless an error occurred through negligence. Ms. Dhami confirmed that meetings with Ms Newell have taken place with governance leads from NHSI and NHSE to review systems.

The Trust Board discussed how having two members of staff checking patients for identification and site location minimised the risk of error and should be achieved in all cases. The bar has been set high and any risks of human error needed to be eliminated. Mr. Lewis stated appointing single people to undertake some processes exposes them to risk therefore having two minimised and removed the risk. If a staff member finds themselves alone to do a procedure they should not continue and wait as to proceed would then become a blame worthy act, this approach is already actioned in many areas of the trust i.e., Undertaking drug calculations etc. It was discussed that any errors by staff would not lead to a sanction but training and communication to learn from mistakes would happen as to have a blame culture would create an environment for cover ups.

Mr. Lewis clarified a distinction needed to be made from someone acting within their competences and acting to our policy, however if a member of staff proceeds to act outside of these, the responsibility is with them not the employer, especially as staff are undertaking core business tasks that they do daily in their work environment. Mr. Tyagi commented that the staff involved are personally devastated about the Never Event and want to work to ensure errors of this type are not repeated in other areas of the Trust.

Mr. Lewis informed the Trust Board that he would look at the governance of Never Events through the Safety QOHD meeting to seek assurance that the governance committee are fulfilling its brief and report back to a future meeting.

ACTION:

- Chief Executive to provide assurance on the governance of Never Events in following up on actions.

13. Never Events actions: status	**SWBTB (07/17) 013**

Dr Stedman reported on the 13th June 2017 a patient was undergoing a course of laser eye treatment on both eyes. The intention was for each eye to be treated separately on more than one occasion. The patient's left eye was booked for treatment but the right eye was treated upon. An immediate investigation took place and a series of actions drawn up. There was no harm to the patient's eye and they presented a few days later for the left eye to be treated. It was noted a similar incident happened in 2013 and those actions have been compared to the actions from this recent incident.

Mr. Tyagi informed the Trust Board that it is common practice to obtain patient consent on the same day for treatment of both eyes even though they will be treated on at different times. The doctors work in silo in the laser clinic and appropriate patient identification checks were carried out but the doctor continued to treat the left eye instead of the right. A planned learning event and the QHID next week will discuss and ask if it is safe for a single person to be carrying out treatments in this way or to have another person in clinic. It was stated the WHO checklist does not apply in this instance as the work is done by a solo staff member.

The non executives challenged the working practices in BMEC enquiring if staff were too busy to carry out thorough identification checks or were staff just too busy with the high volume of patients awaiting treatments. Mr. Tyagi

confirmed that BMEC was a busy place but the ratio of doctors/nurses to patients was good, the environment where patients collect is used by different specialities namely; laser clinics, injection clinics and A&E so the impression looks like a very busy area. It was recommended the consent process should change so two consent forms one for each eye is stored rather than have one form.

Mr. Lewis requested the following immediate action to be implemented:

- Provide a nurse to clinics to stop doctors working in isolation
- 2nd person to assist with checking of patient identification and treatment location
- Have separate consent forms

Mr. Samuda requested an update to the next Trust Board

ACTION:

- An update to be provided to the next Trust Board committee on the recommendations by the Chief Executive.

14. Consistency of Care Programme: progress report	**SWBTB (07/17) 015**

Miss Dhami informed the Trust Board the Consistency of Care Programme was launched in March and there have been weekly executive meetings to keep the programme on track. All 19 medical locations including wards, assessment units and EDs have been actively involved and are at different stages of development. A 2nd LIA event is taking place on 24th July, 12 weeks after the launch where all teams who are multi professional will come back to report on progress. All the work undertaken is linked to the safety plan and the red to green work.

The leadership on wards has improved by clarifying the roles of ward managers and appointing a named ward consultant. The Ward QIHD has provided opportunity for staff to talk and wards have a 'buddy' who provides guidance, coaching and constructive challenge. It was stated there were issues in documentation completeness and timeliness following an audit where no one achieved 100% but some were close, by the 24th July a prototype and documentation would be available to achieve this.

The Trust Board briefly discussed the improvements and acknowledged how the patient journey from assessment unit to ward and having a discharge date within the documentation would make a big difference to the CQC. The improvement in the wards to delivery would be a positive story and by the end of Q2 the majority of wards would have signed off plans. It was acknowledged that Mr. Chetan Varma, Group Director has met with all the named consultants so they understood the expectation and the junior doctors are also aware and do have a voice as part of the clinical ward team.

Mr. Lewis stated the 2 A&E departments were included but the wards were the focus for the CQC, a further discussion on the A&E departments would be held at a future time.

15. Safety Plan: progress report	**SWBTB (07/17) 016**

Ms Newell reported the safety plan is monitored at weekly PMOs and includes 41 wards including medicine who have detailed plans in place. An analysis of data took place at the end of May/June where 63500 compliance checks were done and 3000 failed, which is a compliance rate of 97% this is not acceptable but currently daily reports which are shared with the ward manager shows approximately 11 wards are achieving 100%. If a ward drops below 90% a root cause analysis is triggered. The Quality and Safety Committee is regularly briefed and provide oversight and are reassured that things are on track.

Ms. Newell responded on how to get the outstanding 2% fixed, as part of the work on consistency in care which included DOLS and VTEs assessments where there is a requirement for these to be cleared within 48 hours of a patient being admitted.

ACTION:

- Outcome data to be provided for the next Trust Board if available.

16. Annual Report on the Implementation of Medical Appraisal	**SWBTB (07/17) 017**

Dr. Stedman provided the annual report for information. Over 400 doctors require a medical appraisal who are employees of the Trust. There are 25 doctors who have failed to have an appraisal and they are being actively managed via the HR process. These doctors have semi-permanent contracts and non training grades. The medical appraisal is a GMC requirement which is not performance related and it was agreed to have performance appraisals kept separate for doctors. It was stated only doctors employed by the Trust were required to have a medical appraisal, locums fell outside this area and Dr. Stedman was addressing this area. It was agreed for the People and OD Committee to have oversight and oversee the revalidation of nurses and doctors and to monitor the overdue appraisals and Dr Stedman to discuss with the Chair of that Committee, Mr. Kang outside of this meeting.	
17. Patient Stories to the Board – wider learning	**SWBTB (07/17) 018**
Mrs Newell reported that there has been limited sharing of the patients' stories within the organisation. An action has been agreed that Groups will now identify patients for stories and learning will be disseminated to a wider audience including hot topics, QIHDs and a repository will be available for staff. An annual report will be provided to Trust Board. The Trust Board approved the suggested plan.	
18. Production Plan: June position	**SWBTB (07/17) 019**
Ms. Barlow reported a forecast deficit in June Q1 of £200k. The main areas that led to the deficit in June came from a slippage in Ophthalmology outpatients due to a fall in bookings and DNAs. A review of the governance is being undertaken to understand the reasons. The activity and finances in T&O has been rephrased for the year due to the unavailability of a locum, however the demand changes were small but required replacing with other alternative. In Q2 there is a change in service where patients requiring breast reconstruction will be supported by another Trust, this amount to approximately £180k lost income, but once the post is recruited to this will be re-profiled. Ms. Barlow reassured the Trust Board that annual leave arrangements were in place in General Surgery and in Medicine which has improved. The exception is Trauma & Orthopaedic where theatre case activity has been lost with people being on leave, this is the biggest risk but the recovery is planned and reporting is through the PMO. There is also intensive support and director control of the speciality including the under booking of theatres. The under-utilisation of theatres would be looked at as the theatres needed to be more productive and not lose activity. It was stated £10.2m was from revenue which was a good result and Ms. Barlow confirmed this could be repeated and the signs were good for the year ahead. The loss of business even though financially small in areas were mostly due to change in process not market loss. The Trust Board discussed some of the services which were posting deficits to understand the process changes to that speciality.	
19. Integrated Performance Report	**SWBTB (07/17) 020**
Mr. Waite drew the Trust Board's attention to the positives for May namely, RTT, 62 day cancer and acute diagnostic waiting times. The areas of concern highlighted were Never Events, Hip Fracture and the Mortality reviews which has shown a small improvement. The executive team have focused on the KPIs of the persistent underperforming areas and that report will be provided to the Quality & Safety Committee. The following was highlighted: • <u>ED 4 hour</u>, This target needed focusing to become complaint as there is financial lost if sustainability is not managed. An escalation meeting is to be held with Mr. Lewis and Mr. Andy Williams the ACO at the CCG to review the plan. The step up in June to 87% in BMEC accounted for 2% of the loss. A focus on leadership which was removed has been reinstated especially in out of hours with coaching and informing on the key measures of success, this focus has increased performance this week.	

- Cancelled operations. There is a high level of cancellation which is impacting on patient experience and the Trust contractual obligations.
- Neutropenic sepsis. The improvement from 80 to 92% is proving difficult, however progress is being made with individual reports of missed patients going to Dr. Stedman.
- Recruitment. It was reported more needs to be done to retain staff and Ms. Newell will be focusing on nursing and the rotas. The coaching of departmental leaders will be reviewed which could include executive directors becoming mentors and there will be support for teams on assessing performance and attention of individual leaders as it is vital the right staff are based in the demanding environment of MMH.

20. Finance Report: PO2 May	**SWBTB (07/17) 021**

Mr. Waite confirmed the PO2 report was highlighted within the Update of the Finance & Investment Committee meeting held on 30th June 2017.

21. Application of the Trust Seal	**SWBTB (07/17) 022**

The Trust Board was asked to approve the affixation of the Trust Sale to a number of engrossment leases for, Glebefields HC, Whiteheath HC, Oldbury HC and Yee Tree Healthy Living Centre.

The Trust Board approved the application of the Trust seal.

AGREEMENT:

- The use of the Trust seal was agreed for the documentation regarding the engrossment of leases for the health centres named in the document.

22. Minutes of the previous meeting and action log – 1st June 2017	**SWBTB (06/17) 023** **SWBTB (07/17) 024**

The minutes of the 1st June 2017 were agreed as an accurate record of the meeting.

Action Log

1st June 2017
20 – Diversity Pledges – this can be closed as feedback has been given

4th May 2017
10 – Learning Disabilities. Ms Newell reported an advert is currently progressing
16 – A&E Scorecard – Ms Barlow will be updating the Trust Board at its next meeting

6th April 2017
11 – Ophthalmology Outpatients (Children's) – Dr. Stedman noted the risk was regarding anaesthetising children, it was a quality and safety issue which involves local organisations, work is still progressing.

23. Matters arising	**Verbal**

There were no matters arising.

24. Any other business	**Verbal**

There were no items of any other business.

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

The next public Trust Board will be held on 3rd August 2017 starting at 09.30am in Training Room 2, Archer Ward, Rowley Regis Hospital

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Public Trust Board

Action Log following meeting held on 6th July 2017

	Action	Assigned to	Due Date	Status
1)	Patient Story: Interpreting – follow up on actions and the service as noted in the Trust Board including the use of translation ear pieces, a cohort of staff who can be called upon to assist in translating and obtaining intel on the model used by Birmingham Community Trusts	Elaine Newell	September 2017	Open
2)	STP Governance. A note on the impact of the residents in West Birmingham	Toby Lewis	August 2017	Closed In the August CEO report
3)	An assurance report on Perinatal Mortality to be provided to the September Trust Board following its presentation to the Quality & Safety Committee	Elaine Newell	September 2017	Open
4)	Business continuity: the completed core standard assessment to be presented to the August Trust Board	Rachel Barlow	August 2017	Closed On the August agenda
5)	Business continuity: update including the audit key risks	Rachel Barlow	September 2017	Open
6)	2016/17 Never Events Actions: The Chief Executive to provide assurance on the governance of Never Events in following up on actions	Toby Lewis	August 2017	Closed In the August CEO report
7)	Safety Plan outcome data to be provided to the Trust Board.	Elaine Newell	September 2017	Open
8)	DOLS and DNA CPR consequences to be considered for individuals not compliant with the policy	Toby Lewis	August 2017	Closed In the August CEO report

	Action	Assigned to	Due Date	Status
9)	Integrated Performance Review: An update to be provided on cancelled operations within ophthalmology	Rachel Barlow	July 2017	Open
10)	Diversity Pledges: An action to be presented to the Board on staff and patient pledges	Raffaela Goodby	August 2017	Closed On the agenda
11)	Learning Disabilities – update the July meeting on the advisory service with the Black Country Partnership	Toby Lewis	July 2017	Open
12)	A&E scorecard to be available at the next meeting	Rachel Barlow	August 2017	Closed On the agenda
13)	Risk assessment of imaging and pathology results reporting and acknowledging electronically by clinicians to be sent to CLE and presented to Trust Board in April if required.	Roger Stedman	August 2017	Closed In the August TRR
14)	Smoking cessation: matter to be resolved and reported to Trust Board.	Toby Lewis	Monthly verbal progress report until resolved	Open Verbal CEO update